NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

ninth crm

common review mission

Report | 2015

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Abbreviations

AGCA	Advisory Group on Community Action
AMTSL	Active Management of Third Stage of Labour
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ANMTC	Auxiliary Nurse Midwife Training Centre
APHC	Additional Primary Health Centre
API	Annual Parasite Index
ARC	ASHA Resource Centre
ART	Anti retroviral Treatment
ASHA	Accredited Social Health Activist
AWC	Anganwadi Centre
AWW	Anganwadi Worker
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric & Neonatal Care
BMO	Block Medical Officer
BMWM	Bio-Medical Waste Management
BPHC	Block PHC
BPM	Block Programme Manager
BPMU	Block Programme Management Unit
BPL	Below Poverty Line
CBOs	Community Based Organizations
CEmONC	Comprehensive Emergency Obstetric & Neonatal Care
CHC	Community Health Centre
CMO	Chief Medical Officer
CMOH	Chief Medical Officer Health
CRM	Common Review Mission
CT Scan	Computed Tomography Scan
DH	District Hospital
DHAP	District Health Action Plan
DLHS	District Level Household Survey
DOTS	Direct Observation Therapy - Short-course
DPM	District Programme Manager
DPMU	District Programme Manager Unit
DTC	District Training Centre
DWCD	Department Women & Child Development
EDL	Essential Drug List
EmONC	Emergency Obstetric & Neonatal Care
EMRI	Emergency Management and Research Institute
FMG	Financial Management Group
FP	Family Planning
FRU	First Referral Unit
GNM	General Nursing Midwife
HMIS	Health Management Information System
HMRI	Health Management & Research Institute
HR	Human Resource
HRD	Human Resource Development
HRIS	Human Resource Information System
HSC	Health Sub-centre
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
IDSP	Integrated Disease Surveillance Project
IEC	Information Education Communication
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPD	In Patient Department
IPHS	Indian Public Health Standards
ISO	International Organization for Standardization
IUCD	Intra-uterine Contraceptive Device
JE	Japanese Encephalitis

JPHN	Junior Public Health Nurse
JSSK	Janani Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LLIN	Long Lasting Insecticide Treated Nets
LR	Labour Room
LSAS	Life Saving Anaesthesia Skills
LT	Laboratory Technician
MB	Multi-bacillary cases
MCTS	Mother and Child Tracking System
MDR	Multi-drug Resistant (TB)
MIS	Management Information System
MHW	Male Health Worker
MMR	Maternal Mortality Ratio
MMU	Mobile Medical Unit
MO	Medical Officer
MoHFW	Ministry of Health & Family Welfare
MOIC	Medical Officer In-charge
MoU	Memorandum of Understanding
MPW	Multi-purpose Worker
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHSRC	National Health Systems Resource Centre
NICU	Neonatal Intensive Care Unit
NIHFW	National Institute of Health & Family Welfare
NIPI	Norway India Partnership Initiative
NPCB	National Programme for Control of Blindness
NLEP	National Leprosy Eradication Programme
NRC	Nutritional Rehabilitation Centre
NRHM	National Rural Health Mission
NSSK	Navjat Shishu Suraksha Karyakram
NSV	Non-scalpel Vasectomy
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OPD	Out Patient Department
PCPNDT	Pre-Conception and Pre Natal Diagnostic Techniques (Prohibition of Sex-selection) Act - 1994
PHC	Primary Health Centre
PHN	Public Health Nurse
PIP	Programme Implementation Plan
PMU	Programme Management Unit
PPP	Public Private Partnership
PRI	Panchayati Raj Institutions
PWD	Public Works Department
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RHFWTC	Regional Health & Family Welfare Training Centre
RHP	Rural Health Practitioner
RKS	Rogi Kalyan Samiti
RMP	Rural Medical Practioner
RMSCL	Rajasthan Medical Services Corporation Limited
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojana
SBA	Skilled Birth Attendant
SDH	Sub Divisional Hospital
SHC	Sub Health Centre
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SIMS	Softline Intelligent Micro Systems
SNCU	Special Newborn Care Unit
SPMU	State Programme Management Unit
STG	Standard Treatment Guideline
TB	Tuberculosis
TNMSC	Tamil Nadu Medical Services Corporation Limited
VHND	Village Health and Nutrition Day
VHSNC	Village Health and Sanitation and Nutrition Committee

EXECUTIVE SUMMARY

BACKGROUND

The growth of National Rural Health Mission now subsumed as part of National Health Mission (NHM) over a period of last 10 years has also been marked by shifting focus of programme implementation and expanded scope of service programmes run by the Mission. These changes must be captured for in-depth reviews and mid-course corrections. Annual Common Review Mission (CRM) has been one of the important monitoring mechanisms under NHM and so far nine Common Review Missions (2007-2015) have been undertaken. The Ninth Common Review Mission was held from 30th October to 6th November 2015. The mission was carried out in 18 States.(Andhra Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Haryana, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Odisha, Punjab, Rajasthan, Uttar Pradesh, Uttarakhand and West Bengal). The Terms of Reference (TOR) for 9th CRM were developed by the MoHFW involving different stakeholders and technical experts from the programme divisions and covered various dimensions of NHM ranging from service delivery to governance issues. The TORs however, focused on implementation status of new initiatives and guidelines issued by MoHFW in terms of Kayakalp for Public Health Facilities, Rogi Kalyan Samiti (RKS), National Urban Health Mission (NUHM), Free Drugs and Diagnostics initiatives, Performance Enhancement of Multipurpose Workers (F), Rashtriya Kishore Swasthya Karyakram (RKSK) and Non Communicable Diseases (NCD) programmes. The broad objective of each TOR has been to understand and assess the process, outcome and impact of relevant interventions being carried under NHM.

The members of the Mission included senior officials of MoHFW, Public Health experts from Civil Societies and Academic Institutes, Development Partners and officials from related development sectors of the government like Social Welfare, Women and Child Development, Water and Sanitation department etc. The team members were thoroughly briefed on the objectives and methodology of conducting CRM by the senior officials and technical experts from MoHFW and divided into different state –teams to be led by a senior officer of MoHFW to carry out study visits to the allotted states.

The report is based on the findings of different state teams enriched by the observations and suggestions made by the representatives of the state governments and development partners during the course of discussion and presentations of the report in different states visited by CRM teams.

KEY FINDINGS

TOR 1: Service Delivery: Reaching the Unreached

Key objectives of the TOR were to review the adequacy of health infrastructure, its utilization and status of health system strengthening, with a focus on, drugs, diagnostics, biomedical equipment, AYUSH services and Public Private Partnerships.

- Considerable progress has been made in ensuring physical access to health care institutions during the NHM period. This is reflected in an increase of about 5.2% in Sub Health Centers (SHC), 8.9% in Primary Health Centre (PHCs) and 61.3% in Community Health Centre (CHCs) as compared to 2005.However, shortfalls are still reported from Andhra Pradesh, Rajasthan, Karnataka, Jharkhand, Maharashtra and West-Bengal (CHCs and PHCs) as well as from Himachal Pradesh, Chhattisgarh,

Haryana and Karnataka (Sub- health centres). Irrespective of shortfalls in infrastructure, almost all States except Manipur report an increase in utilization of OPD and IPD services

- All states report progress towards free drugs initiative. Better access to drugs is notable in the States of Rajasthan, West Bengal, Uttar Pradesh, and Madhya Pradesh. Interactions with beneficiaries in these states indicate that Out of Pocket Expenditure (OOPE) on account of drugs has reduced. West Bengal and Karnataka have established generic drugs stores/ fair price shops to meet demands of medicines. All states report free diagnostics under JSSK. On the other hand, Himachal Pradesh, Haryana, Uttarakhand and the NE states of Meghalaya and Manipur have reported high OOPE on drugs. Himachal Pradesh has reported high out of pocket expenditure on diagnostics too.
- There is wide variation in number of medicines that are part of Essential Drugs List ranging from 142 (West Bengal) to 766 (Chhattisgarh. Except Chhattisgarh none of the states have so far initiated or institutionalized prescription audits and Standard Treatment Guidelines are also not adhered to in most states.
- Procurement of drugs is being carried out through special agencies/ dedicated corporations in all States except Assam and Meghalaya. However, efficiency of these corporations/ societies varies from state to state.
- A considerable number of Blood Banks, like in Manipur, Meghalaya and Uttarakhand are operating only during the normal OPD hours. Himachal Pradesh is in process of establishing the Blood Bank Management Information System, which is functional in Punjab. It is a good initiative to make the details of available blood group stocks known to general public besides maintaining a database of voluntary blood donors.
- In almost all States visited, there was no institutionalized mechanism to track non-functional equipment and repair it within a specified timeline. Some of the states like Delhi, Himachal Pradesh, Uttarakhand, and Jharkhand have initiated the process of equipment mapping. Rajasthan's equipment management software e-Upkaran has set a good example for other states to follow.
- AYUSH services appear to do well in States where they are managed by separate Directorates rather than by State Health Society. Availability of AYUSH medicines and supplies is one area which has shown little progress over a period of time when compared with the reports of previous review missions. In some instances medicines and supplies have not been made available since last few years (Haryana, Uttar Pradesh, Jharkhand, Rajasthan, and Madhya Pradesh).
- All states report presence of 108, 102 or state ambulances. Uttarakhand, Uttar Pradesh, and Chhattisgarh report satisfactory deployment and performance of ambulance services. While Chhattisgarh, Haryana, Uttarakhand and Himachal Pradesh report fitting of their ambulances with GPS, some states (like Delhi and Jharkhand) have reported presence of non-GPS ambulances. MMUs are reported to be performing well in Maharashtra, Punjab, and Jharkhand.
- Almost all states except Delhi and Manipur, have already explored or are in process of exploring PPPs for provision of diagnostic services. Meghalaya and Odisha are involved in PPP arrangements to manage the health care services at primary care

level. However, mechanisms to monitor work outputs, adherence to agreed upon TORs and impact of services provided have not been institutionalized.

TOR 2- Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCH+A)

The key objectives under this TOR have been to assess the planning and implementation of RMNCH+A services based on gap analysis and prioritization for ensuring continuum of care. Efforts to achieve reduction of maternal and child morbidities and mortalities and achieve optimal levels of maternal, child and adolescent health by utilization of services delivered through existing programmes have also been areas of focal attention in this regard.

- Consistent efforts made over a period of time to improve implementation of RMNCH+A strategy show positive trends as evidenced by improved programme outcome indicators and reduced levels of Infant, Under 5 and Maternal Mortality in different parts of the country. Total Fertility Rate has reached its replacement level (2.1) in many States like Andhra Pradesh, Himachal Pradesh and Karnataka. However these achievements mask the considerable intrastate and interstate variations, which exist in the country e.g. Infant Mortality Rate is 40 at the national level but ranges from 9 in Goa to 54 in Madhya Pradesh and Assam (SRS 2013).
- In many states, the framework for gap analysis followed in non-HPDs differed from the one followed for HPDs, resulting in incomplete situational analysis and affecting subsequent development of effective health plans at different levels.
- Irrational deployment of human resources has led to under utilisation of available staff in many states. For example, injudicious placement of counsellors and lab technicians in L2/L3 facilities is seen in states like Manipur, Meghalaya, Himachal Pradesh and West Bengal.
- Recently introduced programme intervention guidelines (related to calcium supplementation, gestational diabetes mellitus, hypothyroidism, screening for syphilis and HIV, preterm antenatal corticosteroids for preterm labour) were not being implemented as norms in many States (like Andhra Pradesh, Karnataka, Uttar Pradesh, Punjab, Jharkhand, Meghalaya and Manipur).
- There has been persistent increase in Antenatal coverage across the states. However, poor supply management of diagnostic services for antenatal care has been a constraint faced by many states (Delhi, Manipur, Karnataka, Meghalaya) resulting in high out of pocket expenditure .
- Lack of Blood Storage Units (BSU) and/or Blood Banks (BB) in facilities below district level stands in way of operationalising FRUs in States like Rajasthan, Manipur, Meghalaya, Himachal Pradesh, Jharkhand, Chhattisgarh, and Madhya Pradesh. High caesarean section (CS) rates at District and tertiary care facilities, is an area of grave concern. This is on account of ill equipped and poorly functional FRUs at sub district levels resulting in large number of avoidable referrals to higher level of health facilities.
- Essential drugs (like Labetalol, Tetanus Toxoid, Methergine and Magnesium Sulphate) were available in sufficient quantities in most states except Delhi (RTI/ STI drugs at many facilities), Assam, Jharkhand and Manipur. However, in Rajasthan,

there were problems related to procurement of specific drugs such as Misoprostol, Mag. Sulphate and drug supply management in the two Districts visited. The State of Rajasthan otherwise has a good drug procurement and supply chain management system.

- Standard Operating Procedures (SOP) as per Maternal Newborn Health (MNH) tool kit were not being fully adhered to and training and orientation of workers in this context need to be completed.
- Referral linkages from community and follow up of newborns discharged from SNCU need strengthening in most states.
- JSY implementation has been fairly good throughout the country and beneficiaries reported receiving timely payments under the scheme through DBT in most states. However, cases of non payment of incentives were also reported from Haryana, Odisha, Assam, and Maharashtra as beneficiaries involved did not have a bank account.
- It is encouraging to note increasing utilization of free entitlements under JSSK in almost all the states. However, Himachal Pradesh, Odisha, Assam, Maharashtra, Jharkhand have so far not been able to provide adequate coverage to antenatal mothers in terms of free diagnostics and drop back home services.
- A dedicated grievance redressal mechanism under JSSK has not been set up in most of the states. Madhya Pradesh, Rajasthan, Assam, and Andhra Pradesh have taken initiatives to establish dedicated help lines to provide grievance redressal mechanisms.
- Maternal Death Reviews (MDR) have been initiated in almost all states but leave much to be desired in terms of quality, scope, documentation and follow up action plan to prevent recurrences. Child Death Reviews (CDR) is yet to gain momentum in most states. Maharashtra is the only state which has reported well established CDR mechanism.
- Routine immunization services, including cold chain maintenance and vaccine logistics systems are improving in all states, but need strengthening in Jharkhand, Uttar Pradesh, Meghalaya, Manipur, Andhra Pradesh and Chattisgarh. Under utilization of work plans generated by MCTS and non-availability of due lists seem to be persistent problems in this regard.
- Focus on malnutrition has resulted in better uptake of NRC/MTC services at higher levels in all states. However, Meghalaya, Manipur, West Bengal, Assam, Odisha, Uttar Pradesh, Chhattisgarh and Jharkhand reported low cure rates and poor referral of malnourished cases from community.
- Majority of the States have rolled-out PPIUCD service; but progress is slow in states likes like Himachal Pradesh, Jharkhand, Karnataka, Rajasthan and Uttar Pradesh. These states lag behind in terms of achievement and incentive disbursement.
- Fixed Day Service for sterilization is mostly available at District hospitals and or a few CHCs in States of Himachal Pradesh, Madhya Pradesh & Odisha. In Uttarakhand, sterilization services are mainly provided through camp approach.
- Observations from most of the states show that NSV rate is very low with a declining trend. Male participation in family planning remains a challenge.

- RBSK, though in nascent stages, is fast picking up, with mobile teams and DEIC in place in most of the States. In Andhra Pradesh, RBSK runs as Chinnari Aarogyam. Screening and follow-up mechanisms under the programme are well laid out and effectively implemented in Haryana.
- There has been sub-optimal utilization of Adolescent Friendly Health Clinics (AFHCs) in many states .This is also associated with poor supplies of essential commodities to these clinics specially in Andhra Pradesh, Uttarakhand, West Bengal , Maharashtra and Odisha.

TOR 3: Disease Control Programmes

TOR related to disease control programme is primarily aimed at providing an overview of the implementation of different communicable and non-communicable disease control programmes in terms of disease prevalence, illness management, status of NCD clinics etc. It also assessed the status of integration of disease control programmes with RMNCH+A including adherence to treatment protocol and referral mechanism.

- Despite the increasing burden of non-communicable diseases (60% of total disease burden), communicable diseases continue to be a major public health challenge where we need to sustain high levels of disease control coverage to prevent re-emergence of the problem and adopt innovative approaches to cover difficult to reach population.
- Malaria has shown declining trend in Himachal Pradesh, Chhattisgarh, Punjab, Rajasthan, Jharkhand, Maharashtra and Karnataka while an increasing trend observed in Odisha, which is traditionally a high Malaria burden state. Quality of surveillance activities and issues related to supply of long lasting insecticides treated nets may have been probable contributory factors. Low Annual Blood Examination Rate (ABER) in Category-III (intensified control phase) states like Jharkhand and Meghalaya is also a cause of concern.
- Dengue Fever (DF) cases increased in Punjab, Rajasthan, Andhra Pradesh, Karnataka, West Bengal, and Himachal Pradesh. However, a declining trend in DF reported from Odisha and Maharashtra, which reported highest number of DF cases and deaths in 2013. This may indicate an effective management of water storage practices that halted proliferation of mosquito breeding sites.
- More than 85% of the total number of AES/JE cases and deaths reported from – Assam, Bihar, TN, UP and West Bengal. Two dose of JE vaccine (first at the age of 9 months and second at the age of 16-24 months) have been integrated with Routine Immunisation in endemic states like Uttar Pradesh, West Bengal, and Assam.
- Programmatic Management of Drug Resistance Tuberculosis and Paediatric TB was observed as per guidelines in many states. However, in Rajasthan, delay in identification and testing of suspected MDR TB was reported. Maharashtra reported maximum load of DR-TB (4,738) followed by UP (2,976) in 2015. In Delhi, diabetic screening for all TB cases has been initiated. However, it was observed that many health facilities find it difficult to enter data in NIKSHAY system due to inadequate IT infrastructure like desktops and internet connectivity, in addition to intermittent electricity supply in these areas.
- NCD cells and NCD clinics were not in place in Manipur, West Bengal and Delhi. Similarly, cardiac care units and cancer care facilities were not established in district

hospitals due to various administrative and technical reasons. The state of Punjab has started Mukh Mantri Punjab Cancer Rahat Kosh Scheme to support treatment of cancer patients. The State has also initiated screening and education programme for cancer is setting up cancer registry in collaboration with academic institutions.

TOR 4: Human Resources for Health

The objective of this TOR is to review the adequacy of the present HR and their rational deployment given the present requirements as well as the challenges faced in trying to address these gaps. Apart from this the TOR also scrutinises the capacity of the training institutions, if any, and the methods adopted for skill up gradation of HR as well as their assessment.

- Recruitment processes have been streamlined with the constitution of specially empowered recruitment boards in Assam, Haryana, West Bengal and Maharashtra and the introduction of recruitment counseling in Odisha. These measures have helped fast-track recruitment and increased availability of HR in these states.
- States are still struggling with shortage of HR, especially specialists, in Andhra Pradesh, Chhattisgarh, Delhi, Haryana, Jharkhand, Madhya Pradesh, Rajasthan, Uttarakhand and West Bengal. While some states have attempted to address these HR gaps through the deployment of additional contractual staff, others like Uttar Pradesh and Karnataka report non-availability of adequate health professionals who can be employed even on contractual basis.
- Skill based competency tests have been successfully introduced for skill assessment and during recruitment of skilled care providers. Haryana, Odisha and Rajasthan have been using competency assessment for training needs assessment whereas states like Chhattisgarh have incorporated skill based competency tests for NHM workforce recruitments.
- Measures to improve retention such as hard areas allowances, relaxations for PG admission, performance based incentives and rural service linked promotions have been adopted in Madhya Pradesh, Chhattisgarh, Uttarakhand, Uttar Pradesh, Punjab and Odisha. Uttar Pradesh reported limited effectiveness of monetary incentives in improving HR retention.
- The recently introduced HR policy in Karnataka has helped streamline workforce management practices considerably. In the absence of systematic transfer policies, there has been difficulty in ensuring rational and transparent transfers in Andhra Pradesh, Himachal Pradesh, Manipur and Rajasthan.
- Multiskilling/multitasking of LTs working under different programmes and their deployment at the facilities offering integrated lab services is a welcome initiative undertaken by the state of Odisha.
- Performance appraisal systems for HR under NHM have been developed in Delhi, Jharkhand, Madhya Pradesh and Punjab but are used for renewal of annual contractual engagements only in Delhi and Punjab.
- Maharashtra has a well established public health cadre; Madhya Pradesh and Odisha are actively working towards setting one up.
- Human Resource Management Information Systems (HRMIS) have been developed in Chhattisgarh, Jharkhand, Karnataka and Maharashtra but its functionality is

limited to post training deployment of staff though Assam is currently conducting a trial of a more comprehensive use of HRMIS. In Haryana and Delhi, HRMIS is in the implementation phase.

- Establishing dedicated HR Cells for handling HR management functions has helped states like Assam, Jharkhand, Chhattisgarh, Madhya Pradesh, Maharashtra and Uttarakhand; while one is being established in Karnataka.

TOR 5: Community Processes

- This TOR aims to review the role of ASHAs covering the entire gamut from selection process through support structures to VHSNC and RKS. Other important dimension covered by this TOR includes convergence mechanisms with other departments and programmes, as well as, the involvement of the VHSNCs in village level health planning and the funding mechanisms involved.
- The states of Uttar Pradesh, Punjab, Maharashtra, and Assam lay emphasis on increasing the reach of ASHA to vulnerable households. Some states however, caution that the ASHAs community moorings appear to have become tenuous, indicating that the village level platforms such as the VHSNC and MAS need strengthening, inter-sectoral convergence needs to be stronger, and the role of the ASHA as a mobilizer needs to be better emphasized.
- In terms of ASHA selection, except for four states - West Bengal, Karnataka, Delhi and Uttar Pradesh, selection is over 95%. Yet there are inter district variations, particularly in the high priority districts.
- In context of ASHA programme in urban areas, the key challenge is that states are yet to use and adapt the learnings from NRHM to strengthen the role of the urban ASHA. A second issue is that the incentive amount for ASHA in urban areas needs reconsideration, as there are anecdotal reports of difficulty in recruiting ASHA or higher anticipated drop-outs owing to other available options. The third is the limited clarity about the role of Mahila Arogya Samiti in urban areas. Vulnerability Mapping has begun only in Odisha and Assam. In Karnataka and Maharashtra, the state is faced with the challenge of converting link workers into ASHAs as they are getting fixed monthly remuneration.
- Two important causes of slow pace of trainings of Module 6 & 7 across states appear to be - trainer attrition and lack of fund releases. This is an area of concern particularly since states are required to be readying for accreditation of training sites, trainer and ASHAs as part of certification by the National Institute of Open Schooling. West Bengal and Odisha report a robust training mechanism that has provided hand holding support to the districts.
- Reports from Jharkhand, Haryana, Assam, Rajasthan, Meghalaya, Manipur and Uttarakhand, point to limited skills of the ASHA met in some of these areas in relation to provision of new born care, nutrition counselling, ability to track children with malnutrition and counselling on family planning. There is a gradual improvement in the diagnosis, referral and follow up of sick and low Birth weight newborns, reported from Madhya Pradesh, Maharashtra and Delhi.
- Lack of a consistent mechanism to refill the ASHAs drug kit or to replace broken equipment is another area of concern. Any effort to discuss the effectiveness of the ASHA is nullified by the lack of these two critical support mechanisms.

- In Chhattisgarh the presence of effective support system at state, block and sub block levels accounts for high functionality of not just the ASHA but also VHSNC and PRI engagement. Most states have a support structure as specified in the guidelines. The effectiveness of the support mechanism is hampered in Rajasthan, Madhya Pradesh, Meghalaya, Uttarakhand and Haryana.
- Madhya Pradesh, Delhi, Jharkhand, Manipur, Maharashtra, Meghalaya, Odisha, Punjab, Chhattisgarh, Assam, Karnataka, Haryana and Uttrakhand are using the performance monitoring tool and developing mechanisms, to support ASHA who are not able to perform the ten key tasks. Reports suggest that although non-functional ASHAs are removed, the vacancies created are yet to be filled.
- Delay in incentive payments is an area of concern, despite opening of bank accounts and initiatives to streamline payments. Odisha and Rajasthan are exceptions in this context with the PFMS in Odisha and ASHA Soft in Rajasthan ensuring timely payments
- Madhya Pradesh, Karnataka, Manipur, Meghalaya and Punjab are states where restructuring of VHSNCs has been reported, as per the new GOI guidelines while it is underway in Uttarakhand. Good functionality was observed in only few states like Andhra Pradesh, Chhattisgarh, Maharashtra and Odisha. However in Meghalaya it was an issue.
- Participation of PRI and NGO representatives in RKS was found to be limited in all states. Across most states, meetings of RKS were not held regularly, and in some states meetings of RKS were held only once in the whole year as seen in Dehradun, Meghalaya and West Bengal. Regular meetings with proper records were reported only from states of Maharashtra and Manipur.
- Strong institutional convergence between VHSNCs and Gram Panchayats, is not seen on the ground in most of the states. Even in states where VHSNCs have been formed at the level of Gram Panchayat, this convergence is not better than other states. Maharashtra and Odisha are exceptions, presenting strong convergence at community level.

TOR 6: Information and Knowledge

- The objective of this TOR is to review the use of various Public Health Information Systems, HMIS and MCTS data, the mechanisms for data quality review, training and areas for improvement in HMIS and MCTS. The TOR also oversees the adequacy of the IT infrastructure and the progress towards implementation of telemedicine and/or m-health
- Facility-wise data entry across all states has stabilized in HMIS Web Portal and monthly facility performance data is readily available. Data entry has started stabilizing in MCTS- all states are utilizing MCTS for tracking mother and children however the data completeness is a major concern in states.
- Users across Hindi speaking states have expressed concern regarding non-availability of formats, reports, work-plans in Hindi language both in HMIS & MCTS.
- Reporting from private hospitals is still a concern in all states. West Bengal is the only state which has not institutionalized reporting by urban health facilities in HMIS.

- RCH registers are available in all states except Maharashtra. However their utilization is limited in Himachal Pradesh, Uttarakhand, Rajasthan and Madhya Pradesh. In Delhi, ANMs reported having difficulty in filling these registers due to their complexity. In Chhattisgarh and Andhra Pradesh Tablet-based applications (based on RCH registers) were introduced in pilot phase, for data entry, at the point of care.
- Use of USSD services for data reporting using mobile phones in MCTS needs further push in all States. Partial use was reported in Delhi, MP and Punjab. Only West Bengal has reported advance stages of implementation of USSD services. In most cases ANMs are not aware of the incentives linked with USSD reporting. States such as Delhi and UP reported technical glitches in utilizing USSD services.
- Central as well as state call centers are verifying records of mother and children and spreading awareness about various government health schemes.
- The use of data for program planning and monitoring is good at state and district-level. However almost all states reported poor data utilization below district level, especially at facility level. Often data quality issues can be identified and corrected at facility level itself but due to lack of skills the health workers are not able to manage these issues. Institutional process for data review, feedback and verification is not established in any state except Odisha.
- Training and capacity building with respect to use of information is weak at sub-district level in all CRM states. The induction training programs for new recruits are often delayed with limited focus on data analysis and use.
- Adequate ICT infrastructure (computer, internet, printers etc) is available in all states except Manipur, Meghalaya and Uttarakhand where connectivity issues were observed.
- All States have reported usage of local health information systems in addition to HMIS and MCTS to address local health data/ administrative needs. Among these majority of the states have started Drug Vaccine Logistic System (Assam, Chhattisgarh, Delhi, Odisha, Punjab, Rajasthan, West Bengal); Human Resource Management Information System (Jharkhand, Assam, Chhattisgarh, Himachal Pradesh, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Uttarakhand); Hospital Information System (Himachal Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Odisha, Punjab, Rajasthan, West Bengal). Telemedicine in Assam, Himachal Pradesh, Maharashtra, Punjab; GIS applications (Assam, Chhattisgarh, Haryana, Jharkhand, Odisha).

TOR 7: Healthcare Financing

TOR on Healthcare Financing required review of status of fund release and utilisation under NHM. Scrutiny of the Public Finance Management System and the Action Taken report on Institute of Public Auditors of India (IPAI) were also important concerns.

- Some states are not able to contribute their share of finances to the NHM programs. The transfer of funds from Centre to States and State treasury to SHS is delayed. Delay in release of funds from state treasury to the SHS is observed in Delhi, Chhattisgarh and Haryana.
- All states have allocated additional funds for high priority districts except West Bengal, Delhi, and Haryana.

- In almost all the states, funds are being transferred from state to the district level via electronic transfer (e-transfer). Direct beneficiary transfer (DBT) to facility level and beneficiary has been implemented in most of the states. In Meghalaya, Chhattisgarh, Jharkhand, Andhra Pradesh and Punjab, cheque payment is still being made in some districts for JSY payments.
- Poor utilization of funds (across all pools) was observed in Andhra Pradesh, Delhi, Jharkhand, Maharashtra, Meghalaya, Punjab and West Bengal. All states have reported poor utilization of funds under NUHM.
- Statutory and Concurrent audits are being conducted regularly in most states. Timely submission of these audit reports to Centre remains a problem, especially, in states like Karnataka, Andhra Pradesh, Delhi and Punjab.
- PFMS Registration of agencies has been completed only in the state of Maharashtra. The states of Assam Haryana, West Bengal Uttar Pradesh, Chhattisgarh, Rajasthan and Himachal Pradesh are in the process of completing the registration while Meghalaya and Manipur have achieved less than 50 per cent registration.
- Andhra Pradesh, Meghalaya, Jharkhand, Uttarakhand, Haryana and Manipur still do not use Tally ERP 9 software for book keeping at all levels.
- Most states report physical progress along with financial progress in the Financial Monitoring Reports (FMR) at the District and Block level except for Meghalaya and Chhattisgarh.
- States are implementing several schemes to reduce the burden, of out of pocket payments for healthcare, on households. States are implementing Rashtriya Swasthya Bima Yojana covering secondary care and inpatient care or insurance schemes covering tertiary care and inpatient care. Some states have launched free drugs and diagnostics schemes in all public facilities to cater to the needs of poor and vulnerable population. However, in spite of all this, the latest health survey of National Sample Survey Organization (71st round), reports high per capita OOPE in some states like Punjab, Andhra Pradesh, West Bengal, Maharashtra and Karnataka.

TOR 8: Quality Assurance

This TOR aims to review implementation of the Quality Assurance activities, constitution and functioning of various committees status on recruitment for the QA units and its operationalisation. It also reviews roll-out of Kayakalp Initiative and all its components. Under the Quality Assurance and Kayakalp Initiatives, the states were expected to undertake pre-defined activities, status of which is given below:

- Institutional Arrangements – The States were expected to re-constitute State & District Quality Assurance Committees (SQAC & DQAC) and notification has been issued in all visited states. However recently reconstituted SQACs have never conducted the committee meetings in the States of Delhi, Himachal Pradesh, Manipur and Meghalaya. In other visited States, the committee did not meet at mandated six-monthly interval except in the States of Madhya Pradesh Haryana and Karnataka. Of these three states, Madhya Pradesh and Haryana held regular meetings of DQACs at quarterly interval . Approved QA HR has been inducted in the States of Andhra Pradesh, Delhi, Haryana and Rajasthan. In all other visited states, there have been delays in recruiting the sanctioned QA HR.

- Capacity Building – All visited states have conducted QA Internal Assessors trainings with support of NHSRC and have a pool of the qualified assessors available. Service Provider Trainings have been conducted in the States of Madhya Pradesh, Punjab, Meghalaya, Rajasthan, Uttar Pradesh, Haryana and West Bengal. Remaining states are yet to conduct service providers' training, which would be important for roll-out of the QA activities.
- Assessment of Health Facilities – In spite of having trained HR for the Internal Assessment, complete base-line assessment of all District Hospitals on DH QA Assessors tools is yet to be completed except in the States of Odisha, Haryana and Madhya Pradesh.
- Grievance Redressal – Grievance denotes an extreme case of the dissatisfaction. However no grievance redressal mechanism were evident in the States of Maharashtra, Uttarakhand, Assam, Madhya Pradesh, Himachal Pradesh and Andhra Pradesh. In Punjab the grievance redressal mechanism system worked through a toll free number 104, which has been found to be functioning well in both the visited districts. In Odisha, disposal of complaints is being undertaken at the facility Incharge level.
- Kayakalp Initiative including Biomedical Waste Management – Kayakalp is the initiative for promoting 'Swachhata' in Public Health Facilities, and in the year 2015 the scheme is applicable to District Hospital level facilities. The States were advised to select and declare winner hospitals by 2nd Oct 2015. The States of Andhra Pradesh, Jharkhand, Madhya Pradesh, Chhattisgarh, Meghalaya, Himachal Pradesh, Rajasthan, West Bengal, Haryana, Manipur, Punjab and Karnataka, Assam, Maharashtra and Odisha have completed the process of selection of DH. State of Uttar Pradesh is yet to initiate the process of peer assessment, and Uttarakhand is looking forward to conduct the peer assessment in Jan 2016, while Delhi is yet to initiate the peer assessment for Kayakalp.
- Biomedical waste segregation practices were good in Punjab. In Odisha, autoclave, shredder, colour coded bins and bags were available, covered and demarcated burial pits were available and HR was trained on IMEP guidelines. Maharashtra has a robust system of outsourcing of BMW. In states of Andhra Pradesh, Delhi, Jharkhand, Rajasthan, Meghalaya, Madhya Pradesh, Haryana and West Bengal, knowledge about waste disposal and segregation of waste was found to be lacking inadequate, resulting into poor implementation of the Bio Medical Waste Rules (management & handling) 1998.

TOR 9: National Urban Health Mission

The main objectives of study have been to assess status of NUHM implementation including linkages with pre-existing programmes under NHM such as Reproductive and Child Health, Disease Control Programmes and non-communicable diseases. Focus has also been placed on reviewing the services provided by UPHC and community outreach services in urban centres.

- It has been mandated that NUHM is to be implemented by the State Health Departments and Municipal Corporations. However, barring a few mega cities, the uptake and ownership of the program by the ULBs is very slow. It has been a challenge for both state governments as well as the ULBs to enable the ULBs to

initiate the process of implementation of NUHM. In smaller cities also, ULBs have been slow to play the role of an important implementing partner.

- Human resource recruitments for both program staff and clinical staff have been gradual and difficult in some states, making the implementation progress also slow. The reasons range from low salaries (in view of high cost of living in cities), reluctance to work during evening shifts (for clinical staff), unavailability of trained personnel in smaller towns, and slow recruitment processes at the state level. This is also the reason due to which the expenditure of NUHM funds has been less than optimal.
- Urban ASHA recruitments have been done in all states except Uttar Pradesh and West Bengal. Their training on induction modules have also started in most states. Mahila Arogya Samitis have been established in most states and their trainings have started in Chhattisgarh, Odisha, Jharkhand, Madhya Pradesh and Manipur.
- Due to difficulty in procuring space in and around slum areas as mandated by NUHM, many states are operating UPHCs out of rental premises. States are in process of achieving their target number of UPHCs. Currently, the focus of the UPHC services continues to be on RCH services.
- While geospatial mapping is in process in most states, vulnerability assessment is lagging behind in many. Health facility mapping has also been undertaken by the states.

TOR 10: Governance and Management

The TOR aimed at getting an insight into the functioning of SPMU and DPMU, integration among NHM and DHS and utilisation of available data at various levels. This TOR also had the objective to review the supportive supervision and performance appraisal mechanisms and status of implementation of various regulatory acts in the states.

- Institutional Mechanism of NHM: The State/District Health Mission and Health Societies in Karnataka and West Bengal are still in process of including urban directorate, local bodies & related officials and experts. They are yet to be included in Assam, Delhi, Himachal Pradesh, Jharkhand and Manipur.
- Planning Process: The decentralized planning is poor in States like Andhra Pradesh, Delhi and Manipur and probably this is not just defeat of decentralized process but also an inability to view the entire picture at desired levels. States such as Chhattisgarh, Jharkhand, Karnataka, Odisha, Punjab, Uttarakhand and Uttar Pradesh have initiated planning from village level and they are also aware of tentative allocation limit. Delhi, Chhattisgarh, Jharkhand, Karnataka, Uttar Pradesh and Uttarakhand made cuts in budgetary allocation in district plan with prior consultation with the district while in West Bengal and Haryana, the budget allocation is not as per the District Health Action Plan.
- Convergence Measures: Chhattisgarh, Delhi, Himachal Pradesh, Jharkhand, Maharashtra, Punjab, Uttarakhand, Uttar Pradesh, and West Bengal have a framework for convergence in place and has extended it to ICDS, Education department, PHED and PRIs etc. as line departments and all the other States lack any such mechanism of convergence in place.
- Regulation: Implementation of regulatory acts such as Clinical Establishment Act and PCPNDT need attention. Chhattisgarh, Himachal Pradesh, Jharkhand, Odisha

and Rajasthan implemented CEA 2010. States such as Assam, Delhi, Karnataka, Manipur and West Bengal still have state act in place. Implementation of PCPNDT Act is there in almost all states visited. Very few complaints have been registered under PCPNDT in States where the act has been implemented.It is important to note that implementation of Act would gain from analysis in the trends of sex ratio (gender disaggregated data for all ages) which is by and large not attempted except in the state of Rajasthan and other states may learn from their experience.

- Programme Management Unit and Directorate: Most of states have SPMU in place but the capacity of DPMU is limited. SPM in the states like Delhi, Haryana, Karnataka, Odisha, Uttar Pradesh and Uttarakhand are the designated officers of existing public health cadre for strong integration and support and in other states such integration is not there.

- Well structured performance assessment system is in place in Delhi, Chhattisgarh, Karnataka, Odisha and Uttarakhand but ineffective in Rajasthan and West Bengal and yet to be done in others states.In almost all the states SPMUs and DPMUs are multitasking and as a result the core NHM functions become diluted.

RECOMMENDATIONS

TOR 1: Service Delivery: Reaching the Unreached

- Accessibility issues have largely been addressed in majority of states and it is now necessary to prioritize the key mandates of affordable and assured services under the National Health Mission (NHM) to reduce out of pocket expenditure. Way forward in this direction is to increase the basket of assured services and diagnostics.

- Free Drugs and Diagnostics initiative is a key priority and States need to be pursued to commit to, adopt and execute these initiatives as per their local needs.

- Considering the irrational prescription of antibiotics and other drugs, there is a strong need to institutionalize prescription audits across all states.

- Ensuring availability of blood at District Hospitals and First Referral Units (FRUs) needs prioritization. States must link available infrastructure and human resources to make Blood Banks functional 24x7 based on need assessment. Setting up of Blood Component Separation Units wherever required and establishing blood bank management information system must be on the agenda.

- There is an imperative need to improve quality of care by different means, including development of job-aids, establishment of performance management mechanisms, accountability frameworks, enforcement of regulations etc.

- There is a special need for developing mechanisms to initiate repair of non-functional equipment and policies to reduce the downtime of equipment as per guidelines of Biomedical Equipment Maintenance and Management Program.

- Co-location of AYUSH facilities must be prioritized for health facilities where footfalls are high. Availability of various AYUSH services must be ensured at least at the district hospital level. Further, to improve utilization of AYUSH services and mitigate the challenge of erratic availability of AYUSH medicines (which was observed across

all States) it is suggested that States link AYUSH procurements to drug procurement under the National Health Mission.

- States must link ambulance services with OOPE on account of transport cost, and plan services accordingly. Where multiple ambulance services are made available, States must attempt at streamlining the vehicle availability. There is also a need to strengthen presence of well-trained emergency medical technicians in ambulances.
- States need to institutionalize a mechanism to review the Public Private Partnership (PPP) models for service delivery. The State Health Systems Resource Centers (SHSRCs) should be strengthened and empowered to support state in reviewing the PPP services and conduct its evaluation.

TOR 2: Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCH+A)

- States need to revisit existing mechanisms of planning for health at different levels and adopt innovative methods for decentralized planning. Assured service package under RMNCH+A needs to be put in place.
- Essentially, there is a need to ensure SOPs for all procedures related to maternal care in institutions complimented with internal (inter-departmental) audit mechanisms. TOR for each personnel in this context needs review and modifications accordingly. The pace of implementation of newer interventions for newborn and for maternal health needs to be expedited.
- Protocol on provision of blood to pregnant women in emergency needs standardization across states and related challenges should be addressed systematically.
- States must ensure that data emerging from various death reviews inform the District Health Action Plan (DHAP). At the same time regular feedback must be provided to health facilities and Village Health and Sanitation Committees (VHSNCs)/ Panchayati Raj Institutions (PRI) for action.
- Fixed Day sterilization services need to be operationalized at CHCs in lieu of the camp approach. Training of PPIUCD and post training utilization of the trained manpower in the equipped facilities needs attention. States should work out innovative approaches to promote male participation in family welfare programme including NSV.
- It is essential to develop a strong referral network from community to facility and back to ensure better follow up of children discharged from SNCUs and NRC/MTC.
- States may systematically study the functioning of AFHCs and promote their utilization by providing essential commodities and skilled HR.

TOR 3: Disease Control Programmes

- There is a need to adopt and implement national framework for malaria elimination across all the states and take necessary steps to ensure maintenance of ABER at >10%. Strengthen entomological activities for malaria and dengue with more frequent and regular supportive supervision/monitoring visits from state and zonal

teams. Improve active and passive surveillance and make state surveillance hospital labs operational through filling vacancies and providing necessary logistics.

- States should formulate and enact bye-laws for public health in urban areas to control and monitor mosquito breeding sites particularly focusing on new construction sites to control dengue fever. Promote inter-sectoral coordination by involving other line departments (water and sanitation) and stakeholders in implementation of NVBDCP programmes at the state, district and sub-district level.
- Ensure early diagnosis and improved access to quality treatment for all diagnosed TB cases including MDR-TB in Rajasthan, Haryana, Karnataka and Uttarakhand. Himachal Pradesh and West Bengal need to ensure registration of TB cases in NIKSHAY system and it should be made real-time data entry system. Strengthen involvement of private healthcare providers in reporting TB cases across all the states.
- State like Rajasthan should give high priority to referral and follow up of MDR-TB cases and strengthen cross referrals of TB-HIV as per guidelines. All States should encourage involvement of voluntary organizations/ individuals (community champions) to increase awareness of TB programme.
- Progress in setting up of NCD clinics and functioning of existing clinics should be strictly monitored as per recommended norms and guidelines and capacity of states be developed in this regard. Engage suitable NGOs (not-for-profit organizations) to develop capacity and improve implementation of various NCD programmes. Good initiatives done by Punjab for cancer screening through support of Mukh Mantri Punjab Cancer Rahat Kosh Scheme can be replicated in other States if found to be financially viable for them.
- State should fill-up all sanctioned posts under communicable and non-communicable disease programmes on priority basis for effective implementation. Also rational deployment and use of available human resources in national health programmes should be done for health system strengthening.

TOR 4: Human Resources for Health and Training

- Specially empowered recruitment boards, as present in some states, should also be constituted in other states which experience lengthy delays in recruitment. In addition, the centre has empanelled external HR agencies to support states with large-scale NHM recruitments.
- Skill based competency tests complemented with corrective trainings to address identified skill gaps would help the states in delivering quality care. Competency based tests should also be used for the recruitment of health functionaries.
- Considering the shortage of specialist skill providers, alternative strategies for generating specialist skilled care providers are required that may include multiskilling of doctors in Emergency Obstetric Care (EmOC) and Life Saving Anaesthetic Skills (LSAS) and their effective utilization through a robust supportive system. The system in Maharashtra of a College of Physicians and Surgeons, which undertakes courses of a years' duration to impart specialist skills to doctors with experience of working in the field as a general physician for a number of years, has been helpful in generating specialist skill providers in the state, and this model of good practice should be

considered for emulation in other states too. The Maharashtra Medical Council does not recognise the qualification as a specialist one and the state authorities are taking up the issue with the Medical Council to be able to alleviate the shortage of specialists in the state. States should adopt flexible and innovative mechanisms to engage specialists - in this regard, states will find the recent MoHFW guidance note on strengthening specialist support in public health facilities helpful.

- States need to strengthen existing HR policies to make them more comprehensive and ensure better implementation as observed in the states of Karnataka and Kerala.
- There is a need to establish robust performance appraisal systems, which takes into account employees' performance and also helps in decision-making with regard to salary increments and renewal of contractual engagements.
- To ensure maximum efficiency of health functionaries, consideration may be given to developing comprehensive integrated in-service training for paramedical staff (e.g. lab technicians and counsellors) so that they can multi-task effectively across various national health programmes, where ever appropriate.
- The shortage of faculty at training institutes such as SIHFWs needed to be addressed to ensure that high quality training can be imparted to in-service candidates for health systems strengthening.
- Introduction of public health cadre in States may prove to be helpful towards enhancing career development pathways for the staff. Dedicated staff under the cadre should be given relevant public health training to carry out public health functions effectively.
- Web enabled HR and Training Management Information Systems may be helpful in planning of HR, trainings and promotions and postings and transfers of employees. Such systems are required to be scaled up and strengthened across states.
- Establishing and strengthening dedicated HR cells for streamlining workforce management practices should be a priority for all states.

TOR 5: Community Processes

- States must take district and sub district specific action to address issues such as training, payments and support to the ASHA on the existing set of tasks. Existing vacancies must be filled and training of support staff must be instituted immediately.
- Monetary or non-monetary incentives may be considered for good team performance at block level, i.e. for completion of ASHA training as per training calendar, all targeted new-borns visits completed, and etc. The Block Community Mobilizer and ASHA Facilitator would get an additional incentive for good performance.
- Strengthening ASHA training systems, especially as states move towards ASHA certification is important. Available pool of resources such as Block Mobilizer, ANM and ASHA facilitators as trainers may be used.
- Streamlining incentive payments is to be seen as a priority. Particularly, payments for disease control programmes need to be expedited. Introduction of new campaigns with ASHA being promised an incentive must be monitored for whether payments were actually made.

- The strong coordination between the team of the ASHA, ANM and AWW needs to be taken advantage of. Newer tasks need to be added after workload assessment and accompanied by training and capacity building.
- Orientation of ASHA support structures in priority areas of nutrition, family planning and new-born care needs attention. One way of improving ASHA skills is to develop mobile based application to reinforce key messages and to develop applications for support structures of the ASHA to enable performance tracking and supportive supervision. The REMIND model from the state of Uttar Pradesh is a good example.
- The process of restructuring of VHSNCs needs to be expedited, and key role of ASHAs in mobilising and facilitating VHSNCs should be mandated as per the new guidelines and enabling inclusions of key individuals. Training of VHSNC members needs to be undertaken on priority. More active and sustained involvement of PRI members in supporting VHSNCs and RKS needs to be promoted in all states, through advocacy with Ministry of Panchayati Raj Institution.
- Reconstitution of RKS as per the revised guidelines needs to be undertaken on priority, followed by capacity building of RKS members focusing on community participation and fund management. Financial management systems of RKS, needs to be reviewed at state level and prompt corrective action taken to improve transparency and governance.
- Inclusion of district and block level panchayat structures in supporting and monitoring health programmes, especially involving their standing committees, will enhance effective convergence. Implementation of community Action for Health, should be speeded up, and be integrated with the community processes interventions.
- States need to strengthen or establish State ASHA/CP mentoring group and engage with effective and credible NGOs to serve as resources for all components of community processes including community action for Health.

TOR 6: Information and Knowledge

- Institutional mechanisms for data verification, analysis and use need to be established in all states. Provision of reporting formats of HMIS and MCTS reporting in local language need to be made.
- Technical issues regarding usage of USSD need to be addressed and adequate awareness needs to be promoted to improve reporting through USSD. The scope of USSD services may be expanded to promote single point entry by ANM in only one form, which can facilitate data reporting in all information systems using data standards.
- Integrated training program and training calendar needs to be developed for various levels of functionaries to promote data utilization.
- There is a need to develop integrated e-health architecture with health information exchanges to integrate available information systems at the States. Use of Aadhar/Unique Identifier should be promoted across systems to ensure identity management. Private sector needs to be persuaded to report data into HMIS
- States need to establish integrated dashboards for planning, monitoring and management of various programmes where data from all relevant systems can be put in analysed (indicator) form to support decision making.

TOR 7: Healthcare Financing

- Timely release of funds from centre to state and state treasury to state health societies should be ensured for better utilization of funds. Especially delays in transfer of funds from treasury to society in Delhi, Chhattisgarh and Haryana should be reduced.
- States need to examine the reasons for underutilization of NHM funds in general and NUHM funds in specific and take necessary steps towards better utilization of these funds. Besides NUHM, other areas of low utilization for RNTCP, NTCP and training needs to be assessed and funds reallocated if needs have changed. The concerns related to low fund utilization especially in Andhra Pradesh, Delhi, Jharkhand, Maharashtra, Meghalaya, Punjab and West Bengal should be addressed.
- Necessary steps should be taken to fill finance and accounting positions in Uttarakhand, Uttar Pradesh, Rajasthan, Odisha and Chhattisgarh. Recruitment of accounts officers/accountants at lower facility level or rationalizing posting of available officers to ensure proper book keeping at all levels is required.
- Necessary steps should be taken to strengthen the monitoring of Financial Management at all levels. The physical progress should be submitted along with FMR for integrated monitoring, especially Meghalaya and Chhattisgarh which have not implemented this so far. Monthly meeting of DPMs/DAMs along with CMHOs may be held for monitoring the physical and financial progress of the programmes. Visit calendar should be prepared and enforced. State like Karnataka, Andhra Pradesh, Delhi and Punjab should take measures for timely submission of audit reports to Centre.
- Implementation of DBT through PFMS should be prioritized. All states are moving towards completion. Meghalaya and Manipur especially have to hasten this process as currently they have fewer than 50% registrations. Delays in banks releasing the funds should be examined. Timely payment to JSY beneficiary needs to be monitored from DHS level. DBT though PFMS or Account payee cheque to be issued to JSY beneficiary should be implemented for payment.
- Existing Tally ERP 9 software should be implemented at state and district level in Andhra Pradesh, Meghalaya, Jharkhand, Uttarakhand, Haryana and Manipur and new staff at lower levels to be trained in a timely way. Hard copy of financial report generated from Tally ERP 9 should be kept at all levels duly signed.
- States should take steps to introduce free drugs and diagnostics schemes, strengthen patient transport systems and improve implementation of JSSK to reduce OOPE. This needs more focus in states like Punjab, Andhra Pradesh, West Bengal, Maharashtra and Karnataka that report a high per capita OOPE.

TOR 8: Quality Assurance

- Operationalising Institutional Frame-work

  Though the States and UTs have formed State Quality Assurance Committees (SQACs), and District Quality Assurance Committees (DQACs), however it needs to be ensured that SQACs and DQACs hold their meetings at six monthly and quarterly

intervals respectively. Haryana and Madhya Pradesh are the two States which reported that regular meetings of SQAC and DQAC were held.

- Quality Improvement Activities
  a. Introduction of prescription audit, death audit and clinical audit at health facilities is recommended to be implemented on priority as it is not reported from any State.
  b. Culture surveillance of critical areas such as OT, labour room, SNCU and ICU (where applicable) needs to be started. In absence of local facility for the microbial culture, linkage with nearest Medical College hospital may be established.
  c. For enhancement of patient satisfaction, an on-going system of OPD and IPD satisfaction survey at all health facilities needs to be operationalised in all states. A sample size of 30 OPD patient and 30 IPD patients per month could be starting point. Result of satisfaction survey should be discussed at the facility, district and state level. Delhi, Punjab, Maharashtra, Jharkhand, Karnataka and West Bengal are the only States with some patient satisfaction survey/feedback mechanism in place, but they again are underutilized.
  d. Laboratories of Health Facilities should join External Quality Assurance Programme, run by AIIMS New Delhi & CMC Vellore, for external validation of laboratory results.

- The states should endeavour to have health facilities at each Quality certified – State & National certification against the National Quality Standards. The approach should be target based and approved by DQAC & SQAC. All States are at different levels of quality certification of facilities as per National standards.
- Quality Assurance programme needs to be extended to Urban Health Facilities in the year 2016-7.
- Strengthening Bio-Medical Waste Management - Performance of common waste treatment facility operator needs to be monitored rigorously. At the facility level, meticulous segregation of Bio-Medical Waste needs to be strengthened. Such efforts may need training of the facilities' staff in Biomedical Waste Management and Infection Control. Punjab is one State which reports good BMW management with the license being renewed by Punjab State Pollution Control Board, on yearly basis. Maharashtra reports an out source model for BMW management. All other States have reported different mechanisms of BMW management at State and District levels.
- Kayakalp - The States need to prepare a plan for roll-out of Kayakalp initiative to CHCs/SDH and PHCs in the year 2016-17. The states should analyze Kayakalp Gaps, detected in the year 2015 during the assessment of District Hospitals and take appropriate action of their closure so that all round improvement in 'Swachhata' at Public Health Facilities takes place.

TOR 9: National Urban Health Mission (NUHM)

- States such as Delhi, Himachal Pradesh, Uttarakhand and Uttar Pradesh must devise context specific strategies for enhancing ULB participation in NUHM implementation. States must organize orientations, hold collaborative meetings and prepare joint work plans and roadmaps for NUHM implementation.

- Vulnerability Assessment and Mapping must be undertaken as the first step towards planning for urban health services in almost all states except Delhi. The outcomes of mapping will be the foundation for preparation of PIP and micro planning of activities at the UPHC level.
- Integrated service delivery from the UPHC for RCH, communicable and non-communicable diseases must be aimed for. Reporting under disease control programs in urban areas must be streamlined and should involve both UPHCs/CHCs and health facilities run by ULBs.
- There is a large scope for innovations and novel implementation strategies involving other stakeholders in the urban space, as done by Uttarakhand. However, in such collaborations, TORs for each partner must be clear, with effective monitoring and supervisory mechanism laid down.

TOR 10: Governance and Management

- State-wise mapping of ULBs and directorate needs to be undertaken with a clear directive at state and district level for including them in State/ District Health Mission as done in Chhattisgarh, West Bengal.
- The objective of decentralized planning can be achieved if States indicate in advance the tentative budget allocation for the districts and blocks before the planning process is initiated. This will help in preparing meaningful action plans. Also, information from MIS sources, survey data at local situations, etc. must be referred to cull out information which reflects in the district health action plans as done in Assam, but lacking in Uttarakhand.
- States must ensure involvement of other departments in preparing district action plans/ district PIP since many activities under health are cross cutting. Assam, Himachal Pradesh, Punjab, Odisha, Rajasthan, Uttar Pradesh are some States showing good convergence models.
- Effort for better convergence between NHM/SPMU and health directorate will improve if the officials in the directorate are given financial powers or at least made joint signatories. This will help in developing ownership of the programme. Chhattisgarh, Himachal Pradesh, Jharkhand, Odisha, show good convergence between NHM and Directorate. Chhattisgarh and Karnataka have implemented this devolution of financial power at all levels. States may introduce incentives (monetary/non-monetary) for good performance particularly for those who are working in hard to reach areas.
- States must work towards formulating a transparent HR policy for all levels of contractual staff, which should be linked with performance based incentives and has clearly defined deliverables/targets for each cadre of staff as implemented in Delhi, Jharkhand, Karnataka,

MANDATE AND METHODOLOGY

of the 9th Common Review Mission

MANDATE AND METHODOLOGY OF THE 9TH COMMON REVIEW MISSION

The National Rural Health Mission was launched in 2005, to address the health needs of underserved rural areas. In the 12thPlan, the flagship programme of NRHM is strengthened under the umbrella of National Health Mission. The focus on covering rural areas is continued along with inclusion of non-communicable diseases and expanding health coverage to urban areas. In May 2013, National Urban Health Mission (NUHM) was launched as a sub-mission of the overarching National Health Mission (NHM). The ninth Common Review Mission was undertaken when NRHM marked ten years of implementation and the NUHM just two years. The Ninth CRM TOR focused on assessing implementation status of new initiatives and guidelines issued by Ministry of Health and Family Welfare in terms of progress towards Kayakalp scheme for public health facilities, RKS guidelines, National Urban Health Mission, free drugs and diagnostic service initiative, operational guidelines for enhancing performance of multipurpose worker (female), Rashtriya Kishor Swasthya Karyakram (RKSK) and progress on Non Communicable Diseases (NCD) programme. Common Review Mission undertaken so far has provided valuable insights and understanding of the strategies which were successful and have led to several significant mid-course adjustments.

THE BROAD OBJECTIVES OF 9TH COMMON REVIEW MISSION

1. Review the progress of NHM implementation:
    - As against set goals and objectives related with IMR, MMR, TFR and goals related with various disease control programs
    - In terms of its impact on accessibility, equity, afford ability and quality of health care services
2. Review implementation status of new initiatives and guidelines issued by MoHFW in terms of following:
    - Progress towards Kayakalp award scheme for Public Health facilities
    - Rogi Kalyan Samities (RKS) Guidelines
    - Progress made under National Urban Health Mission
    - Free Diagnostic Service Initiative
    - Free Drug Service Initiative
    - Operational Guidelines for Enhancing Performance of Multipurpose Worker (Female).
    - Rashtriya Kishor Swasthya Karyakram (RKSK)
    - Progress on NCD programme
3. Review the extent of compliance to recommendations made by earlier CRMs.
4. Review the progress and the State's response to conditionality and issues related to non-compliance.

5. To review the progress in addressing critical issues in Health systems by lead Development Partners in the State specifically in context of HPDs.
6. Document good practices and innovations identified by the State.
7. Make recommendations to improve programme implementation and design.

GEOGRAPHICAL COVERAGE OF 9TH COMMON REVIEW MISSION

Under the 9thCRM, a total of 18 States/UTs are being taken up for review (11 High Focus States including 3 North-Eastern States and 7 Non High Focus States). The States were selected with a view to provide a representative picture of the progress made under National Health Mission.

The states covered under 9th CRM include: Andhra Pradesh, Assam, Chhattisgarh, Delhi, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Odisha, Punjab, Rajasthan, Uttar Pradesh, Uttarakhand, and West Bengal. In each state two districts were selected based on service delivery indicators – one which was good performing and another which was under performing.

COMPOSITION OF TEAMS FOR 9TH COMMON REVIEW MISSION

Each State was visited by a 15-17 member team comprising of the following:

1. 5-7 Government Officials
2. 2-3 Representative from Public Health Institutions
3. 2 Representative of Development Partners
4. 1-2 Representatives of Civil Society
5. Consultants of various divisions of the Ministry

On 30th October, 2015 all the participants were briefed on the objectives of 9th Common Review Mission. During this briefing, teams were provided with a detailed terms of reference for the visit, including checklists. The TORs were divided among team members according to area of expertise. Team members were expected to submit observations on these within a specified time frame. Each state report would be a compilation of these findings.

TIMELINE OF 9TH CRM

The 9th CRM started on 30thOctober and ended on 6th November, 2015. The first event, as is the practice was a day long briefing at New Delhi followed by briefing at each state capital. Thereafter the teams visited the identified districts. On the last day, there were state de briefings in the respective state capitals.

TERMS OF REFERENCE FOR THE 9TH CRM

The observations and analysis of the 9th CRM is based on ten themes. These are –

1. Service Delivery : Reaching the Unreached
2. RMNCH+A
3. Disease Control Programme
4. Human Resources for Health and Training
5. Community Processes and Convergence
6. Information and Knowledge
7. Healthcare Financing
8. Quality Assurance
9. National Urban Health Mission
10. Governance and Management

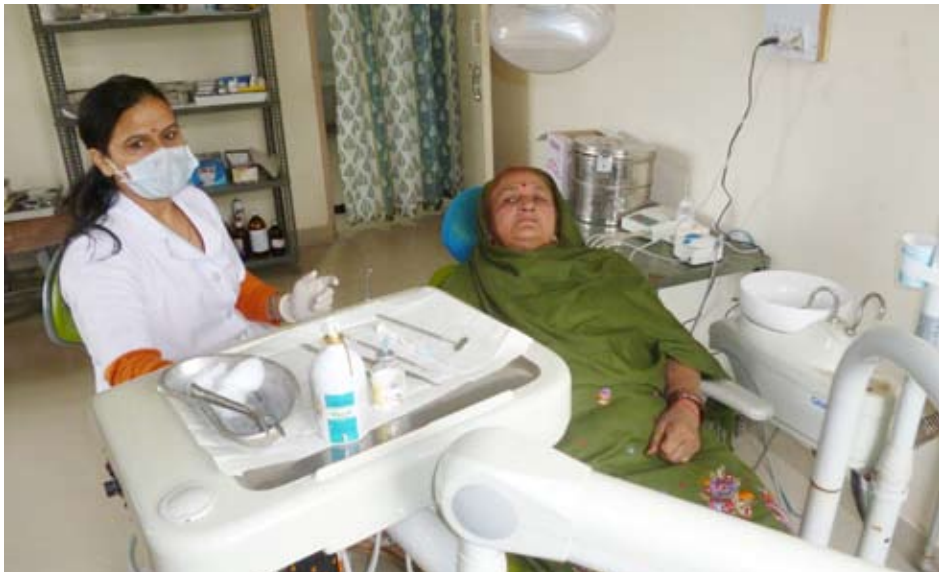
The final report contains an analytical review on each of these themes and summary of key findings from the respective state reports. It also contains recommendations and state specific findings. While discussing each theme we first present the 9th CRM theme wise objectives, then an analytic summing up of the observations from across all 18 states and the recommendations. This is followed by a brief summary of findings on that theme from each state. An effort has been made to capture the richness of the state reports and include as many observations as possible.


LABOUR ROOM
OPERATION THEATRE (O & G)
O & G IPD
ପ୍ରସୂତୀ କକ୍ଷ
ଅସ୍ତ୍ରୋପଚାର ଗୃହ
ସ୍ତ୍ରୀ ଓ ପ୍ରସୂତୀ ବିଭାଗ
REGISTRATION COUNTER
ପଞ୍ଜିକରଣ କାଉଣ୍ଟର
ENTRY

Term of Reference


जन औषधि
BPPI
जन औषधि
(दाम कम, दवाई उत्तम)
(दाम कम, दवाई उत्तम)
जैनरिक दवाई भण्डार
प्रबन्धन: रोगी कल्याण समिति, क्षेत्रीय चिकित्सालय, हमीरपुर
दवाईयाँ
PLEASE TAKE BILL

TOR 1
Service Delivery
Reaching the Unreached



OBJECTIVES:

1. To review the adequacy of health infrastructure in term of population norms, its accessibility as per time to care norms, and progress of infrastructure works and its utilization.
2. To oversee the health system strengthening components with a focus on drugs and procurement, diagnostic services, blood transfusion services, inventory mapping of bio medical equipment, integration with the AYUSH services, Ambulance Services, Mobile Medical Units, modes of operation, effective utilization and other PPP mechanisms if any.
3. To review the extent, reach, quality and visibility and availability of IEC, effectiveness IT based IEC/BCC such as SMS, pre-recorded voice calls, Interactive Voice Response System etc.

NATIONAL OVERVIEW

Physical access to care has improved considerably over the last few years, particularly in rural area. Data from the Rural Health Statistics (2015) show substantial increase in numbers of health care facilities as compared to 2005, particularly in secondary level health care facilities. In comparison to 2005 there has been an increase of about 5.2% in Sub Health Centers (SHC), 8.9% in Primary Health Centre (PHCs) and 61.3% in Community Health Centre (CHCs). As per RHS 2015, a sub-center covers on an average four (4) villages, a Primary Health Centre (PHC) covers on an average 25 villages and a Community Health Centre (CHC) covers on an average 119 villages in India.

Consequent to the increase in the infrastructure, there has been improvement in rates of utilization of public hospitals HMIS data reflect that utilization of health services has increased across the country over the years during the NRHM/NHM period. However, certain States (e.g. Manipur) show a decreasing trend in utilization of public hospitals.

Amongst the factors that affect utilization of public hospitals are access to quality drugs and diagnostic services. The country spends only 0.1% of GDP on publically funded drugs and this combined with inefficiencies in procurement and supply of drugs has resulted in erratic availability of drugs and supplies.

To improve the IPD outcomes such as lower IPD death rate, improve bed occupancy rate, etc and provide surgical care the National Health Mission has focused on ensuring availability of blood in First Referral Units and District Hospitals. There are now a total of 2760 blood banks in the country, out of which, 981 are in public facilities and the remaining are in private health sector.

Keeping in view the pluralistic health care system in country the National Health Mission also focused on providing patients a choice of accessing care of AYUSH systems through a) co-location of AYUSH facilities, b) improving HRH availability and training of AYUSH functionaries, c) investing in infrastructure, d) increasing range of AYUSH services, and e) streamlining procurement and availability of AYUSH medicines.

Over the years' significant progress has been made in all these areas and close to 512 District Hospitals, 2734 CHCs and 9050 PHCs now provide an option of AYUSH care. Further the Rashtriya Bal Swasthya Karyakram utilizes services of about 10,579 AYUSH Medical Officers.

Apart from supporting infrastructure development, NHM improved physical access to care and reduced type 2 delay (delay of reaching at healthcare facility to receive care) through the strengthening of ambulance services. Many States have supplemented the 108 and 102 ambulances with other patient transport services and these form part of current CRM assessment too. In addition, Mobile Medical Units (MMUs) were strategized to provide outreach services in difficult to reach and underserved areas. So far 349 districts across country, have 1307 functional MMUs of which 515 are in High Focus Districts (Source: NHM State wise progress under NHM as on 31.03.2015, Published on 29.07.2015)

The National Health Mission also involved partnerships with the private sector for provision of various services, particularly ancillary in nature. Extent and scope of such PPPs (Public Private Partnerships) have been increasing and recent programs like the Biomedical Equipment Management and Maintenance Programme (BEMMP) hinge heavily on PPP mode.

IEC and BCC activities have expanded in scope, however, challenges persist in terms of designing and implementing an integrated Plan of Action for effective IEC coverage

KEY FINDINGS

A. Healthcare Infrastructure and Adequacy of Facilities

- Of the 18 states visited in 9th CRM, five states (Andhra Pradesh, Rajasthan, Karnataka, Maharashtra and West-Bengal) report shortfall in number of health facilities, mostly at the level of CHCs and PHCs (as per the population norms). On the other hand states such as Himachal Pradesh, Madhya Pradesh, Chhattisgarh, Haryana and Karnataka particularly report shortfall in number of sub-centres. In addition, barriers to access exist on account of poor geographical distribution of health facilities in States of Jharkhand and Manipur. While efforts to improve access to care is visible across all hilly states, 'Time to care' approach is yet to be institutionalized in hilly states such as Manipur, Meghalaya and Uttarakhand. Progress of various construction

works is satisfactory in all states except Assam, West Bengal, Meghalaya and Chhattisgarh.

B. Utilization of Facility Based Services and Continuity of Care

- Irrespective of shortfalls in infrastructure, almost all States except Manipur report an increase in number of OPDs indicating increased footfalls in public institutions. Most states report improvements in availability of assured IPD care at sub- district level facilities; however it is still a challenge in states of Assam and Uttar Pradesh. District Hospitals and Medical colleges continue to be overburdened with IPD cases in these States. Among the states visited, only Tamil Nadu has operationalized the desired number of FRUs at sub-divisional level. Other states are yet to achieve the desired number.

C. Health Systems Strengthening through Public and Private Sector

C. 1. Drugs and Diagnostic Services

- **Drugs:** All states report progress towards free drugs initiative (either through explicit policy directive or through operationalizing drug stores that provide generic drugs at cheaper costs). States reporting relatively better access to drugs are Rajasthan, West Bengal, Uttar Pradesh, and Madhya Pradesh and interactions with beneficiaries in these states indicate that OOPE on account of drugs has reduced. On the other hand, Himachal Pradesh, Haryana, Uttarakhand and the NE states of Meghalaya and Manipur have reported high OOPE on drugs.

- West Bengal and Karnataka have established generic drugs stores/ fair price shops to meet demands of medicines that are not available in hospitals. West Bengal allows sale of commercial non-generic medicines too from such fair price shops.

- Another concern is the range of free medicines that are made available as part of free drugs initiative. For instance, Himachal Pradesh has reported high out of pocket expenditure on drugs as the state provides only 38 drugs in its essential package. Similar variation is seen in the number of medicines included in the essential drug list that range from 142 (West Bengal) to 766 (Chhattisgarh).

- Except Chhattisgarh none of the states have so far initiated or institutionalized prescription audits and STGs are also not adhered to by most states. Procurement of drugs is happening through special agencies/ dedicated corporations in all States except Assam and Meghalaya. However, efficiency of these corporations/ societies varies from state to state. For instance, Rajasthan has ensured more streamlined purchases and distribution as compared to Jharkhand. However, sporadic incidents of stock-outs are witnessed in States with relatively better procurement systems. Almost all states have reported local purchases to meet contingent demands of medicines.

- Progress towards online indenting (through software such as E-aushadi) at the district level is also being reported from most states visited. In all states however, sub district level facilities are indenting manually, except in West

Bengal where block level facilities are also indenting online. Quality of supplied drugs is being monitored through independent and accredited labs in all the states except Uttar Pradesh and Jharkhand.

- **Diagnostic Services:** Most states have already explored or are in process of exploring PPPs for provision of diagnostic services. Himachal Pradesh has reported high out of pocket expenditure on diagnostics (especially for Above Poverty Line populations). All states report free diagnostics under JSSK; however range of other diagnostic services is generally poor at sub-district level health facilities.

C. 2 Blood Transfusion Services

- Infrastructure challenges persist, particularly related to establishment of Blood banks. Further, a considerable number of Blood Banks are operating only during the normal OPD hours. In states like Manipur, Meghalaya and Uttarakhand non-availability of blood post OPD hours was reported as a concern. Wide disparity is witnessed across states with regards to user fee charged for Blood Transfusion services ranging from Rs.350 in Manipur to Rs.1050 in Chhattisgarh. Some other states like Uttarakhand have abolished user charges for blood transfusion during pregnancy; for blood disorders (like Thalassemia, Haemophilia, Sickle Cell Disease) and for BPL patients. Apart from user charges replacement of a unit of blood remains a common norm.
- Himachal Pradesh, Punjab and Uttarakhand have reported a good rate of voluntary blood donations. On the other hand, most of the blood is collected in the districts visited in Madhya Pradesh through replacement.
- The Blood Bank Management Information System which is functional in Punjab and under the process of implementation in Himachal Pradesh is a good initiative to make the details of available blood group stocks known to general public besides maintaining a database of voluntary blood donors.

C.3 Bio Medical Equipment

- A centralized system for procurement as established in Rajasthan and Haryana has advantages in terms of inventory management and also in negotiating for the rate contract of equipment. However, functionality of equipment is an area of concern and a high rate of equipment failure and downtime has been reported. This has been attributed to the failure in incorporating a maintenance clause at the time of procurement of equipment and the absence of well formulated Annual Maintenance Contracts or Comprehensive Maintenance Contracts. In almost all of the states (visited during CRM) at present there is no institutionalized mechanism to track non- functional equipment and repair it within a specified time line. The non-functional, non-repairable equipment were reported to occupy a large space in facilities. The reason cited is absence of or lack of clarity on policies related to condemnation of biomedical equipment. Some of the states like Delhi, Himachal Pradesh, Uttarakhand, and Jharkhand have initiated the process of equipment mapping. Rajasthan's equipment management software e-Upkaran has set a good example for other states to follow.

C. 4. AYUSH

- AYUSH services appear to do well in States where they are managed by separate Directorates rather than by State Health Society. AYUSH MOs are available in most States (both through National Health Mission as well as through State appointments). However, trainings for AYUSH medical officers are limited to screening for defects under RBSK program. None of the States, except Madhya Pradesh and Punjab, have reported training AYUSH MOs on National Health Program elements, even though most report co-locating these medical officers at PHCs, CHCs and District Hospitals. Apart from providing OPD services, AYUSH medical officers are involved with the RBSK program across all States and in some instances (such as in Manipur and Madhya Pradesh) they are supporting institutional delivery services (for normal deliveries). Erratic availability of AYUSH medicines and supplies is one area which has shown little progress over a period of time when compared with the reports of previous review missions. In some instances medicines and supplies have not been made available since last few years (Haryana, Uttar Pradesh, Jharkhand, Rajasthan, and Madhya Pradesh).

C. 5. Ambulance, Referral Services and Mobile Medical Units (MMU)

- All states report presence of 108, 102 or state ambulances. Few states such as Madhya Pradesh, Karnataka and Assam report multiple types of ambulances (particularly to cater to JSSK drop back and for increasing access to remote areas). Uttarakhand, Uttar Pradesh, and Chattisgarh report satisfactory deployment and performance of ambulance services. While Chhattisgarh, Haryana, Uttarakhand and Himachal Pradesh report fitting of their ambulances with GPS, some states (such as Delhi and Jharkhand) have reported presence of non-GPS ambulances. In absence of this facility, it is difficult to track ambulances performance and ensure rational deployment of vehicles. Where state reports have provided data, it emerges that on an average 150-200kms are covered by ambulances and average response time is 30-35minutes. Instances of OOPE on drop back services were observed in Himachal Pradesh, Madhya Pradesh and West Bengal. MMUs are reported to be performing well in Maharashtra, Punjab and Jharkhand, while lack of micro-planning has been reported from Meghalaya and Manipur in this context.

C. 6. Public Private Partnership

- As per State reports, most of the States except Delhi, and Manipur have initiated PPP arrangements in managing ambulance, diagnostic, biomedical equipment maintenance and waste management services. Meghalaya and Odisha are involved in PPP arrangements to manage the health care services at primary care level. Few States (Andhra Pradesh, Himachal Pradesh, Karnataka, Jharkhand, and Rajasthan) are adopting PPP mode to improve quality, contents and outreach of health care services. However, mechanisms to monitor work outputs, adherence to agreed upon TORs and impact of services provided have not been institutionalized.

RECOMMENDATIONS

1. States need to undertake comprehensive planning of infrastructure linking the time to care approach (in hilly areas) and expected footfalls. Districts must be made an important stakeholder in this process, and like Maharashtra other States could consider administrative and financial decentralization of infrastructure construction to districts.
2. There is also a need to increase the basket of assured services, particularly those relating to primary management of emergencies and assured treatment of minor ailments.
3. Progress on infrastructure development must be monitored on regular (preferably every quarter) basis and resolution of delays in construction should be accorded highest priority.
4. States now need to improve provision of IPD services at sub-district level so as to stem unnecessary referrals to higher institutions. In addition, with increasing OPD load. states should initiate monitoring of prescriptions (at least in high case load facilities) so as to promote use of generic medicines and adherence to standard treatment protocols
5. There is a need to strictly monitor compliance to free drugs and diagnostics initiatives and reduce OOPE on account of drugs and diagnostics. Institutionalizing prescription audits would be helpful in this direction. Range of diagnostic services, particularly imaging services, need strengthening at sub-district levels.
6. Cross learning from state's experience in procurement and best practices in this regard need to be shared and implemented. Audits of stock-outs at health facility levels also need to be initiated so as to resolve issues of erratic indenting supplies at sub-district level.
7. States need to be pursued for improved implementation of free drugs and free diagnostic services as per their local needs and contexts.
8. It is imperative to operationalise at least one functional Blood Bank per district in all states. Once this target is achieved states can look forward to establishing Blood Storage Units/ Blood Banks at all the FRUs prioritizing the ones with higher caseloads. States must prioritize making Blood Banks functional 24*7 based on needs assessment. The needs assessment could be carried out based on the available infrastructure and human resources at the District Hospitals and the linked FRUs and SDHs. Setting up of Blood Component Separation Units where necessary must be on the agenda. Implementation of Blood Bank Management Information System would be a commendable step in streamlining the Blood Transfusion Services, to keep real time account of stocks available at Blood Banks and can act as a platform for promoting voluntary blood donations.
9. The states must complete the exercise of Equipment mapping in all the facilities. This should lead to development of a mechanism to repair non-functional equipment and policies to reduce downtime, States may also consider including a clause for turnkey installation of equipment being procured as per norms. Calibration of equipment should be a priority and states which do not have a policy on condemnation of equipment/work-aids must formulate one.

10. Co-location of AYUSH facilities must be prioritized for health facilities where footfalls are high. At district hospital level, whole complement of various AYUSH systems must be ensured. AYUSH medical officers must be trained on NHM components including program management and service delivery. They could be involved in program functions relating to supportive supervision, and conducting review meetings with ANMs and ASHAs. States where low utilization of AYUSH services is reported must be advised to invest more in IEC on these systems so as to generate adequate awareness. Biggest challenge emerging across various States relates to availability of AYUSH medicines and supplies. It is suggested that States link AYUSH procurements to medicine procurements under the National Health Mission.

11. States must link ambulance services with OOPE on account of transport cost, and plan services accordingly. Where multiple ambulance services are made available, States must attempt at streamlining the vehicle availability. There is also a need to strengthen presence of well-trained emergency medical technicians in ambulances. Where PPP arrangements have been made, the States must establish mechanisms of monitoring service delivery targets by service provider, for e.g., link payments to the service provider with impact targets such as reduction in OOPE on transportation or on diagnostic care. Such monitoring mechanisms must be an inherent part of MoUs between both the parties.

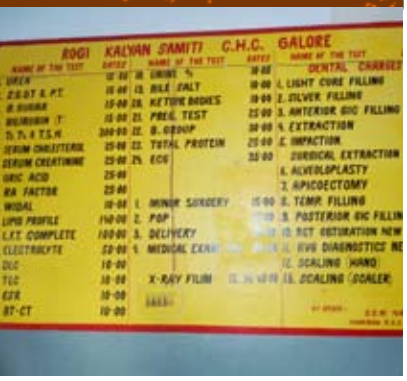
12. There should be a process to regularly review the implementation of Public Private Partnership mode and assessment of services provided as per TOR of the contract between the parties. State Health System Resource Centre should be strengthened and empowered to support state in reviewing the service delivery under PPP and conduct its evaluation. SHSRC can help state in identifying broad deficiencies in health care delivery that could be addressed under PPP mode.

13. The thrust on BCC activities must be sharpened and more priority should be given to developing, implementing and measuring BCC activities. For IEC to be effective display of information and educational material must move beyond the facilities into strategic placements at key public areas. These placements must also be targeted depending upon the public area and the population who visit them and suitable changes incorporated based on feedback received Making optimum use of indigenous arts and cultural activities in IEC campaigns must be encouraged.

STATE FINDINGS

ANDHRA PRADESH

- State reports shortage of up to 50% facilitiesas per population norm. Further, only 50% of SHCs are in government building.
- OPD load has increased by 30% and IPD by 57% in the last two years. Numbers of major surgeries and institutional deliveries have also increased remarkably.
- State has a free drugs policy in place. Stock-outs were observed against EDL. Indenting is being done using online mechanisms. However the current software application performs the function of recording rather than projecting the demand.
- Some of the designated FRU's do not have functioning Blood Storage Units or Blood Bank.



- The report highlights irrational distribution of equipment in the state.
- AYUSH services are available at general hospital, district hospital and some PHCs but they are underutilized across all level of health facilities. These are working in vertical silos and governed by vertical system with no local controls. Inadequate availability of drugs may be one reason for under-utilization.
- 108 ambulances-are functional in the state. As per information available from records, average travel distance of each ambulance is 200 km (and 5 cases) per day. One ambulance is catering to 110,000 population and average reach time is 29 minutes in rural and 19 minutes in urban areas. Maintenance of ambulances is poor.
- The state has taken up a Public Private Partnership (PPP) initiative, in the name of 'Medall' for providing necessary laboratory services at public health facilities and "E-Vaidya" is an Urban Primary Health Centre at Vizag run by e-Vaidya Ltd and operated under NUHM.
- Printed material was available for a lot of programs excepting NCD, NUHM and RBSK. Inadequately designed posters. No hoardings or posters beyond health facilities.

ASSAM

- Considerable delay in construction work was noticed.
- The OPD cases have increased steadily in the state over the years. However, there is no significant increase in the number of IPD cases. District wise variation in caseload exists. Footfalls are mainly concentrated at Assam Medical College and Civil hospitals.
- State has a policy for providing free drugs but diagnostic services are not free in State except for pregnant women who receive free diagnostic services under JSSK. Presently there is no central drug procurement agency in the state, however Government of Assam proposes to entrust the responsibility of procurement and logistics to a single autonomous entity under the name of "Assam Medical Services Corporation Limited". While State has satisfactory levels of drug availability, sporadic events of stock-outs were noted.
- State has facility level specific EDL (98 at DH level, 58 at CHC level, 58 at PHC level and 19 at SHC level), which are updated from time to time based on need.
- The online Drugs Stock Monitoring System implemented in the state serves the limited purpose of ascertaining stock position of various drugs in different health institutions and for initiating action for replenishing stocks as and when needed. State has placed mechanisms to test quality of drugs. Bio Medical Equipment mapping exercise in the state is in progress. The task has been completed in 22 districts as 02-11-2015 and for the remaining 5 districts it is expected to be completed by end November 2015.
- Co-location of AYUSH health facilities were observed at many of the visited health facilities. However, in some instances AYUSH doctors were observed to be prescribing allopathic medicines (due to lack of AYUSH supplies). Against a sanctioned strength of 1231 Medical officers (470 regular and 761 contractual), the state has 1132 MOs

(91%) in position. State also reports 100 percent availability of AYUSH pharmacists against the sanctioned strength. Apart from providing OPD based services, AYUSH medical officers are engaged in RBSK and School Health Programs in the State. Medicines are supplied by SHM/DHS. However, a mismatch between indent and supply was observed.

- Five types of ambulances were found in the field - 108, 104, Ambulances for Tea Garden Estates, Facility Ambulances provided by the Assam government, and Sanjeevani. As per the data provided by the state, on an average 3 trips are made by 108 ambulances per day. Facility Ambulances are under-utilized and is chargeable for cases other than JSSY. There are a total of 50 MMUs in the state of which 47 are state operated and 3 are operated through a PPP mechanism. There seems to be under utilization of the MMU services.
- The Public Private Partnership arrangements are made primarily to improve accessibility of health care services to employees of tea garden, operationalize three MMU services, and ensure public accessibility to health services through 108,102 and Adarani ambulance services.
- Need for Strengthening of IEC activities. Adequate IEC on comprehensive abortion care (CAC) was found lacking at all facilities which were visited. IEC on Adolescent Health, WIFS and NLEP was observed in almost all the facilities visited.

CHHATTISGARH

- State reports shortage in number of health facilities, particularly in Sub Health Centres. For instance, there is a shortage of 81 SHCs in tribal areas. Although support has been received under NHM for infrastructure up-gradation the progress has been sub-optimal.
- The institutional delivery has increased from 57.07% in 2011-12 to 73. 77% in 2014-15 and, overall OPD and IPD attendance has increased in the state over the last few years.
- State has about 750 drugs in its EDL. However, supply of these drugs varies and most of the health facilities did not display the EDL
- State has STGs in place and training of the staff has also been conducted on the same. State is in process of revising the STGs currently. Prescription audits are conducted in the state. SHSRC is the audit agency. Prescription audits have shown that most practitioners are adhering to the recommendation of prescribing generic drugs.
- State level indenting of drugs is done through IT enabled inventory management system i.e. DVDMS. Drug Procurement is done through a central procurement agency, i.e. Chhattisgarh Medical Services Corporation (CGMSC). However, there is scope to upgrade on-line indenting system and percolate it down to PHC level in the first place and to the SC over a period of one to two years. Largely the supply of drugs has improved on account of online indenting. State has mechanisms to test quality of drugs.
- Diagnostic services were available at most of the facilities. Cost exemptions are provided for children below 18years, ANC cases, Malaria and for some vulnerable communities. State is yet to roll out free diagnostic services initiative of NHM.

- Blood transfusion services need strengthening. One of the districts visited had no operational government blood bank or Blood Storage Unit but one functional private Blood Bank. The other district has one operational blood bank but a high user fee is charged along with replacement of one blood unit.
- The mapping exercise of all biomedical equipment in the state has been undertaken by HLFPPT and the report is yet to be shared with the districts. The policy and procedures for condemnation are yet to be clearly communicated.
- All the ambulances have GPS fitted in them and these are as per national guidelines. Functional call centre present. A prudent mix of 108 and 102 ambulances were seen in the blocks visited; strategically positioned at the DH and CHCs to cater to the call on priority. At present the state does not provide services through MMUs but has conceptualized to provide mobile medical services through the 108 vehicles which are unutilized.
- PPP arrangements are made for outsourcing HR through private agencies in districts where the posts are vacant since a long time. Apart from this, Bio-Medical Equipment Management and ancillary services such as diet facility has been out sourced. Specific MoUs have been signed for conducting cataract surgeries.

DELHI

- Distribution of health facilities appears iniquitous. This has led to clustering of health facilities run by different agencies. Specific initiatives to reach out to slum populations (Mohalla Clinic) have been initiated.
- The pace for establishing infrastructure facilities for CHC and PHCs is significantly slow
- Almost all dispensaries have reported an increase in patient load; however, accessibility of health services for the population, in peripheral areas and slums still remains a challenge.
- State has a free drug policy in place. Various agencies are involved in the provision of health services and poor coordination among these agencies is leading to a situation where either there is oversupply or stock-outs.
- Facility wise EDL were not found and instances of out of pocket expenses on drugs were observed as doctors often prescribe medicines beyond the supply available at the health facilities.
- STGs were neither available nor practiced by providers. No mechanisms for prescription audit were observed.
- Largely indent of medicines at the health facility level is manual (particularly below SDH level). However, efforts to digitalize indenting process (Nirantar) have been launched. State has mechanisms to test the quality of drugs.
- Blood Transfusion services are provided through an array of Blood Banks and Blood Storage Units.
- The process for mapping of the equipment has already started, but it has not yet been rolled out in all the facilities.

- Co-location of AYUSH was seen in very few facilities (only at SDH and DH level). 157 AYUSH dispensaries are functioning (101 Homoeopathic Dispensaries, 37 Ayurveda Dispensaries & 19 Unani Dispensaries). Sufficient space, equipment and infrastructure were available. AYUSH doctors not included in the trainings under various National Health programs. OPD services with a footfall of an average 100 - 125 patients/ per day. Directorate of AYUSH procures AYUSH Drugs through e-tender enquiry / from the firms approved by Government of India for regular dispensaries and AYUSH drugs not approved under NHM. No shortages noticed.
- GPS not fitted in ambulances. Call centres are operational but the response times of ambulances to calls made to the call centre varied between 30 minutes to 1 hour. CATS ambulances are being basically used for inter facility transfer and the same ambulances are intended to be utilized under JSSK, hence home pick up and drop back both are very low in the State of Delhi. MMUs are not functional in Delhi. No PPP arrangements reported by State.
- There is an insufficient display of IEC material both within and outside public health facilities. It was observed that multiple cultural and media forms such as nukkad nataks, quiz competitions, songs, health melas and ASHA rallies etc. were used to communicate messages on various health issues at community level

HARYANA

- State reports 22% shortage in number of sub-centres. Further 37% SHCs are functioning out of rented buildings. A total of 938 projects are under construction.
- There has been a steady increase in the OPD and IPD cases in the state in last few years. However, there is inter-district variation in the provision of services. Private sector is also an important provider in state and 32 % of all institutional deliveries are in private institutions.
- In 2014, Haryana Govt. notified establishment of Haryana Medical Services Corporation Ltd with a mandate for purchase, storage and distribution of drugs, medical consumables and equipment for the various departments of Haryana i.e. State, NHM, Medical Colleges etc. However, a poor supply of drugs (including AYUSH drugs) was observed. Out of pocket expenditures on drugs were also seen.
- State has notified tests which are to be provided free of cost at different levels of health facilities. The state has also started 24X7 pathology lab at district hospital under Mukhyamantri Muft Ilaj Yojana.
- Blood banks are functional in all the districts and no user fee is being charged at government facilities.
- AYUSH facilities available at 100 PHCs. However, there are concerns relating to vacancies (19% vacancy of Doctors in DH, 4% in CHC and 23% in stand-alone AYUSH dispensaries) and availability of medicines. AYUSH drugs have not been supplied since 2013 and the procurement of AYUSH drugs is not linked with online indenting system under NHM.
- All ambulances (342) are GPS fitted.
- Most of the IEC displays in the facilities were disorganized and worn out. Community level messages are conveyed in a passive rather than an active way.

HIMACHAL PRADESH

- State has adequate health facilities at different levels as per population norms (Hilly Area) excepting in case of SHCs where shortage exists (10%) as per population norms.
- OPD has increased from 9.1 million in 2010-11 to 11.5 million in 2014-15, an increase of 26% over a period of five years. Similarly, utilization of IPD services increased to 14.4% from 2010-11 to 2014-15. However the OPD and IPD footfalls are concentrated at regional level hospital and to some extent at CHCs. Utilization of these services was observed to be least at PHC level.
- State has notified 38 essential drugs free to Below Poverty Line (BPL)/IRDP families. However, this is too less a range for medicines and considerable amount of out of pocket expenditure on medicine was observed. Facility specific EDLs were not observed and many prescriptions mentioned brands/combinations beyond the supply of hospitals, contributing to high out of pocket expenditure.
- Drug procurement systems in the state are through three different channels – the Himachal Pradesh State Civil Supply Corporation Ltd., Jan Aushdhi outlets and through local purchase (using RKS funds). The rate contract for the drug purchase is decided at the state level. Implementation of DVDMS (E-Aushadi) through C-DAC is in final stage.
- For high footfall facilities, particularly at zonal hospitals, the state has out sourced lab services to SRL labs (a private organization) and it has been observed that this partnership has led to the in-house public laboratory becoming almost defunct. Out sourced lab provides free services to BPL, RSBY, RBSK and JSSK beneficiaries. Significant OOPE was observed to be incurred on account of lab services.
- State has initiated online blood bank management information system, which provides information on real time availability of blood group stock across all the district blood banks and also the list of blood donors registered with the district blood banks. High rate of voluntary blood donation was witnessed in the state majorly through small blood donation camps.
- Mapping of biomedical equipment completed in 734 facilities and this covered 20,845 medical equipments, worth Rs. 115 crore in the state. Biomedical inventory indicates around 18% of medical equipment are dysfunctional. State is in the process of floating a tender for comprehensive biomedical equipment maintenance. There is no plan in place to condemn nonfunctional biomedical equipment/furniture available in the facilities.
- The directorate of AYUSH functions as a separate directorate in the State. Co-location has been done in 101 PHCs, 33 CHCs and one DH. Apart from co-located facilities, there are 1,113 Ayurvedic dispensaries, 31 Ayurvedic hospitals, 14 & 3 Homeopathic and Unani dispensaries, 4 Amchi clinics and one Ayurvedic hospital in the state. Essentially OPD services are provided by AYUSH systems; however there was no involvement of the AYUSH doctors in the running of the national health programmes. Shortage of AYUSH drugs and non-availability of AYUSH pharmacists have been observed as bottlenecks in ensuring availability of AYUSH services in the co-located facilities.

- Out of a total of 196 ambulances only 96 have GPS fitted in them. The State has an additional 125 vehicles under JSSK, which are operational in the state. These ambulances are available only for drop back for delivered women, while 108 ambulances are used for pick-up of pregnant women. Although there are state owned ambulances they are used for cross-referrals and they charge Rs.10 per kilometer. State has got approval to run MMUs in 10 districts.
- Patient rights and schemes were displayed. IEC material was not displayed in strategic locations. There was no outreach strategy to create awareness and enable behaviour change at community level.

JHARKHAND

- State needs to address the challenge of inadequate distribution of health facilities in tribal areas Vis a Vis non-tribal areas.
- The OPD and IPD services in state are improving gradually; however, due to geographic constraints the utilization of outdoor and indoor facilities is poor at most of the health facilities
- State has recently launched the free drugs policy. State budget also supports free medicines for IPD and OPD patients but the range of drugs provided free of cost is very limited.
- National List of Essential Medicines of India 2011 has been adopted by the state and it has 181 drugs in its EDL. STGs are yet to be formulated by the state. Prescription audits not yet initiated in the state.
- Jharkhand Medical and Health Infrastructure Development and Procurement Corporation have been set up as Central procurement agency. However, it is still in nascent phase and procurements at district level are essentially done by a committee (of MO, DPM and Finance manager).
- Quality assurance system of drugs found to be weak in the state. For Drugs procured at state level, random sampling is done by Drug Inspectors and tested in State Drug Laboratory.
- State has recently notified Free Diagnostics Scheme. As of now good range of diagnostic services is available in the state in public facilities. All tests are free for BPL populations. State has also entered in collaborations with private providers to provide enhanced range of lab services at district hospitals.
- Due to non-availability of blood transfusion facilities at many FRU's, cases have to be referred causing unnecessary trouble and expenditure.
- M/S HLL Ltd. NIT has completed mapping work and the state is under process of developing a Comprehensive Annual Maintenance Contact. Uninstalled equipments were spotted in a few facilities.
- Largely AYUSH systems have not been co-located within PHCs/CHCs and District Hospital level facilities. Most AYUSH dispensaries are non-functional. Poor availability of AYUSH drugs was observed.
- Ambulances are not GPS fitted and there is limited monitoring of inter-facility transfer and drop back services. However, the MMUs are well equipped with staff and conduct 25 camps per month on an average.

- The State entered into partnership with NGO to operationalize the Mobile Medical Unit and with Medall and SRL for free Pathological test in district hospital. The Mobile Medical Unit serves the purpose of extending of the health services to inaccessible area.
- IEC material display varied across the two districts covered. IEC material related to ANC, PNC and Immunization was well displayed. The list of essential drugs was also available. However there was no material related to Kayakalp, citizen's charter or grievance redressal mechanism.

KARNATAKA

- State reports a shortfall of 33% CHCs and 85% sub centers
- The uptake of the OPD and IPD services in state shows a positive trend; however, the footfalls are concentrated mostly at the CHCs and District hospitals. Overall, PHCs had a range of 30-100 OPD cases per day while CHCs catered to 200-300 OPD cases per day
- In order to improve access to drugs the state has operationalized 176 generic medicine outlets at Taluka level, these outlets provide medicines at subsidized rates. However, at the visited health facilities stock outs and presence of expired medicines were frequently observed.
- State has an EDL specific to facilities of various levels (starting from PHC level) and this EDL has been displayed for public information across various facilities.
- Though state has adopted STGs for various health conditions, these are not being used by providers. No mechanism for prescription audit in place.
- State has a centralized procurement agency; the Karnataka State Drugs Logistics & Warehousing Society (KSDLWS). While state has put in place e-tendering mechanism and largely rolled out e-indenting in facilities (CHC and above) the state has not been able to plug in the supply chain gaps. Lack of real time monitoring of stock position at sub-district levels is leading to stock outs and presence of expired medicines. State has mechanisms to test quality of drugs.
- Diagnostics services for haematology available at most health facilities. However, free diagnostic scheme is yet to be implemented.
- During exit interviews conducted in the facilities there were complaints of non-issuance of whole blood, short supply of whole blood and plasma in the blood banks. Also at BSUs negative group whole blood was not available.
- There are no standalone AYUSH facilities and all AYUSH doctors are posted under co-located facilities at level of PHC, CHC and DH. However, adequate infrastructure is not provided to AYUSH MOs. Currently the state does not have sanctioned positions for Siddha system. AYUSH doctors are involved in providing OPD services and assisting allopathy doctors.
- State has 607 State ambulances out of which 180 are functioning as Janani SurakshaVahinis (JSV) and are used for inter facility transportation of pregnant women, mothers, neonates and infants. In addition 200 Nagu-Magu ambulances are deployed for drop back of postnatal mothers. However, as per the Nagu Magu

data only 14 % of the total deliveries conducted at public health facilities received drop back facilities

- The State has entered into MoU with GVK-EMRI to implement Arogya Kavacha -108. State executed another MoU with PSMRI (HMRI), which is a Health Information Help Line
- Enough IEC material is available about emergency services, family planning, and methods of contraception. ASHAs and ANMs are oriented on how to involve community members in the prevention and control of Vector Borne Diseases. There is a need to monitor the materials used by ASHAs and ANMs for methods of preventing unwanted pregnancies.

MADHYA PRADESH

- In the two districts visited, there is a shortage of peripheral health facilities as per the population norm. For instance, there is a 12 % shortfall in the number of SCs, given the requirement.
- The access to health facilities and utilization of services has improved substantially in recent years. However, the situation varies from district to district, sub-centers were accessible in Shahdol district while it was difficult to access them in Dewas.
- The state has a free drugs policy in place. Awareness level about free drugs scheme among beneficiaries is satisfactory. Adequate availability of free drugs was observed. Audit prescription practice needs strengthening. Adequate provision of diagnostics observed across health facilities.
- The state report highlights that the blood transfusion service is available only at district level in both the districts visited during CRM and underline the scarcity of skilled human resource. Voluntary Blood Donation is rare and most of the collection is through replacement.
- Stare has 1773 standalone Government Ayurveda Hospitals. In addition there are 110 facilities (CHCs and PHCs) which are functional with AYUSH doctors but no MBBS doctors. AYUSH facilities are not co-located at most of the places. AYUSH MOs are provided training in the implementation of national programs (including disease control programs like malaria and leprosy), family planning, nutrition and maternal and child health (e.g. ante-natal care and immunization) by the CMHO. Female AYUSH MOs are provided training in SBA. RBSK program has involved AYUSH doctors in community based screening. A shortage of supply of medicines, equipment and storage space was noted.
- Operational issues related to 102 and 108 observed across facilities in both the districts. Limited awareness about Janani Express in community was observed at ground level. These are not adequately utilized and timely response of ambulances was a major concern. Although majority of pregnant women are transported through 102, these do not have technical staff which is a cause for concern. The drop back for mothers and infants through Janani Express from facility to home is poor. The issue of some out of pocket payments was reported by beneficiaries for drop back facilities under JSSK. Mobile Medical units have not commenced in the state.

- Various ancillary services such as Security, Laundry, Hospital cleaning, have been out sourced, with outsourcing contracts being done at District level. However, the quality of services is poor and monitoring is weak. No supervisory checks or controls were observed in both the districts.
- IEC material displayed at the facilities were good but there is room for improvement with regards to the quality, comprehensiveness and strategic positioning of the material

MAHARASHTRA

- The gap in the existing health facilities across the state against the sanctioned facilities for SHC, PHC and CHC is 21%, 17% and 33% respectively. Construction work in the state is decentralised and delegation of power for administrative approval is given to Executive committee and health officials to plan health infrastructure as per need and plan of District
- OPD services increased by 60% and IPD services increased by 97% at the all PHCs. The Central facilities (Medical College and Women hospital) reported to have high footfall. The PHCs and CHCs despite good infrastructure have low footfalls. Major surgeries and institutional deliveries have increased remarkably
- State has a free drug policy and satisfactory levels of drug availability were observed. State has 192 drugs in its EDL of which 87 have been identified as vital medicines. State has put in place STGs for various conditions. Although all medicines are purchased by a centralized mechanism, local purchase is also permissible with some conditions. There is need to upgrade the software to indicate daily/monthly consumption of drugs to monitor indenting process and consumption pattern. Currently, the software is not able to account for the medicines purchased during emergencies and through other sources. Essential Diagnostics tests are partially being provided by the facility and facilities are charging for X-ray, lab test, Sonography, CT scan however users fee are not being charges for JSSK beneficiaries
- As per the norms, the blood storage units are being set up in every district where the population of the district is more than 10 lakhs, in Maharashtra. There are 50 blood banks which are functional and out of these, 32 are under Public Health Dept. and 18 are under Medical Education and Research Dept. The blood banks are functional at district hospitals. Timely and adequate supply of blood to the patients is ensured
- All DHs, WHs, GHs, MHs, SDHs, RHs, PHCs covered as a part of mapping and 2298 institutions were mapped. The mapping indicated that 81 % of the equipments are functional. State has not uploaded the inventory data on State website under mandatory disclosures. However, all works related to RFP is done. There is no cataloging of the equipment andalso at places there is no AMC plan. About 20-30% of the space occupied by either non-functional or non-repairable equipment at all levels of health facilities. Store rooms at health facilities are not maintained as per state financial guidelines and rules. The Skill Development Lab at Nashik is being sub-optimally utilized.
- Total 711 AYUSH dispensaries and 114 Hospitals are functioning in the state. Total 23 District Hospitals and 238 CHCs are having AYUSH wings as collocated AYUSH

facilities in the state. All AYUSH Doctors are trained in various national health programme such as (MEMS/108), RBSK, MMU, other health programme under NHM. State is laying stress on main streaming AYUSH as these are traditionally well accepted by communities. Over 62 lakh patients utilized AYUSH OPD services and over 1.5 lakh patients utilized AYUSH IPD services in 2014-15. Additionally specialized AYUSH camps are also organized in the State at DH/SDH levels. AYUSH services are well accepted by patients. Non-availability of desired range and quality AYUSH drugs is a challenge reported by the State

- 108 and 102 ambulance services are available in both urban and rural area. As per the available data and records, the average travel distance of the ambulance is 65 km per day and 2 cases per day. One ambulance caters for about 20000-25000 population and the average reach time is 20-30 minutes. The maintenance of 102 ambulances is poor. There are 40 MMUs operating in the state through outsourcing to NGOs/RKS. MMUs are reportedly performing well in the State.
- The state has PPP arrangements for provision of additional HR in tribal areas, organization of services for sickle cell anaemia, epilepsy camps, provision of palliative care, 104 call centre, Maher scheme, MMU services for tribal areas, organization of specialist medical and dental camps through Medical Colleges in tribal areas and Community Action for Health implemented in 600 villages across the 13 districts.
- IEC materials for MCH, RNTCP, RKSK, NVBDCP, JSY, FP were largely available at the facility in local language. IEC posters and hoardings were not seen in outreach and beyond health facilities. Awareness on free entitlements was largely due to information chain through ASHAs and ANMs. The state is using SANGRAM IT platform for distributions/BCC materials related to health awareness.

MANIPUR

- State lacks comprehensive infrastructure planning leading to poor access to health facilities.
- There has been no significant improvement in utilization of facility based care for last four years. Peripheral facilities as well as District Hospital, CHC and PHCs prefer to refer patients with minor ailments to Medical College in Imphal. Non- availability of free drugs and diagnostics and out of pocket expenditure in public health facilities is leading to low utilization of services. Irrational facility distribution is also one of the major reasons for low patient load and sub optimal utilization of existing infrastructure.
- State neither has a free drug policy in place nor does it run any state specific scheme to ensure availability of free drugs at public health facility as an entitlement.
- Stock-outs and expired medicines were observed at various health facilities visited.
- Despite having huge demand, blood transfusion services have been found to be weak in both the districts. Out of the two districts, only one Blood Bank is functional in district hospital Thoubal which is a single First Referral Unit (FRU) in the entire district and even this doesn't provide 24x7 services and operates in normal OPD hours. There is no functional Blood Storage Units in both the districts despite many delivery points. User fee is charged for availing services.

- The procurement of equipment was not commensurate with the need. The State has not initiated mapping of biomedical equipment and is still to undertake the procedure to develop maintenance contract. High downtime of instruments was reported.
- AYUSH services are largely related to delivery of Homeopathy only. AYUSH doctors are posted where Allopathic Specialist/Doctors are not available. At many places, AYUSH HR is being utilized to provide services such as fixed day USG for ANC, attending cases in MMUs, operating AFHCs, and conducting institutional deliveries. Caseloads are poor at AYUSH OPDs. One reason for this could be the dissociation between the posting of doctor and the type of medicines supplied (Homeopathic doctor and Ayurvedic medicines) to that institution. All procurement related to AYUSH drugs and equipment is done through Directorate of AYUSH.
- Manipur has 9 MMUs run by State government. The range of services offered has been limited to general OPD and ultrasonography. Apart from this micro planning and deployment of MMUs is a challenge. The use of available human resources seems to suboptimal.
- Public Private Partnership mechanism for diagnostic careis yet to be developed inthe State as of now as per report.

MEGHALAYA

- While State has reported adequate number of health care facilities at sub district level, 4 districts do not have district hospital
- The utilization of IPD services increased by 16 % from year 2013-14 to 2014-15. The OPD and other services like C-section and major operation increased 3 -4 % from year 2013-14 to 2014-15. There was a minor increase in institutional delivery is 1.8 % during this period.
- The state is yet to notify the free drugs policy. Availability of drugs at public facilities was observed to be very poor. Patients are incurring out of pocket expenditure ranging from Rs. 150 to Rs. 430 on account of purchase of these drugs.
- State has its own EDL which covers approximately 280 drugs and has not been updated since its implementation in 2008.
- Standard Treatment Guidelines (STGs) are yet to be received by the practitioners at the facilities visited Service providers are not aware of the prescription audit mechanism. None of the providers were observed to be prescribing generic drugs.
- State has executive mechanism for deciding procurement related matters and has a Joint Procurement Committee which provides guidelines for the procurement of drugs however procurement for most of the drugs has been decentralized to the district level. Hence, this mechanism has not been able to streamline the procurement and ensuring the availability of drugs.
- State has mechanisms to test quality of drugs. However, there are no NABL accredited drug testing labs.
- There is a limited range of free diagnostics and that too only for JSSK beneficiaries. Other beneficiaries are charged user fee even for the basic investigations such as MP for malaria, RDT for malaria, Hb. investigations etc

- In the districts covered under CRM Blood Bank doesn't provide 24x7 services and operates in normal OPD hours. There is no Blood Storage Unit in both the districts despite many functional delivery points. Under the current PIP 3 new Blood banks have been approved and are being set up.
- The state has not begun mapping of Biomedical Equipment. Certain incidences have also been reported where equipment have not been installed and lying idle since many years.
- The state provides mobile medical services with each mobile medical unit equipped with 1 Medical Officer, 2 Staff Nurse, 2 Technicians, 3 Drivers and 1 Helper. Glitches were observed in the functioning of MMUs such as limited range of services being offered and area of operation also lack of micro planning and monitoring was observed
- The state of Meghalaya has Public Private Partnership for managing PHC, Ambulances and MMU services, however it varies from district to district
- IEC material was sufficient and displayed in both local language as well as English, but, was limited to the health facilities and not seen at the community level

ODISHA

- Overcrowding was observed at high caseload health facilities. There is a need to sync health facility infrastructure planning with footfalls.
- There is an increase in IPD by 186% from 2008-09 to 2014-15 and OPD by 247% from 2008-09 to 2014-15. Nirmaya scheme, an initiative to provide free medicine to the people by the Odisha Government, increased the utilization of services at district and sub district level.
- Nirmaya Scheme is an initiative to provide free medicines to all by Odisha government. E-Aushadhi is only fully functional till district level.
- Benefit of free diagnostic services not extended to all categories of beneficiaries accessing public health facilities. Diagnostics under JSSK are free however, OOPE have been reported on account of lack of USG services in public facilities.
- Free drug services have been launched by the Chief Minister for health facilities in State upto SDH level since April 2015.150 drug distribution stores have been functional against 725 sanctioned in State.
- 108 and 102 are functional but have remained underutilized due to inadequate awareness amongst beneficiaries about these services.
- Blood services need to be improved. 52 BBs have a valid license and 36 out of 43 sanctioned BSUs are currently functional.
- State has several PPP initiatives; for e.g. sub centre in tribal areas with support from NGOs to provide primary services, ASHA Griha etc. and state has lined up external evaluations for those completed few years.
- Utilization of AYUSH services has been innovatively built into the existing system where in AYUSH doctors are involved in ANC, delivery, child care, capacity building of ASHAs, and sector level meetings, epidemic management, etc., but AYUSH system

remains largely co-located rather than integrated within the existing health system. Referral system for AYUSH services was found to be lacking.

PUNJAB

- Keeping in view the population norm, the available number of infrastructure in the state as well as visited district is adequate
- The utilization of services at CHCs and PHCs level are affected due to non-availability of requisite services, inadequate human resources and inequitable distribution of delivery points. The state government's initiatives to strengthen 100 district health units in Punjab have adversely affected the functioning of CHCs and PHCs located in peripheral areas
- State has a free drug policy. Essential drugs as per the EDL were available at the health facilities visited. The state has 228 drugs (228-DH and 159 at CHC/SDH), 41 consumables and 18 suture material under its EDL/ECL.
- There is a central drug procurement system (Punjab Health System Corporation) and e-Aushadhi Software is being used for on-line supply chain management. At District level, contingency funds are also available for purchasing of medicines from outside in case of any shortage.
- State does not have a free diagnostic policy. Diagnostic services are freely available for only for the beneficiaries are under JSSK, Punjab Government Service, and Below Poverty line patients
- Blood Transfusion services were found to be well established in Punjab. The report specifies that information regarding daily stock of blood units, monthly and year wise report by category, inflow and outflow of blood units, and waste management system was well displayed at the facilities visited.
- The state is yet to begin with equipment mapping and maintenance procedures.
- State has 174 AYUSH dispensaries co-located under the National Health Mission. State has 159 AYUSH MOs. Average OPD case loads at AYUSH facilities range from 20-40. AYUSH MOs have been trained in various national health programs and are utilized in school health program. Pulse polio drives, immunization and RBSK program. Availability of AYUSH medicines is a challenge in the State.
- In the state, referral transport is being carried out by 108 with a fleet of 240 ambulances. State owned ambulances (256) are in service also. Utilization of MMU services has been reported to be satisfactory in the state. The only drawback is the user fee being charged for tests without any display of charges which is a deterrent for people to avail this service.
- State runs a medical college under PPP arrangement.
- IEC material related to ASHA incentives, labour protocols, user charges, family planning and gender awareness etc. was found but the posters and banner were sparse and were not visible and 5X5 matrix was not seen in none of the district. Extensive media publicity is being carried out through TV/Radio/Print Media etc.

RAJASTHAN

- The number of facilities providing Level 2 and Level 3 delivery care were less as per the population norm. Further, state has a shortfall for 50 L3 facilities.
- Due to referral of pregnant women, the utilization of services has increased at the district hospitals/medical college. One of the reasons for the referral is the non –availability of adequate Human Resources (Medical officers and Specialists) at peripheral facilities. Very few functionaries have been trained on SBA, RI, IMNCI and PPIUCD. There is no adequate training provided for skill upgradation of both regular and contractual staff.
- State has a free drug initiative in place and it is being implemented satisfactorily. The state reported satisfactory level of availability of drugs and interactions with the beneficiary indicated that free drugs initiative is largely successful.
- Rajasthan Medical Services Corporation is the central procurement agency responsible for procurement of generic medicines, surgical and diagnostic equipment for all healthcare institutions of the State. Local purchase was made for those medicines which were not available through the central purchase.
- Inventory management is being done through the e-Aushadhi and efficient use of this application was observed in the state for generating on-line demand, on-line purchase order generation, stock ledgers, expiry drug details, transfer of drugs from one District Drug Warehouse to another District Drug Warehouses.
- State has mechanisms to test quality of drugs.
- State has launched the scheme of free essential diagnostic tests in government hospitals across the state called *Mukhyamantri Nishulk Janch Yojna* (MNJY). Under the scheme, patients can undergo 57 free diagnostic tests at government hospitals linked to medical colleges.
- As on December 2014, out of total 85 Blood Storage centre (71 licensed + 14 applied) 57 were functional. At present, 107 Blood Storage centres are licensed and 87 are functional. Despite this improvement, a large number of designated FRUs still don't have a functional Blood Storage Unit. Non availability of trained staff and dysfunctional equipment hamper service delivery severely.
- E-Upkaran, a comprehensive software to improve the inventory management and maintenance services of equipment in hospitals is in place. This covers all the 2,500 facilities of Rajasthan, including medical colleges and hospitals across all districts. Mapping has been completed in the state.
- The state has 1013 sanctioned AYUSH co-located facilities. Reported average OPD of AYUSH for the year 2014-15 was 1660 per PHC/CHC. AYUSH Medical officers are also engaged in RBSK, vaccination, pulse polio, Family planning, RNTCP and vector born disease prevention activities and conducting institutional deliveries, supportive supervision and health education. Procurement of AYUSH medicines is not streamlined and it was observed that (in the facilities visited), there hasn't been any AYUSH supply from last 3 years. In absence of the AYUSH medicines, these doctors provide OPD services using allopathic medicines.
- The ambulances are equipped according to guidelines. 104 ambulances are being managed at district level and at facility level. It is mostly utilized for drop back

services. It was found that women and communities were mostly utilizing private vehicles to reach to the facilities for which they were being reimbursed.

- All districts of Rajasthan are equipped with Mobile Medical Units and Mobile Medical Vans providing a range of services including immunization, ANC services and screening for malaria, leprosy and blindness. In addition to difficult to reach villages, PHCs without MOs and SCs without ANMs are also targeted. State has implemented centralized GPS Monitoring for all the MMUs/MMVs in the State.
- Ambulance services except Janani express are being managed under Public Private Partnership Mode. The State entered in partnership with GVK for 108 ambulance services.
- IEC material was not displayed sufficiently in focal points.
- Lack of role clarity in ASHA support structures in both the districts visited.

UTTAR PRADESH

- It is observed that adequate physical health care infrastructure exists in the state at different levels except for CHCs which are less in number.
- There is a substantial increase in number of OPD and IPD cases from 2013-14 to 2014-15. However, lack of services at sub-district level substantial number of referrals are being made to District Hospitals
- The State has implemented "Free Drugs for all" policy. On enquiry from few patients about supply of free drugs, they were found to be aware about it and utilizing it. Most drugs from EDL were found to be available at health facilities. With free drug and diagnostic policy, OOPE for those seeking care in public sector hospitals for MNCH appears to be low. This observation is based on informal discussions with patients at various health facilities visited.
- State has facility-wise EDL The State is procuring drugs through a centralized system and the CMO and CMS are placing on line orders on vendors through approved rate contracts. However, quality certificate is being provided by the drug provider, rather than by an independent laboratory.
- State has implemented the policy for free diagnostics but only a limited range of laboratory services is available at CHCs and PHCs
- The District Hospitals in both the districts visited provide blood transfusion facilities. However, availability of Blood Components is insufficient due to unavailability of functional Blood Component Separators
- AYUSH facilities were found to be co-located and functional at District Hospitals. The average AYUSH OPD is about 150-200 patients per day. AYUSH doctors also informed that they are taking part in different health programs but they have not received any training since last one year. There is acute shortage of AYUSH medicines. Ayurveda and Homeopathic medicines were supplied in 2015 after a gap of two years. Unani medicines have been supplied for the first time in 2015
- 108 and 102 Ambulance services are working well with sufficient utilization. Drop back system is working. These services are being operated through PPP arrangement.

At the State level utilization of 102 ambulance is 8.24 trips/ambulance/day and 213 km/ambulance/day; response time is 26.6 minutes in rural areas and 19.6 minutes in urban areas. However inter district transport is not available.

- Mobile medical Unit services were started in the state in 2011 in PPP mode. However, legal proceeding against the private partner has grounded a fleet of 130 vehicles since 2012
- Over all IEC/BCC activities are weak and there is little evidence of a coherent strategy-across methods/facilities.

UTTARAKHAND

- While the state has adequate number of facilities given the population norm; it still needs more facilities with respect to 'time to care approach'. The general up keep of the health facilities is good.
- There is significant increase in service utilization in terms of outpatient, inpatient and surgeries over the last three years. The regional and district hospital are overburdened, while service utilization at CHC, PHC and sub-center varied from facility to facility. The dependence on public health institutions is higher as there are no significant private health services available.
- State has put a revised drug policy in 2015 which mentions the provision of generic drugs for free. However, shortages/stock outs of RMNCH+A 5/5 Matrix essential commodities was seen across many of the facilities leading to out of pocket expenditure.
- State has about 575 drugs in its EDL and these are made according to the level of facility. However, at most health facilities the EDL was not displayed and no mechanism for prescription audit is in place.
- For procurement the state is using e-procurement mechanism through state e-tender portal. State has mechanisms to test quality of drugs. Currently diagnostic services are provided with minimum user charges to the APL category of patients while the BPL patients are provided these services for free of cost.
- The state does meet the requirement of having a blood bank in each district. Out of total functional blood banks, only 4 blood banks are 24X7 (Doon Hospital Dehradun, Base Hospital Srinagar, Base Hospital Haldwani, Sushila Tiwari Govt. Hospital Haldwani); other blood banks work only for 16 hours (two shifts) and during night, if required, service is provided on call. None of the blood storage centres are functional 24X7. User fee is charged by the blood bank except for Pregnancies and sick infants (JSSK), thalassaemia, haemophilia and BPL.
- A large number of equipments were found to be dysfunctional. Biomedical Equipment Mapping and segregation of usable/non-usable equipment at facilities has been completed. Based on this report, the State is preparing to issue an RFP by mid November 2015. Modus operandi for unused equipment and maintenance of all bio medical equipment yet to be worked out.
- Many hospitals at district/sub district level have AYUSH services co-located. However, there is variability in infrastructure for AYUSH services. For instance, Doon hospital

has got a very good AYUSH infrastructure (even attracting many VIPs for treatment) but in Kalsi CHC, a security watchman's cubicle is allotted for one Ayurveda and another Homeopathy doctor.

- The patient load in all AYUSH sections visited was low because the alternative system has not become popular and wherever AYUSH services are initiated, the full complement of physician, drugs and therapies are not available.
- Fitting of GPS in vehicles is underway and already most of the vehicles are covered. State has one centralized call centre. 108 ambulances are performing well in the state with an addition of providing referral services under school health programs and Khusiyon Ki Sawari. MMUs are operating in the state in partnership with NGOs.
- The State of Uttarakhand entered into partnership with GVK-EMRI for 108 Ambulance and Emergency services and with Rajbhara Medicare Privated Limited for managing the health facilities (Community Health Centres and Urban Primary Health Centers).
- IEC material well displayed in most institutions in Dehradun while same is grossly lacking in Nainital districts. The extent, reach, quality and visibility and availability of IEC materials is also satisfactory especially the ongoing "Indradhanush" campaign.

WEST BENGAL

- Overall, there is a 21%, 58% & 36% shortfall in SHCs, PHCs & CHCs respectively. There is slow progress on new constructions/ up-gradation/ renovation work in the state
- The OPD at facilities has increased by 19.61% from year 2012-13 to year 2014-15. District and sub-divisional hospitals are overburdened due to poor service provision at PHCs
- The State has notified Free Drug Policy. However, there are instances reported by patients and pharmacists when in case of non-availability of drugs, patients are required to purchase the medicines from the fair price shop. These outlets provide drugs at a subsidized rate- 48% to 77% discount on MRP of medicines. The fair price outlets have also been permitted to keep stock of branded medicines in addition to the 142 generic drugs as per the essential drug list.
- State has operationalized the IT enabled Inventory Management system in place which is available up to the block PHC level. State has mechanisms to test quality of drugs.
- State has entered into Public Private Partnership for provision of diagnostic services. Free diagnostic services is being provided to all JSSK patients and no out- of- pocket expenditures were reported by any of the beneficiaries interviewed in the facilities. For other patients, in the PPP mode up to the Block PHC level, negotiated rates are as per the West Bengal Health Systems 2008 rates
- Two SDHs in Cooch Behar District reported regular shortage of blood. The SOPs for conducting the blood tests and hygiene practices were not displayed in the blood bank
- Inventory Mapping has been completed by HLFPPT. The new equipment is being procured with warranty time and quarterly comprehensive maintenance contract.

Hindustan Latex Ltd has been contracted for AMC, cold chain equipment AMC with National Refrigeration Company LTD. HLL presently segregating the available biomedical equipment as fit/unfit for further use. Eastern Regional Testing Laboratory (ERTL) has been approached for calibration of equipment

- Co-located AYUSH facilities exist at different levels, but are mainly confined to Homeopathy (as uptake of Ayurveda services is lesser than the Homeopathy services). The medicines are procured through the government system and are provided annually by AYUSH Department. However, it was observed that the supply of medicines is mostly not in accordance with the indent submitted by the facility. This therefore, leads to stock outs of certain medicines that are required in larger quantities and wastage of others that are not required in that facility
- Most inpatients reported out of pocket expenditures for transport at both district hospital and sub district hospitals in Purba Medinipur varying from about Rs. 200-600. State has 55 sanctioned MMUs out of which 41 are reported as operational till date.
- The State entered into partnership with agencies and NGOs for managing diagnostic services, Mobile Medical units, JSSK referral transport, biomedical waste management and AMC of Biomedical equipment maintenance at many level.
- Citizen Charter, IEC material, signages generally not displayed well in all facilities. District Information Culture Officer used folk media to create awareness and demand generation for all public health issues.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TOR 2

Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A)

OBJECTIVES:

1. To assess the planning of RMNCH+A , alignment with RMNCH+A 5x5 Matrix based upon gap analysis and prioritization for continuum of care based upon utilization and delivery points.
2. To review delivery and quality of PPIUD services, JSY & JSSK entitlements, establishment and functioning of SNCUs, NBSUs, NBCCs, NRCs, RBSK screening, Immunization, alternate vaccine delivery arrangements, maternal and child death review and organization of AFHCs etc.
3. To oversee community level care arrangements for Home based new born care, safe delivery at home through SBA, advance distribution of Misoprostol, Iron Supplementations, Adolescent Health Days, Peer Educator and AH counseling etc.

NATIONAL OVERVIEW:

The tremendous efforts made for implementation of RMNCH+A strategy shows positive trends in-terms of improvement in outcome indicators. The Infant, Under 5 and Maternal Mortality Rates have consistently declined over the years and are close to the level of Millennium Development Goals 4 and 5. Total Fertility Rate has reached its replacement level (2.1) in many States like, Kerala, Tamil Nadu, Andhra Pradesh, Himachal Pradesh, Karnataka and Maharashtra. However, in States like Bihar, Madhya Pradesh, Uttar Pradesh, Jharkhand and Chhattisgarh, TFR continues to be in the range of 2.6 to 3.4. The SRS 2014 shows a significant decline in the Crude Birth Rate over the decades from 29.5 in 1991 to 21.4 in 2013. However these achievements mask the considerable intrastate and interstate variations, that exist in the performance of reproductive and child health indicators e.g. Infant Mortality Rate is 40 (2013) at the national level however this ranges from 54 in Madhya Pradesh to 9 in Goa. Inadequate planning, lack of functional First Referral Units (FRUs), unavailability of essential commodities and non availability of specialists and skilled health personnel in facilities are some of the critical aspects that have resulted in variation of performances across states and more so in high focused districts.

Institutional delivery rates have seen increase in most of the States (National average 88.3% in 2015-16-HMIS) owing to assured referral transport and improved quality of facility level care. Out of pocket expenditure on

account of child birth in public facilities in rural areas has reduced due to entitlements such as JSSK and free drugs and diagnostics initiatives.

Newer initiatives to further limit maternal mortality and morbidity such as Calcium-supplementation, de worming, management of GDM (Gestational Diabetes Mellitus), screening of hypothyroidism, syphilis and HIV and corticosteroids use for pre-term labour are in initial phases of implementation in most of the States visited and needs further acceleration in implementation.

Referral linkages from community to facility and follow up with newborns discharged from SNCU, children identified under RBSK and high risk pregnancies needs strengthening in most of the states. RBSK, though in nascent stages, is picking up fast, with mobile teams and DEIC in place in most of the States.

KEY FINDINGS

RMNCH+A planning and monitoring

- Framework for gap analysis followed in non-high priority districts differed from the one followed in High Priority Districts in Himachal Pradesh, resulting in incomplete situational analysis and inadequate district planning.. Assam has initiated many high impact interventions in the HPDs after thorough gap analysis. In both CRM districts of Andhra Pradesh, there was no district level planning exercise undertaken. . Punjab reported to have district level planning happening across districts with help from development partners.
- Inadequate functional delivery points and lack of trained human resources, equipment and inefficient supply chain management system at FRUs have affected availability of CEMOC/EMONC services against demand as observed in Meghalaya (one EmOC trained doctor in the entire SW Garo Hills district), Manipur (lack of need based trainings for EmONC, LSAS, SBA and IMNCI) , Himachal Pradesh, Rajasthan (EMOC services not available at SDH Badi (Dholpur district) despite availability of all three specialists- Gynaecologist, LSAS trained doctor and Pediatricians), Uttar Pradesh (slow pace of trainings in District Jalaun) and Karnataka. In Karnataka, although the number of PHC delivery points has increased, there has been a decline in sub-centre delivery points.
- Irrational deployment and under utilization of support staff (i.e. counselors and lab technicians) at the L2 &L3 health facilities was observed in Manipur, Meghalaya, Himachal Pradesh and West Bengal. In remaining states, irrational deployment was observed for both technical and non-technical staff.
- For RMNCH+A monitoring, Jharkhand has established model supportive supervision mechanism through State Review Mission which is well appreciated and is being replicated in Uttarakhand.
- Essential drugs were found available in sufficient quantities in most states except Rajasthan (ART drugs, RTI/STI drugs, Misoprostol and Mifepristone are not available at Bikaner and Dholpur), Delhi (RTI/STI drugs at many facilitites), Assam (CHC Deragaon did not had MgSO4 since September 2013), Jharkhand (Misoprostol not available in both districts) and Manipur. The State of Rajasthan has a good drug procurement and supply chain management system called E-aushidi.

ANC Services

- Though Antenatal checkups (ANC) were found to be regular, complete ANC coverage was not ensured in states like Delhi (Tetanus Toxoid two dose (52%), IFA (<50%), Andhra Pradesh, Uttar Pradesh, Manipur, Himachal Pradesh, West Bengal, and Jharkhand due to lack of adequate follow-up.
- Line listing for anemia and follow up of high-risk pregnancies was not being conducted adequately in visited facilities in Delhi, Andhra Pradesh, Meghalaya, Chhattisgarh, and West Bengal. Counselling for IFA supplementation during pregnancy was not adequate in Andhra Pradesh, Chhattisgarh, Uttarakhand, Jharkhand, Uttar Pradesh, and Meghalaya.
- New activities such as Calcium-supplementation, de worming, GDM (Gestational Diabetes Mellitus) management, screening for hypothyroidism, syphilis and HIV, use of corticosteroids for pre-term labour are either not being implemented or their implementation is slow in Andhra Pradesh, Uttar Pradesh, Punjab, Jharkhand, Maharashtra (District Bhandara), Meghalaya and Manipur. Some states have planned cascade trainings/orientations for implementing these guidelines, but the overall pace of these activities is slow. West Bengal on the other hand has implemented most of the new RMNCH+A initiatives as per the national guidelines.
- Unavailability of USG for ANC was a common problem observed in Delhi, Karnataka, Meghalaya (not even a single facility with USG services in South-West Garo Hills District).

Institutional Delivery

- Availability of blood banks and blood storage units below district level remains a serious limitation in establishing EmONC services in states like Rajasthan, Manipur, Meghalaya, Himachal Pradesh, Jharkhand, Chhattisgarh and Madhya Pradesh. These states have not been able to operationalise these units in secondary care facilities, which create more pressure on already overcrowded tertiary centres.
- Non-compliance to intrapartum and newborn care protocols in labour rooms has resulted in high cases of newborn sepsis and birth asphyxia in SNCUs as reported in Delhi, Assam (increased inborn deaths due to asphyxia) and Rajasthan (nearly 50% admissions in NBSU (Dholpur district) due to asphyxia). Andhra Pradesh and Meghalya reported non-compliance with infection prevention practices in most facilities visited.
- In addition inadequate addressal of patient privacy concerns were widely reported in Assam, Chhattisgarh, West Bengal, Meghalaya, Jharkhand, Uttar Pradesh and Manipur. Madhya Pradesh, Delhi and Odisha reported a mixed scenario for labour room services. Excessive use of oxytocin and misopristol to induce labour was reported in Assam.
- High Cesarian Section (CS) rates at tertiary care institutions and low rates of C-section at FRUs were reported in West Bengal, Chhattisgarh, Jharkhand, Himachal Pradesh and Odisha due to lack of functional FRUs at sub-district levels. West Bengal reported that the consent taking procedure before surgery is not diligently followed in the state.

- Standard Operating Procedure (SOP) as per Maternal New born Health (MNH) tool kit were not adequately followed in Delhi, Andhra Pradesh, Meghalaya (DH West Jaintia Hills), Uttarakhand (Doon Female Hospital Dehradoon), West Bengal (District Hospital Cooch behar) and Jharkhand (LR at Mdical college Dhanbad).
- Sub-Centres as delivery points, in hilly areas, conducting more than 10 deliveries a month were struggling for running water, pits for disposal of biomedical waste and basic instruments like BP apparatus etc.
- SBA/Dakshata/NSSK training was not provided to the staff nurses/ANMs in many states.

Referrals

- Most of the district hospitals visited do not have a functioning OT during nights. Since the OT functions only till 4pm, many emergency cases or complicated cases were referred to other hospitals in the neighbouring districts (Baba Saheb Ambedkar Hospital in Delhi).
- High referrals were also observed from districts hospitals where blood bank is not available or blood storage unit is not fully functional and only limited supply RH positive blood is stored (CHC Jharia, CHC Kuru in Lohardaga Jharkhand).
- Absence of functional referral linkages have created hurdle for patients as they are declined admissions in these facilities. As a result of this, in some states, deliveries have taken place on the way back home (Assam)
- Referral linkages from community and follow up of new-borns discharged from SNCU need strengthening in most of the states (Assam, Jharkhand). Many new-borns diagnosed with developmental delays or other birth defects did not receive proper referral because the weak linkage between the community and District Early Intervention Centres (DEICs). Better utilization of referral services, both for pregnant women and sick newborns was reported from Chattisgarh.

JSY

- There is awareness about the JSY scheme amongst the service providers, ASHA and the community; however, in certain instances misunderstanding about entitlement exists due to state level variations.
- Overall, JSY payments are made through direct benefit transfer (DBT) and cheques. *Aadhar* card and other biometric enrolments are mandatory for availing this benefit. This has streamlined payment delays and reduced malpractices. However, non-payment of JSY incentives due to lack of beneficiaries bank account was reported in Jharkhand, Haryana, Assam, Maharashtra and few other states. Madhya Pradesh reported delay in DBT to JSY beneficiaries at some facilities owing to insufficient information provided by beneficiaries about their bank accounts. However, ASHA incentive payments were reported to be on time. District Nabrngpura in Odisha reported delay in payments due to poor internet connectivity.

Janani Shishu Suraksha Karyakram (JSSK)

- Utilization of free entitlements under JSSK has shown an increasing trend in almost all states. However Himachal Pradesh, Odisha, Assam, Maharashtra, Jharkhand and

Delhi are still struggling to ensure free drop back service and diagnostic care during ANC. In Rajasthan despite availability of toll free emergency transport system, low utilization was reported (20% from home to facility) leading to increased spending on transport.

- States have been successful in decreasing the out of pocket expenditure (OOPE) on drugs (except DWH Nainital, Uttarakhand), consumables and diet, but OOPE continues to be high for transport, diagnostics (especially USG; cost Rs. 700-1400 across states) and blood services (in Uttar Pradesh). A dedicated grievance redressal mechanism under JSSK has not been established in most states except Madhya Pradesh, Rajasthan, Assam, and Andhra Pradesh, where toll free help line numbers are displayed in facilities.
- In Manipur, and Meghalaya, availability of pick up and referral to higher facilities was minimal and no drop back facility was provided. Instead, cash compensation of Rs. 15/20 per km. was being provided to the patients in lieu of transport.
- Provisioning of good quality food in health facilities was reported from Uttar Pradesh, Odisha, Rajasthan and Jharkhand. In Rajasthan, a good example of PPP mode for JSSK services was noted. A collaboration with a NGO has been created to provide food at reasonable cost to the patient and attendant at District Hospital, Bikaner. In remaining states food supply is either limited or poor quality food is procured from dhaba outside the health facility. In Assam, 1 kg pack of Horlicks was given instead of diet whereas in Andhra Pradesh cash payment of only Rs 56 is made for diet to the patients.

Maternal Deaths

- According to HMIS (2014-15) report, all states except Bihar and Andhra Pradesh reported maternal deaths at health facilities. Maximum maternal deaths across all States (64.6%) are attributed to the category of "other causes" and 15.6% maternal deaths are attributed to bleeding followed by eclampsia/preeclampsia. Other causes reported are high fever (3.6%) and obstructed or prolonged labour (3.5%).

Maternal Death Review (MDR)

- Poor maternal death reporting and audits were reported in Assam (poor FBMDR), Chhattisgarh (only 21% of Maternal Deaths reported in 2014-15) Himachal Pradesh, Uttar Pradesh, Jharkhand (Only FBMDR conducted from only one medical college hospital in the state), and Punjab. Andhra Pradesh, Maharashtra, Odisha and West Bengal have reported a comparatively better MDR process in place.
- Maternal near miss review is either not initiated or is poorly implemented in almost all the states visited.

Family Planning

- Majority of the states where PPIUCD services are rolled out, is limited to higher level facilities only. States like Himachal Pradesh, Jharkhand, Karnataka, and Rajasthan & Uttar Pradesh are lagging behind in PPIUCD implementation & incentive distribution. Assam has imparted PPIUCD training to AYUSH MOs however states like Delhi, Punjab & Uttarakhand still need to expedite the training of SNs and ANMs.

Incidences of un-informed insertion i.e. absence of prior consent were reported from Delhi & Jharkhand. Delhi also reports incidences of side effects and high number of IUCD removals.

- Fixed Day Service approach for sterilization is in place in many states. However this is available only at higher levels (DH & a few CHCs) in Himachal Pradesh, Madhya Pradesh & Odisha. In Uttarakhand, limited availability of fixed day services was noted where sterilizations are being conducted through camp approach.
- Home delivery of contraceptives by ASHAs is being carried out in most states except in Jharkhand & Meghalaya. ASHAs have fair understanding of the scheme.
- Availability & supply of pregnancy testing kits was found to be regular in most of the states. Irregular supply of Condoms, OCPs & ECPs was reported in Odisha, Karnataka, Jharkhand, Haryana and Chhattisgarh.
- Trained RMNCH+A counsellors are in position at facilities in almost all CRM states except Madhya Pradesh where shortage was reported. However quality of counselling services needs further improvement in Andhra Pradesh, Jharkhand, Maharashtra, Odisha and West Bengal.
- Observations from most states suggest that NSV rate is very low and is showing a declining trend. Most of the state findings emphasized for policy level intervention to increase the male participation in family planning programmes.
- It is encouraging to observe that states are taking initiatives for online registration of private providers to provide FP services. E.g. "*Housla Sajhedari project*" in Uttar Pradesh.
- State/District Quality Assurance Committees and Family Planning Indemnity Subcommittees need to be put in place across states and meetings to be held regularly to ensure quality in FP services & ensure the timely release of compensation for FP failure/deaths.

Child Health

- **Facility Based Newborn Care (FBNC)**
  - The overall utilization of SNCUs varies from state to state. Madhya Pradesh, Andhra Pradesh, Delhi, Karnataka has shown adequate number of SNCUs. However states like Uttar Pradesh, Jharkhand, Meghalaya, and Chhattisgarh are struggling to establish FBNC services as per the required norms. Either the radiant warmers are not available or are non-functional in many facilities in these states.
  - Majority of SNCU admissions are premature and low birth weight cases. Also, inborn admissions were higher than the out born admissions in SNCUs as reported in Assam (DH Golaghat) and Andhra Pradesh (KG Hospital Vizag).
  - Unavailability of a follow up process, irrational placement of trained MOs and SNs, lack of maintenance of SNCU equipment, were observed in Delhi, Andhra Pradesh, Himachal Pradesh, Meghalaya, Rajasthan, Manipur and West Bengal.
  - Indiscriminate use of antibiotics was observed at the facilities in Meghalaya and there is a need for compliance with national guidelines in this regard.

- Kangaroo Mother Care (KMC) method is practiced only at the SNCU level. Parents/caretakers were not counselled about the benefits of KMC in most of the states. Separate KMC rooms were available near SNCUs in Madhya Pradesh, Haryana, Delhi, Andhra Pradesh, Karnataka and Meghalaya .
- Under utilization of NBSUs is a prime issue in almost all the states visited, especially Himachal Pradesh (unavailability of equipment), Andhra Pradesh, Delhi, Karnataka, Rajasthan (untrained staff) and Uttar Pradesh.

Home Based Newborn Care (HBNC):

- Overall coverage of HBNC was fond to be is good in all states. However, except poor referrals of cases from community to facilities whereas identified as an important concern during CRM visit.
- ASHA training for 6 & 7 module has yet not been initiated in Himachal Pradesh as the state has started the ASHA programme only recently. Haryana has been performing well in implementing Home Based Post Natal Care (HBPNC).
- New HBNC guidelines have not been rolled out in most of the States and non-replenishment of HBNC kits is another issue observed in Delhi, Andhra Pradesh, Chhattisgarh, Uttar Pradesh, Jharkhand, Punjab, Manipur, Meghalaya and Karnataka.
- Weak linkage between ANMs and ASHAs for supportive supervision was also reported from Delhi, Manipur, Jharkhand, Meghalaya, Punjab and Karnataka.

Nutrition rehabilitation centres:

- NRCs in Andhra Pradesh, Uttar Pradesh, and Delhi are underutilized with no follow-up process in place. Due to limited inter-sectoral convergence referrals from the community to NRCs is poor and needs to be addressed e.g. in Delhi, most of the NRC admission were from pediatric wards.
- Himachal Pradesh is yet to start the NRC in most of facilities due to slow recruitment process. Similarly, Haryana also does not have NRCs at Sonepat and Yamunanagar districts as reported by CRM teams.

Rashtriya Bal Swasthya Karyakram (RBSK)

- RBSK, though in nascent stages, is picking up fast, with mobile teams and DEIC in place in most of the States. DEIC has not been established in Delhi, Assam (District Golaghat), both CRM districts of Uttar Pradesh, Manipur, and Meghalaya.
- In Andhra Pradesh, RBSK runs as Chinnari Aarogyam. State needs to expedite the process of equipment procurement at DEICs to make it operational.

Screening and follow-up mechanisms under the programme are well laid out and effectively implemented in Haryana, Odisha and Jharkhand, but require strengthening in Chhattisgarh, Uttarakhand and Madhya Pradesh.

- Although the reporting and screening mechanism is good in Odisha, the tertiary linkages and referral facilities were found to be weak.
- Micro-planning of team visits to field and home based screening requires attention at all levels in States. Issue of inadequate number of teams was reported from Jharkhand, Assam, and Punjab.

- **Immunization:**
  - Pentavalent vaccine has been introduced in Meghalaya, Haryana, Himachal Pradesh, Punjab, West Bengal and Delhi.
  - Alternate vaccine delivery system requires strengthening in Delhi, Andhra Pradesh, Himachal Pradesh, Assam, Uttar Pradesh, Meghalaya and Manipur. Also, the training process for AEFI identification and management needs further strengthening in all States.
  - Cold chain maintenance is good in almost all the states but processes of training and cold chain equipment replacement plan is to be expedited across all states. Haryana, Madhya Pradesh, Odisha Himachal Pradesh, and West Bengal are some of the good performing states in this context. Open vial policy is well implemented in all states except at a few facilities visited in Rajasthan (Bikaner District), Manipur, and Jharkhand.
  - Chhattisgarh, Jharkhand, Himachal Pradesh, Punjab, Meghalaya, Manipur and Karnataka, Delhi and Himachal Pradesh reported that ANMs and ASHAs did not have any due lists. The work plans are not generated on a regular basis and thus were unavailable with ASHAs.
  - EVM assessment and training is yet to be rolled out in all states.
- **Community based interventions:**
  - Focus on IYCF counselling, early and exclusive breast feeding components, and other such components of newborn & child nutrition need strengthening at VHNDs in States like Chhattisgarh, Meghalaya, Manipur, Uttar Pradesh, Jharkhand and Himachal Pradesh.
  - There was weak implementation of IMNCI in States like Assam, Andhra Pradesh, Uttar Pradesh, Meghalaya, Himachal Pradesh, Manipur, Jharkhand, Chhattisgarh, Delhi and Punjab. Uttar Pradesh, Rajasthan, Manipur, Punjab, Andhra Pradesh reported issues related to delays in organising trainings of ANM, Medical Officers for F-IMNCI. Or rational deployment of trained human resources
  - Performance under Integrated Diarrhoea control Fortnight (DCF) was reportedly varied in contents and coverage in different states, with Chhattisgarh, Karnataka, Jharkhand, Maharashtra and West Bengal reporting better coverage.
- **Child Death Review (CDR)**
  - Child Death Reviews (CDR) is yet to gain momentum in most states. Maharashtra is the only state which has reported well established CDR mechanism.
  - Karnataka is in process of implementing the CDR guidelines as per GoI norms and has identified nodal officers for strengthening community based and facility based CDR system.. Maharashtra reported effective implementation of CDR in District Bhandara.
  - All other States have yet to organize ando implement the CDR system

Rashtriya Kishor Swasthya Karyakram

- There is sub-optimal utilization of Adolescent Friendly Health Clinics (AFHCs) as reflected by the low footfalls in twelve states – Delhi, Andhra Pradesh, Chhattisgarh, Uttarakhand, Haryana, Rajasthan, Manipur, Jharkhand, Odisha, Maharashtra, Madhya

Pradesh and Karnataka. This could be attributed to non-availability of dedicated space and trained manpower. AFHCs in the states of Andhra Pradesh, Uttarakhand, West Bengal, Maharashtra and Odisha did not have essential commodities like sanitary napkins, OCPs, ECPs, condoms etc. There was also lack of visibility of IEC material related to adolescent health in the health facilities. In only two states - Jharkhand and Uttarakhand, counsellors were reported to have undertaken outreach activities to schools and colleges.

- There was a lack of engagement of education and ICDS department observed in Assam, Andhra Pradesh, Haryana, Uttar Pradesh, Jharkhand and Uttarakhand with regards to implementation of Weekly Iron Folic Acid Supplementation (WIFS) program,. This often resulted in sub-optimal reporting on the field activities along with low awareness regarding the benefits of IFA tablet consumption among the beneficiaries.
- The uptake of sanitary napkins under Menstrual Hygiene scheme (MHS) was low, largely due to poor quality as reported in Himachal Pradesh and irregular supply of the sanitary napkins as informed in Delhi, Himachal Pradesh and Odisha. Further, in a few states like Uttarakhand, Haryana and Karnataka, ASHAs did not organize the monthly meetings with the adolescent girls to create awareness on menstrual hygiene.
- The peer education component under RKSK is yet to be rolled out in Odisha, Punjab, Delhi, Himachal Pradesh, Chhattisgarh, Manipur, Jharkhand and Uttarakhand. All states except Haryana and Karnataka have completed regional level training of the master trainers for the PE component. The process of selection of peer educators is yet to be institutionalized.

Recommendations

1. States need to revisit existing mechanisms of planning for health at different levels and adapt innovative methods for decentralized planning. Assured service package under RMNCH+A needs to be put in place.
2. Strengthen inadequate supply chain management for drugs, vaccines and commodities by leveraging the use of IT enabled supply chain & logistics mechanisms.
3. Essentially, there is a need to ensure SOPs for all procedures related to maternal care in institutions complimented with internal (inter-departmental) audit mechanisms. TOR for each personnel in this context needs review and modifications accordingly.
4. Protocol on provision of blood to pregnant women in emergency needs standardization across states and related challenges should be addressed systematically.
5. States must ensure that data emerging from various death reviews inform the DHAP. At the same time regular feedback must be provided to health facilities and Village Health and Sanitation Committees (VHSNCs) for action.
6. Payments made through DBTS needs to be expedited through PFMS. There is a need to sensitize banks on JSY-PFMS payments.

7. Irrespective of in-house or out-sourced kitchen services, there is a need to prescribe standard operating procedures for provision of dietary services under JSSK.
8. Fixed Day sterilization services need to be operationalized at CHCs in lieu of the camp approach. Training of PPIUCD and post training utilization of the trained manpower in the equipped facilities needs attention.
9. Distribution of PPIUCD incentives and informed consent of women for PPIUCD insertions should be addressed. States needs to focus on implementation of sterilization quality guidelines including sterilization certificate, consent form and medical record checklist.
10. The pace of implementation of newer interventions for newborn and for maternal health needs to be expedited.
11. It is essential to develop a strong referral network from community to facility and back to ensure better follow up of children discharged from SNCUs and NRC/MTC.
12. Training of the AFHC counsellors on RKSK needs to be conducted on priority. AFHCs should be appropriately positioned as per the guidelines. Considering the common target age group of 10-19 years, it is suggested to collaborate with Rashtriya Bal Swasthya Karyakram (RBSK), which does screening of children (including adolescents) for various health conditions in schools.
13. States should ensure provision of better quality sanitary napkins. Involvement of self help groups may be considered for provision of low cost high quality napkins. The states should also maximize the coverage to include adolescent girls in all districts.
14. There is a need to strengthen inter-departmental coordination with Department of Education and Ministry of Women and Child Development for effective implementation of WIFS program in schools and AWCs. Mass media campaigns can be planned where uptake has been low due to lack of ownership by teachers or reported adverse events after IFA consumption. Also, states need to improve the supply chain management system for the IFA tablets to ensure no stock outs at the field level.
15. States should expedite the recruitment and training of peer educators. Since the master trainers have already been trained at the regional level, they should be used in training of ANMs without any further delays.

STATE FINDINGS

ANDHRA PRADESH

- Exercise to prioritize and operationalize facilities based on service demand was largely absent in the state.
- The pace of implementation of recently launched guidelines is slow. Home distribution of misoprostol is not implemented in the state. Two percent of home deliveries are not attended by SBAs.
- Partographs are being filled post-delivery, which makes them ineffective as a tool for gauging the progress of labour.

- While a new MCH wing is being setup at the DH in Vizag, the MCH wing was not planned in district Anantapur, despite both medical college and district hospital having more than 130% of bed occupancy.
- JSSK entitlements are in place but in sub-district hospital Rs. 56 is being paid in cash for diet which is low as per the practice across India.
- District Collector actively reviews all maternal deaths. However maternal near miss protocol is not being implemented in both CRM districts.
- Family planning fixed day services exist up to District Hospitals and Medical College hospitals. Family planning counselling is not done in many facilities or during outreach.
- Inadequate knowledge and skill of staff nurses in IUCD insertion was observed. Follow up of women with complications after performing IUCD was not in practice.
- The SNCU at KG Hospital in Vizag provides services for newborns from 3 districts with 21.8% outborn admissions. New born Stabilisation Unit (NBSU) were found to be non-functional in most of the places visited in Anantapur, but were functional in Vizag's Area Hospital.
- Average client load per month at the AFHCs is extremely low. AFHCs at the Area Hospital level are not fully functional as they lack dedicated space, and trained manpower. Privacy of the clients was compromised as there were no curtains or the clinic was not strategically located. Equipment and medicines/contraceptives were not available at the AFHCs.
- Under WIFS program, lack of ownership by the government schools was observed. Further, orientation of teachers on WIFS was not satisfactory and IFA tablets were not available in the schools. For out-of-school girls, IFA tablets were not available at any of the AWC visited.

ASSAM

- Much high impact RMNCH+A interventions have been initiated with special focus on high priority districts and Tea Garden areas. E.g. Supervised IFA tablets and iron sucrose administration for severe anaemic (Hb<9 gm %) women Identification of 'Responsible Officer' for each high risk case, special ANC sessions in the Tea Garden areas and dedicated ambulances.
- According to population norms, there should be 3 FRUs in each of district but only one FRU exists. As per State report there are currently 14 functional FRUs, whereas the requirement is of 84 in State. Owing to high delivery load in these functional FRUs, quality of care is found to be compromised.
- Essential drugs under RMNCH+A matrix were found to be in short supply (CHC Dergaon does not have supplies of Inj. MgSO4 since September 2013).
- No rest rooms for ASHAs available at any of the facilities visited by the CRM team ASHA drug kits not available across all the facilities visited
- Although maternal death reporting has progressed but review still need improvement in the state.

- Fair understanding/ skills of nursing staffs on AMTSL in all visited health facilities was found. Partograph was incompletely and incorrectly filled in all facilities except Assam Medical College, Dibrugarh.
- Line listing of severe anaemic pregnant women was done in all health facilities which were visited but there was no clear road map for their management, referral and follow-up. Pregnancy test kit (Nischay) was not available at Sub centres of both the districts visited.
- Under JSSK, instead of food, beneficiaries were provided with one kilogram of Horlicks.
- Dibrugarh and Golaghat districts visited have effectively rolled out PPIUCD up to the level of CHC but PP-IUCD supplies are a major issue across facilities. AYUSH MOs were also trained for PP-IUCD. Interval IUCD is seen to be happening at all levels of health care facilities.
- Regular fixed day sterilization was being done in select facilities. There is lack of trained surgeons to provide sterilization services.
- Home Delivery of Contraceptives has been initiated by ASHAs. They were not aware of the incentives and hence not charging beneficiaries.
- ASHA drug kits and RMNCH+A counsellor kits not available across all facilities due to which roll-out of HDC is affected.
- AFHC counselors are yet to be trained on RKSK. IEC on adolescent Health issues was displayed at the AFHCs. Standardized registers were not maintained at DH, Golaghat.
- Blue tablets under WIFS program were being given to pregnant women due to unavailability of IFA .Under WIFS, stock of IFA tables were available in the schools visited, however, due to adverse media publicity in isolated cases of adverse effects of IFA tablets, poor uptake was observed. Regional ToT on PE component has been completed; however, a delay in peer education selection and block level training of ANMs on the PE component was reported.

CHHATTISGARH

- There are 75 designated FRUs in the state, of which 48 are providing C-section facilities. The number of functional FRUs has increased from 28 (2014-15) to 48 (2015-16).
- Line listing and tracking of severely anemic mothers is not followed in Balrampur. HIV, VDRL, HBsAg, CBC, RPR, PVC tests are not being done during ANCs in the District.
- 7 Private Hospitals have been accredited for JSY Services in Rajnandgaon. Their contribution has been 790 Institutional Deliveries out of a total of 10037 in the district till September 2015.
- Utilization of 102 Mahtari Express for the transportation of Sick Newborns is still suboptimal in the state.
- Trained providers are conducting PPIUCD insertions in the state but the number is considerably lower than the number of deliveries reported.

- Most of the ANMs in both the districts were trained in IUCD insertion and performing the procedures in peripheral facilities as well. However records of follow-up & cases of removal are not maintained.
- Condoms and OCPs are available with Mitanins and they possessed adequate knowledge of modern contraceptives &Pregnancy Testing Kits. However emergency contraceptive pillswere not available in most of the facilities.
- Laparoscopy, Tubectomy, NSV not being performed in district Balrampur. In Rajnandgaon, sterilization services are provided in the district hospital on fixed days (Uptake of Permanent Sterilization Methods has taken a dip after the Bilaspur incident last year).
- Huge shortage of FBNC services throughout State. There are 16 Sick New Born Care Units (SNCUs) sanctioned in the state, of which 13 are functional. Essential medicines such as Syrup Salbutamol, Nebulizer, and Pulse Oxymeter were not available in few facilities in Balrampur.
- AFHCs were not functional in the visited districts. No information was available about the client load as no records are maintained by the counselor. Operationalization of the existing AFHC to be done as per RKSK guidelines.
- Under WIFS program, IFA tablets were available in schools and AWCs visited in both the districts. Students and teachers were aware of the benefits of consuming IFA tablets.

DELHI

- Line listing of anaemia and follow up of high-risk pregnancies was not maintained.
- Lack of availability of equipment noted at some centres and due to this Out of pocket expenditure on diagnostics was high.
- 79% institutional delivery rate is reported. However institutions are still ill equipped to handle the caseload due to non-functional OT's, inadequate human resources and equipment for handling emergency cases.
- Coverage and utilization of JSY is hampered due to constraints in providing identity proof for bank account opening for DBT transfer as per GoI norms.
- Data indicates that 97% maternal deaths are at facility level. Cases of maternal death in transit were also reported, albeit on the lower side. Within the cases reviewed, sepsis (17.8%), hypertensive disorders (17.8%) and hemorrhage (13%) were main causes of death.
- Only 30% of the total deaths are actually reviewed. Community based MDR was not observed. In the data from North Delhi recorded in Sept 2015, only 2 maternal deaths were reported, but no reviews had been conducted.
- Unmet need for family planning appears to be a major concern as facility data is reflective of multipara. Side effects and removal rates of PPIUCD is quite high.
- RBSK is not rolled out in the State and District Early Intervention centres not established

- Cold Chain equipment available in sufficient quantity in the facilities visited. However there is a serious lacuna in temperature monitoring and charting, availability and upkeep of thermometers.
- Though AEFI (Adverse Event Following Immunization) recording is in place, the management kits not available at the facilities observed
- AFHCs are still in the initial phases of implementation and thus have low footfall. In the West district, it was observed that data on adolescent health issues is not reported through the standardized reporting mechanism but through the general OPD registers. Efforts for outreach need to be augmented.
- Under Menstrual Hygiene Scheme (MHS) in 11 districts, sanitary napkins were distributed in government and government-aided schools. However irregular supply is affecting program implementation.
- Peer Education (PE) programme has not been rolled out yet and is expected to be rolled out in November- December 2015. Celebration of Adolescent Health Days has not initiated yet.

HARYANA

- The state has developed robust online maternal and infant death review mechanism but there is a need to improve the analysis mechanism. Currently it is focused on identification of medical causes of death but the focus needs to shift to systemic issues.
- MCP Cards were not being filled at the SC and PHC and MCTS number was not being provided to the beneficiaries.
- Haryana has shown good performance in facility based newborn care, with 22 SNCUs currently operational in State and one each in Sonepat and Yamunanagar. The State has 60 NBSUs against the 66 approved and NBCCs have been established at all the delivery points.
- Line listing of severely anaemic pregnant women was being maintained by the ANM.
- It was reported that the patients are reluctant to stay for 48 hrs post-delivery.
- Total number of IUCD insertions declined in the state with a marked increase in PPIUCD insertions in the same duration. OCPs and ECPs have not been received by the state in the current year due to budgetary constraint.
- Abortion Services were not being utilized in the government health facilities. Around 90% of all abortions in the State are happening in private facilities.
- State has formed the State Newborn Action Plan along with the District specific plans. The district plans are currently under review at the State level.
- Low client load was observed at the AFHC visited. The counsel or was yet to undergo the RKSK training and currently did not undertake any outreach activities as no mobility support was provided.

HIMACHAL PRADESH

- Most of the health facilities visited had adequate availability of RMNCH+A commodities.
- In both the districts, the maximum load of institutional deliveries is skewed towards DHs and Civil Hospitals such as CH Ponta, Sirmaur and RH Hamirpur.
- Most of the health facilities visited had adequate infrastructure, were well maintained and clean; however, non-availability of adequate HR, especially specialists remains a major obstacle in operationalization of FRU.
- 24x7 laboratory services are available only upto DH level. Blood Storage Unit (BSU) at CH Poanta & CH Rajgarh are under the process of establishment.
- The staff at facilities visited had limited knowledge about the appropriate doses of essential medicines such as tablet Misoprostol and injection magnesium sulphate (MgSO4).
- In both the districts, MDR were being conducted and reviewed however, fewer maternal deaths were being reviewed against the estimated number of maternal deaths. Near misses of maternal deaths capturing and review is not yet initiated in Hamirpur district.
- Comprehensive Abortion Care (CAC) services are available at DH only. There was no service provider trained on MMA and MVA techniques of abortion. HIV testing for ANC cases was available and mandatory.
- Free diagnostics & free blood transfusion facility were being provided only to JSSK beneficiaries in the RH/DH/CH and were found prominently displayed at all facilities visited. However, at CH Paonta, CHC Barsar and DH Solan significant out of pocket expenditures were being incurred for diagnostic services by beneficiaries.
- Only RH/District Hospitals were providing C-Section services with Blood Bank facility. None of the CHs/CHCs in the district have blood transfusion facility due to non-establishment of blood bank and Blood Storage Units (BSU). Home delivery of contraceptives by ASHAs is being carried out with good acceptability in the community.
- The PPIUCD acceptance percentage in the state is only 5%. PPIUCD incentive scheme has not been rolled out in the district.
- Under the WIFS program, the average monthly in-school coverage is around 47%. Currently, the state is not covering out-of-schools girls through AWCs. Standardized reporting formats of WIFS program and IFA tablets were available in the schools visited.
- MHS had good acceptability in Sirmaur district; however, issues related to poor quality of napkins were reported. It was informed that sanitary napkins were not available with ASHAs for last 2 months.
- Community based interventions, like peer education and adolescent health day, have not yet been initiated.

JHARKHAND

- RMNCH+A essential commodities were available but Medical Methods of Abortion drugs (MMA drugs), RTI /STI color coded syndromic drug kits, etc. were not seen in many facilities visited in both the districts.
- IEC was good at CHCs and SCs in Lohardaga District on various aspects of RCH with protocol posters being displayed in labor room.
- No MCH wings established at either Lohardaga or Dhanbad. The labour room at the medical college at Dhanbad was not designed as per the MNH tool kit. Neither was the infection prevention protocols were displayed.
- The newer interventions such as Calcium Supplementation, De worming, Syphilis and hypothyroidism and GDM during pregnancy are yet to be implemented in both districts.
- Janani Suraksha Yojana payments were being made timely through Account payee cheques. DBT is partially implemented as bank accounts of all beneficiaries are not yet opened in both districts.
- Free entitlements under JSSK were largely being provided; however, drop back after delivery is still low.
- Line listing of severely anemic and high risk pregnancies needs strengthening along with management and follow-up.
- Maternal Death Reporting and review is poor. Only FBMDR being practiced in Patliputra medical college and hospital. There were no maternal deaths being reported in any other facilities. CBMDR concept was totally missing.
- Focus on IUCD and PPIUCD insertion being done, however, counseling on spacing at SC or PHC level is non-existent.
- Jharkhand Newborn Plan (JNAP) 2015-2030 prepared by the State of Jharkhand. Bottleneck analysis, gap analysis of RMNCH+A, supportive supervision reports of the 11 high priority districts (HPDs) and district consultation have been conducted to prepare the JNAP.
- Only two SNCUs are functional out of 25 districts in the state
- ASHAs home visits are low in HPDs as compared to non-HPDs. On an average 5.7 % babies are detected as high risk and 4.8 percent of newborns are referred by ASHAs. 1.6 % of neonatal deaths are reported by during home visits.
- NRC functionality is reportedly good. Out of the total 88 sanctioned NRUs for the state of which 86 were reported functional. 39 NRUs are present in the HPDs. 99% admissions were new cases; the reported relapse rate is only 0.13%.
- RBSK implementation needs strengthening, with less than 50% RBSK teams operational in the State. Over reporting of screened children observed(17000 children over-reported for the period of April- August 2015). Around55.1 % of screened children reported with "Identified D's" out of which 56.6% of children are females.
- Peer Education component under RKSK is yet to be implemented, however, identification of peer educators has been initiated.

KARNATAKA

- Institutional deliveries in rural areas have not shown increasing trend over the last five years (99.9). Madilu Kits available and were being distributed. Entitled payments were being paid timely to the beneficiaries. Negligible OOPE reported for delivery at facilities.
- Reported maternal deaths cases increased from 1033 cases in 2008-09 to 1227 in 2009-10. This could be attributed to the increased reporting rather than lack of access of maternal care services.
- Partograph was maintained for all deliveries especially in District Koppal as nurse mentoring program under the Sukhema Project and Karnataka Health Promotion Trust institutionalized this..
- Female sterilization is the most preferred method in the state. The major concern however is the poor spacing between births, which also reflects in high maternal mortality.
- ASHAs were also well aware of Home Delivery of Contraceptives and had all the necessary supplies in their kits. Beneficiaries are also aware of multiple spacing and limiting FP methods (except injectable contraceptives).
- Considering the fact that state has poor birth spacing and huge unmet need for spacing there is a huge potential for Interval IUCD and PPIUCD. PPIUCD training seems to have picked up well in Mangalore as compared to Dakshin Kanadda (even though some gaps remain in implementation). The targeting of permanent methods of sterlisation are still focused on women with little emphasis on motivating males to accept No-Scalpel Vasectomy
- SNCUs are functioning satisfactorily in both the district. However there are no functional NBSUs at General Hospitals and CHCs.
- The IMNCI reports are collected quarterly and analysis is done at State level. Supportive supervision reports that MOs and ANMs need skill up gradation.
- State has initiatedl implementation of the CDR system as per MoHFW guidelines with the nodal persons being already identified and in place for conducting CDR
- AFHCs (called Sneha Clinics) are held every Thursday 2:00 to 4:00 PM. Sub-optimal functioning of the clinic was observed due to non-appointment of counsellors.
- WIFS programme is implemented well in both the districts visited. During interaction with adolescents it was highlighted that except for the month of October 2015, IFA tablets are regularly available. In 2015-16, state reported an overall coverage of 53.13%.
- Under MHS, 'SUCHI' napkins have not been given in Koppal district. Also during interaction with the ANMs and ASHAs it has been highlighted that during VHND sessions, there is no interaction with adolescent girls.

MADHYA PRADESH

- In both districts the institutional delivery rate has increased significantly, however, Caesarean-sectionfacilities with blood bank (CEmONC) were available only at District Hospital.

- There is perceptible improvement in quality of Antenatal Care (ANC) services being provided at all levels from sub-cente rupwardsupto district hospital.
- Provision of Anemia Management Card with details of doses of Iron Sucrose introduced by States was found to be use din across all facilities. The consumption of IF A was found to be good.
- ASHAs were accompanying the pregnant women for delivery in many cases and many mothers had used Janani Express for coming to the facility, but there is need for improving transport facility (home to institutional) by Janani Express.
- In both district, JSY payments were made within the stipulated time of discharge through direct bank transfers.
- PPIUCD has gained momentum as the main method of spacing and gradually replacing Interval IUCD services. Mechanism of follow up after PPIUCD is to be streamlined in both districts visited.
- NSV rate has shown a very sharp decline in last three years. Strategy to increase male involvement in FP services is to be developed.
- Comprehensive Abortion Care services (CAC) are being provided only at district hospital level in both districts.
- Both districts had well-functioning SNCUs at respective District Hospital and reporting online. However, SNCU in Shahdol district was overloaded.
- Cure rate from NRCs remains comparatively low at around 50-60 percent.
- Vitamin K prophylaxis at birth was being provided at all facilities visited in both the districts with some exceptions due to unavailability.
- The utilization of services in the AFHCs that were visited was low, especially where there is no female counsellor. Adolescent Helpline and career counselling center is functional in Bhopal and offers counseling facilities on the telephone and in person.
- All govt. and govt. aided schools and AWCs are covered under WIFS. No stock outs have been reported in the last 3 months.
- MHS is currently implemented in 8 districts and 19.2 lakh sanitary napkins have been provided through social marketing to adolescent girls. Production and supply of sanitary napkins by self-help group, at Jamgod (Dewas), is a good initiative that can be scaled up across the districts and state in a phased manner.
- Of the 8360 PEs identified, 7959 PEs have been recruited. 53 master trainers have received ToT on PE component and the district level ToT is expected to start in November, 2015.

MAHARASHTRA

- Maharashtra has shown remarkable progress in terms of maternal health: in past years state has achieved MDG 5 with a 54% reduction in MMR from 149 in 2001-03 to 68 in 2011-13.
- State has good systems for birth preparedness and management of High risk pregnancy. State has also developed birth waiting room called as “Maher Ghar”

for pregnant women in labour in 9 districts with remote areas in order to manage delays.

- ASHAs are ensuring high compliance of IFA supplementation to pregnant women through DOTS and without any additional incentive which is a unique initiative of district Bhandara.
- Some of the ANMs were not aware of correct doses and indication for use of Gentamyc in as reported in District Bhandara.
- JSY and JSSK schemes are effectively implemented in the State. However awareness and utilization of JSSK for the treatment of sick infants was found to be low in both the Districts.
- JSY Physical Performance is 41% of the annual target. Financial achievement is 65% of available Fund. JSY Payments are done by giving account payee cheques in the name of beneficiary.
- Recently launched guidelines by GoI like home based distribution of Misoprostol, DAKSHATA training, screening for HIV and syphilis, etc. are not yet implemented.
- Maharashtra has overall good family planning indicators with TFR of 1.8 and CBR of 17.2 (Rural) & 15.4 (Urban). The State has effectively implemented the Family Planning program.
- Bhandara district has a strong home based delivery of contraceptive program. ASHA are having a decent earning from the FP services.
- Family planning counseling services are not taking place across the facilities and also not being provided during outreach visits.
- There is not much difference in the Infant and under-5 mortality and almost 65% of all the child deaths are happening during the first month of life.
- State reports effective implementation of CDR in District Bhandara.
- Under WIFS program, the coverage is more than 90% in Bhandara district. The program is being regularly reviewed by CEO-Zilla Parishad at district level and by Block Development Officer at block level. In Osmanabad, lack of lack of ownership of WIFS program by schools and the ANMs was observed.
- ToT on peer education is completed and around 65% of peer educators had been selected.

MANIPUR

- Top down planning and implementation of RMNCH+A programme is being done in the state. The state follows resource based financing rather than results based planning.
- HR is generally adequate, but not rationally deployed; especially Laboratory Technicians.
- Poor coordination was observed between health functionaries and ICDS workers especially for provision of nutrition interventions.

- 24x7 electricity not available in most facilities (District Senapati), hence provision of essential services get affected. Lack of blood storage facility in 24 x 7 FRUs was noted.
- Poor utilization of services was noted due to lack of assured services at the public facilities and an expanding private sector in healthcare provision.
- Maternal Death Reviews were being conducted only for a few cases, child death reviews just being initiated in the state
- No SNCUs functional in the state; babies needing care being referred to NICUs at RIMS and JNIMS at Imphal.
- Under WIFS, school nodal teachers have been trained. IFA tablets have been procured and distributed across the state.
- Regional level ToTs for Peer Education (PE) programme has been completed. Recruitment of PEs has been initiated.

MEGHALAYA

- Significant drop outs from ANC1 to ANC3 to delivery were noticed. Line listing of high risk pregnancies is available only in few facilities. Tests like Hb, Urine, Blood Grouping, Syphilis and HIV are conducted for all ANCs only at district hospital and CHC level.
- Lack of comprehensive abortion care services noticed even at District hospital level.
- Maternal Death Review (MDR) is being done in district West Jaintia Hills – however crucial action points were missing from MDR proceedings.
- Presently, there is only one EmONC trained doctor in the entire South West Garo Hills district. Additionally, there is a need to rationalize the deployment of SBA trained staff in the district.
- Availability of pick up & referral facility to higher centres was minimal and no drop back facility was being provided. Instead, cash compensation was given to patients in lieu of transport @ Rs. 15-20 per km.
- The state has one of the highest rural total fertility rate (TFR) and very high unmet need of contraception. Home delivery of contraceptives by ASHAs is almost non-existent and their knowledge and skills on the topic is poor.
- Although the awareness of Kangaroo mother care (KMC) among the staff was found to be missing, KMC was observed as it was done as a home care practice by the mothers.
- Majority of AFHCs had separate waiting and counselling room to ensure privacy of the adolescent clients. The average client load was around 8 – 10 clients per day.
- WIFS is currently implemented, both in schools and AWCs. The total coverage of the beneficiaries under the programme was satisfactory, however due to poor convergence with Education and ICDS department the reporting and recording mechanisms were not in place.

ODISHA

- In general, awareness on the RMNCH+A 5x5 matrix among the health care providers at facilities and Block Programme staff was good. IEC material on RMNCH+A was prominently displayed including list of essential drugs in most of the facilities visited.
- Basic lab investigations for ANC were not being done at PHC level. Some PHCs were found to prescribe the investigation and these were done from private facilities leading to increased OOPE.
- No line listing of severely anaemic women and identification of high-risk pregnancies being done at SHC/PHCs.
- Prescription audits were done at the DH and few CHCs and it was seen that third generation antibiotics were routinely used post delivery.
- IV Iron Sucrose for severely anaemic mothers was not available in most of the FRU visited.
- Out-of-pocket expenses reported by beneficiaries on diagnostics including USG and transportation.
- Maternal Death Review committee is functional and regular meeting minutes were recorded. However, infant and child death review committee are not functional and no review is taking place.
- Fixed day family planning services and PPIUCD services were provided through district hospitals and very few CHCs, with fairly good quality of care.
- Pregnancy testing kits (Nichchay kits) are available at all facilities except in few sub centres. Emergency contraceptive pills were not available at most of the facility and also the knowledge of EC was poor among the staff.
- Although FBNC services are commendable at all levels, rampant use of Anti-biotic was noticed in Nabrangpur.
- Under RBSK the record keeping was found to be good in the schools visited. However, absence of tertiary linkages and referral facilities leave outcome to be desired.
- WIFS program was implemented in schools and for out-of-school girls. In Nabrangpur district, stock of IFA tablets was seen at the school but on interaction, many girls reported that they never consumed the tablets.
- Peer education programme is in the nascent stage and no program activity was observed at the field level.

PUNJAB

- Decentralized planning is being done in all Districts with support from development partners.
- Essential commodities as per the 5X5 Matrix on RMNCH+A were available in both Districts visited.
- It was observed that line listing of high risk pregnant mothers for severe anaemia was maintained in Hoshiyarpur but in Mansa mixed response was seen.

- Awareness of the new guidelines on use of Gentamycin for neonatal sepsis or Antenatal corticosteroids (ANCS) for mothers in pre term labour was found to be inadequate.
- JSSK executed well for women delivering at the health facilities, but the women are still incurring huge OOP on investigations
- Referral Transport is being provided through 108 – but the awareness on availability of referral transport is poor. Similarly, drop back rate was poor.
- Fixed days are being held to provide family planning services. Supplies of condoms and OCPs were available across all SCs.
- Sterilization was being provided in DH and SDH facilities only, thus affecting uptake of sterilization by willing beneficiaries.
- 11SNCUs, 58 NBSUs and 236 NBCCs are functional in State. State is in the process of establishing SNCUs via the grant received by the State for reduction of IMR.
- The adolescent health programme is in initial stages of implementation. The AFHCs have been established; however they are not as per the guidelines of RKSK.
- The established AFHCs are not as per the RKSK guidelines. ICTC counsellors are used to provide counseling services to adolescents but are yet to receive any training on RKSK.
- Peer education program has not been rolled out in any of the districts visited.

RAJASTHAN

- The first trimester registration for ANC is low in Dholpur district when compared to state average. District hospitals are taking maximum load for delivery services. There is only one functional CEMONC centre in each of the two districts.
- Some of the essential drugs as per 5*5 matrix were in shortage like Misoprostol, Nifedipine, Mifepristone, Labetalol, RTI/STI drugs etc. in both the districts visited. Folic acid is available in 5mmg form instead of 400mcg where in Bikaner or Dholpur .
- To ensure early initiation of breast feeding and immunization of newborn and postnatal counseling of mothers at facilities, Yashodas are deployed in DH and CHC. However, role of these volunteers is still very limited, as seen in Bikaner district.
- Only 1 sonography machine available in each of the districts (at DH) resulting in long waiting period and in many cases the OOP expenses for USG at the private facilities turned out to be high.
- Only one third of maternal deaths are reported in Bikaner & Dholpur against the estimated maternal deaths. 90 percent of the total reported deaths are transit deaths, and the remaining 10 percent are being reported as "other than transit" deaths.
- State has established a functional grievance redressal system for JSSK- Rajasthan Sampark, however awareness among community regarding this system was found to be poor in Bikaner district.
- RMNCH+A counsellors are in position at DH & Medical College but their training is yet to be completed.

- RBSK has not implemented in Dholpur & Bikaner district; teams formed in previous year dissolved; nodal persons for RBSK (AYUSH doctors) not in position.
- High cases of birth asphyxia reported from DH DHolpur, indicating poor implementation of labour room protocols. It indicates the need for more skilled staff in the labour room and management of high risk cases by Gynaecologist.
- The AFHCs (known as 'Ujala' clinics) had a separate room but had low footfalls. The ANMs were not trained in RKSK. Launch of helpline for adolescent - 104 as 24X7, and development of the protocols for the helpline is underway.

UTTAR PRADESH

- The percentage of institutional deliveries in both districts has shown a gradual increase, but is still reported to be approximately 50-60%. The ANC registration is reported to be more than 85%. The early registration of pregnancies was reported to be around 40%
- The line listing of anaemic pregnant women was available in majority of the facilities visited. The management of severe anemia using injectable iron was not available below the DH level. Partographs usage during labour was varied across facilities.
- The CS rate in both districts was notably lower than the estimated figures (less than 3% in Jalaun and 6% in Sitapur).
- The JSSK implementation appeared to be good in both districts as majority of the patients reported zero OOP expenses, with all the entitlements under JSSK being provided at the facilities. The reporting of maternal deaths was poor in both districts (Jalaun 1.6% and Sitapur 10% reported against estimated maternal deaths.
- The PPIUCD program has been initiated and is showing improvement. However, it is limited to the Level 3 and few Level 2 facilities. The acceptance of PPIUCD was reportedly only 9% in Sitapur and 21.8% in Jalaun. The male and female sterilization is lagging far behind the estimated level of achievement and was being done in camp mode at selected facilities.
- The *Housla Sajhedari Project* (Online registration of private providers for FP services) with support of the TSU is yielding good results and is expected to boost the FP services across the state.
- State has been able to set up only 27 SNCUs across the 75 districts with variable functionality and expected to provide care to approximately 50,000 newborns which is only 6% of the estimated 8 lakh newborns which would require special care.
- There is no NRC in Jalaun though one NRC was available in Sitapur with very low bed occupancy (30%). There was lack of awareness among patients about entitlements under NRC and there was no field level follow-up. Screening for SAM in the community needs to be initiated in Sitapur.
- Under WIFS program, distribution of IFA tablets has been started in government and government-aided schools and AWCs. There is a need for better linkage and improved coordination with other departments for successful implementation of the WIFS program.

UTTARAKHAND

- Poor display and low Awareness on RMNCH+A 5x5 matrix was evident among the service providers and programme management staff in both Dehradun and Nainital which are non-High Priority Districts.
- Shortages / stock outs of RMNCH+A essential commodities such as IFA, Mg So4, Vitamin A, Pregnancy testing kits, Condoms, Medical Methods of Abortion drugs (MMA drugs), RTI /STI colour-coded syndromic drug kits, etc. were seen in many of the facilities visited in both the districts.
- Privacy in labour rooms was compromised in Nainital district and the facilities reported poor supply of essential commodities listed in 5X5 Matrix. Sub-centre Palio in Dehradun which is conducting >10 deliveries a month had no running water supply and no pits for disposal of biomedical waste.
- Delivery records as well as immunization records were missing in most of the facilities visited as no ANMs were posted at facilities.
- Safe motherhood booklet was not available at facilities and thus was not given to pregnant women at the time of registration.
- In Nainital District Women Hospital, high OOPE was reported by outdoor ANC cases on account of purchase of certain drugs, which were unavailable in the hospital.
- Partographs were not routinely maintained in the facilities visited, post delivery stay at institution was frequently noted to be less than 48 hours.
- Though villages reporting high number of home deliveries have been identified, their plan for advance distribution of Misoprostol was not in place in both the districts.
- RMNCH+A counselors were in place at the CHCs and higher centres in the facilities visited.
- Quality Assurance Committee for family planning at district level was found to be weaker on their role.
- Readymade milk substitutes (Lactogen) was purchased after being prescribed for all C-section cases at SPS Rishikesh.
- Oral Rehydration Salt and Zinc tablets were available in both the districts for the management of diarrhoea, but prescribing ORS& Zinc was not in practice.
- *Alternative vaccine delivery is not operational in hilly terrain and remote areas* eg. Chakrata and Kalsi blocks and also in some of the areas under Sehaspur block.
- WIFS programme is not being properly implemented in both districts. It was observed that there was no supply of blue IFA tablets at the schools and AWCs visited. Poor awareness of the WIFS program was observed among the functionaries.
- Menstrual Hygiene scheme is not operational in the districts visited.
- Peer education programme is in the nascent stage and selection of peer educators has been initiated.

WEST BENGAL

- Adequate numbers of delivery points are functional as per population norms. However, most of the L1 level facilities are non-functional, as the state policy does not permit conducting deliveries at Sub center level. In all facilities the infrastructure, equipment, drugs and other supplies are available as per the 5*5 matrix.
- Unusually high CS rates were reported in both districts (Cooch Behar 30% & Purba Medinipur 44% in both Public & Private), and taking consent before C-section was not strictly followed in both the districts.
- There is high out of pocket expenditure on radiological investigations. In few remote places, diagnostic services are provided through PPP mode with user charges.
- District has not yet worked on the universalization of screening for syphilis during pregnancy.
- PPIUCD insertion was very well implemented in the both the districts visited.
- The service uptake of Interval IUCD was very poor in the district. ANM/SN demonstrated good skills in insertion of IUCD at all facility.
- Counselling skills of service providers on family planning methods was found to be poor during PNC and ANC visits of the beneficiaries. There were certain gaps reported in the manner of taking consent for PPIUD insertion.
- Scheme of home delivery of contraceptives was well implemented in the districts.
- Sterilization services were provided at DH on fixed day basis.
- AFHCs are operational at the district, Sub Divisional Hospital and CHC level and have dedicated counselors. Majority of adolescents reportedly visit to the clinics for skin and learning related problems. AFHCs did not have any stock of ECP/OCP drugs, condoms, IFA tablets etc. Standardized printed registers were not available at the clinics visited.
- Under WIFS program, there is no mechanism for receiving reports from the education department; hence the district level WIFS coverage data was not available.
- Counsellors had constituted five-six peer support groups in their community areas. The peer support groups were formed almost one and a half year back and had chosen two peer leaders who are sensitized on important adolescent health related issues. These peer leaders in turn conduct sessions for adolescents in the community.

TOR 3
Disease Control Programme

OBJECTIVES

1. To review the responsiveness of various communicable disease control programme against the disease prevalence patterns, changes in disease pattern, extent of implementation of specific public health strategies under each programme, illness management and data usage.
1. To oversee progress of various non communicable disease control programme activities viz, establishment of Eye Operation Theatres, status of establishment of NCD clinics, progress in NCD screening, COTPA etc.
1. To assess the integration of disease control programmes with RMNCH+A initiatives, adherence to existing referral mechanisms and treatment protocol, timely payment of ASHAs, extent of engagement of AYUSH doctors in prevention and management of disease control programmes etc.

NATIONAL OVERVIEW

COMMUNICABLE DISEASE

India is undergoing an epidemiologic, demographic and health transition. Amidst this transition, India is experiencing transformation in the age pattern of morbidity and mortality, the changes in disease patterns and consequent double burden of diseases and mortality. Nevertheless, communicable diseases still constitute a major public health challenge where we need to sustain high levels of disease control coverage to prevent re-emergence of the problem and adopt innovative approaches to cover difficult to reach population. In addition, there is an increasing trend of non-communicable diseases including injuries that requires cost-effective programme intervention to control NCDs. Disease specific overview is as follows

Since inception, RNTCP has diagnosed and treated more than 17.4 million TB cases and 3.1 million additional lives have been saved. TB prevalence has been reduced from 465 cases per lakh per year in 1990 to 211 cases

per lakh per year in 2013. Incidence of TB has come down from 216 cases per lakh per year in 1990 to 171 per lakh per year in 2013 and mortality from 38 per lakh per year in 1990 to 19 per lakh per year in 2013. Recently RNTCP programme has taken a policy decision to screen all TB patients for diabetes under RNTCP programme setting. There are more than 13,000 designated microscopy centres for sputum smear microscopy, 62 RNTCP certified culture and DST laboratories and 89 Cartridge Based Nucleic Acid Amplification Test sites to provide rapid decentralized diagnosis of MDR-TB services in India. The country reported more than 76,000 MDR-TB cases and these pose critical challenge to RNTCP.

Malaria cases have consistently declined from 2 million in 2001 to 0.88 million in 2013; however more number of cases (1.13 million) occurred in 2014 due to focal outbreaks. The Annual Parasite Incidence has come down from 1.68 per thousand in 2005 to 0.89 per thousand in 2014 (provisional). Deaths due to malaria have come down from 1005 in 2001 to 287 (provisional) in 2015. Overall, in the last 10 years, total malaria cases declined by 42%, from 1.92 million in 2004 to 1.1 million in 2014. The Pf (falciparum) cases showed a decrease from a reported 0.89 million cases in 2004, to 0.46 million in 2013.

The progress of National Filaria Control Programme (NFCP) is well towards meeting its targets – coverage of Mass Drug Administration (MDA) has improved from 73% in 2004 to 86% in 2012. The microfilaria (Mf) rate has declined from 1.24% in 2004 to 0.45% in 2012. The phasing out of MDA has started in 50 districts, 43 districts are in the pre transmission assessment survey (TAS) phase and seven districts have qualified for TAS in 2014.

Kala-azar (KA) or Visceral Leishmaniasis (VL) is endemic in four states (Jharkhand, Bihar, Uttar Pradesh and West Bengal), 54 districts and 587 blocks with an estimated 130 million population at risk. More than 80% of cases are from Bihar, where nine districts contribute 65-70% of the countries disease burden.

The numbers of Dengue Fever (DF) cases are increasing in states such as Assam, Bihar, Delhi, Karnataka, Maharashtra, Rajasthan and West Bengal. DF is also becoming more prevalent in rural areas. The Case Fatality Rate (CFR) is currently 0.2%, much below the national target of 1%. There has been a decrease in chikungunya cases countrywide during the past five years. The Acute Encephalitis Syndrome (AES)/ Japanese Encephalitis (JE) is endemic in about 171 districts across 20 states and UTs. JE as a viral disease represents only 10 to 15% of all AES cases. As a result of increased involvement of Health Ministry in JE control, the CFR has decreased from 20% (2010) to 17% (2015).

National Leprosy Eradication Programme achieved an appreciable milestone in December 2005, when prevalence of Leprosy reached below 1 case per 10,000 populations (elimination) at National Level. Prevalence rate (PR) of less than 1 per 10,000 population achieved in 34 states/UTs. Chhattisgarh has remained with PR 2 per 10,000 population in 2014-15. Two states – Odisha and Delhi, which achieved elimination earlier, have shown slight increase in PR of 1 to 2 per 10,000 population in the year 2014-15.

The IDSP makes provision for facility based collection and analysis of disease surveillance reports, which is followed by field investigation and necessary action whenever a disease outbreak is detected. There are 776 IDSP sites in states/districts connecting with

IT networks. On an average, 30-40 outbreaks are reported every week by the States. Around 1935 outbreaks reported and responded to by states in FY 2015-16. Media scanning and verification cell (MSVC) was established to capture unusual health events reported in the media. As of now, 25 newspapers (13 English & 12 Hindi newspapers) and 74 websites (62 English & 12 Hindi sites) are scanned on a daily basis. Four states from where most alerts were reported are Uttar Pradesh, Karnataka, Odisha and Delhi. The top four diseases responsible for these alerts are Food Poisoning, Dengue, H1N1 (Swine Flu), and Jaundice.

NON-COMMUNICABLE DISEASE (NCDS)

National Overview

Non-Communicable Diseases (NCD) emerged as an important public health problem due to changes in lifestyle, increase in life spans and rapid urbanization. Latest data on burden of diseases in India indicate that Non Communicable Diseases account for 60 % (Cardiovascular diseases 26%, Chronic Respiratory diseases-13%, Cancers-7%, Diabetes-2% and other NCDs-12%) and Injuries 12% of morbidity load Considering the growing problem of NCDs, Ministry of Health and Family Welfare under National Health Mission launched NCD programmes focusing on prevention, screening, early intervention and new treatment modalities with the aim to reduce the burden of chronic diseases. Guidelines for strengthening of tertiary care of cancer under NPCDCS estimated prevalence of cancer to be 28 lakh while the annual incidence and mortality is estimated to be 11 lakhs and 5 lakh respectively. In addition, rising occurrence of other NCDs -hypertension, diabetes and ischemic heart diseases etc. account for 53% of all deaths (WHO 2011) which is a major public health challenge that requires renewed focus on prevention and management of NCDs.

Some states have already initiated NCD programmes and the central government supplemented state efforts by providing support through various NCD programmes including NPCDCS programme. The NPCDCS programme started in 2008 as pilot and expanded in a phased manner across all the states. However, the progress of NPCDCS programme varies from state to state.

The goal of the National Programme for Control of Blindness is to reduce the prevalence of blindness from 1.1% to 0.3% by 2020. Main causes of blindness are – cataract, refractive error, corneal blindness, glaucoma and surgical complication. There are total 248 functional eye banks available and many of these facilities function under private not-for-profit organisation across all the states.

Programmes like National Iron Deficiency Disease Control Programme, National Tobacco Control Programme, National Oral Health Programme, and National Programme for Health Care for Elderly, National Mental Health Programme, National Programme for Prevention and Control of Fluorosis and Palliative care are in different stages of implementation in different states. However, the progress made under these programmes leave much to be desired.

Major finding from 9th CRM across 18 states visited by CRM teams followed by state summaries age given next page.

KEY FINDINGS

COMMUNICABLE DISEASE CONTROL PROGRAMMES

1. National Vector Borne Disease Control Programme (NVBDCP)

- National framework for Malaria elimination classifies states/UTs based on Annual Parasite Incidence (API). Based on the framework, CRM states were classified as Category-I: elimination phase (Delhi Haryana, HP, Manipur, Punjab, Rajasthan and Uttarakhand); Category-II: Pre-elimination phase (AP, Assam, Karnataka, Maharashtra, Uttar Pradesh and West Bengal); Category-III: Intensified control phase (Chhattisgarh, Jharkhand, MP, Meghalaya and Odisha).
- Low Annual Blood Examination Rate (ABER) seen in Jharkhand, Meghalaya, Himachal Pradesh, Uttar Pradesh, Manipur, Uttarakhand; ABER was satisfactory in Chhattisgarh, Andhra Pradesh, Assam and Odisha. Low ABER in Category-III states like Jharkhand and Meghalaya is a serious concern. The quality of peripheral smears needs improvement in Himachal Pradesh, Uttar Pradesh and Maharashtra.
- Declining trend in Malaria was observed in Himachal Pradesh, Chhattisgarh, Punjab, Rajasthan, Jharkhand, Maharashtra and Karnataka while an increasing trend observed in Meghalaya, Manipur, Andhra Pradesh and Odisha. However, increasing trend in Odisha is a serious cause of concern, which is traditionally a high Malaria burden state. Quality of surveillance activities and issues related to supply of long lasting Insecticides treated Nets have been probable contributory factors
- Dengue cases increased in Punjab, Rajasthan, Andhra Pradesh, Karnataka, West Bengal, and Himachal Pradesh. Epidemic of Dengue reported in Delhi; Cases continue to be reported from Jharkhand, Madhya Pradesh and Assam. Increase in DF may be associated with urbanization and improper water storage practices in urban and peri-urban areas. A declining trend in DF reported from Odisha and Maharashtra, which reported highest number of DF cases and deaths in 2013. This may indicate an effective management of water storage practices that halted proliferation of mosquito breeding sites.
- JE cases continue to be reported from Jharkhand, Karnataka, Assam whereas Andhra Pradesh did not report any case till October 2015. However, more than 85% of the total number of AES/JE cases and deaths reported from – Assam, Bihar, TN, UP and West Bengal. Two dose of JE vaccine (first at the age of 9 months and second at the age of 16-24 months) have been integrated with Routine Immunisation in endemic states like Uttar Pradesh, West Bengal, and Assam etc.
- Chikungunya shows increasing trend in Karnataka, while the disease is under control in Andhra Pradesh, Rajasthan, Odisha and Punjab; No case of Chikungunya reported in Jharkhand. Chikungunya cases reported mostly from Southern and Western parts of the country.
- Declining trend of Kala Azar with zero mortality seen in Jharkhand. Kala-azar is endemic in four states (Jharkhand, Bihar, Uttar Pradesh and West Bengal), 54 districts and 587 blocks with an estimated 130 million population at risk. More than 80% of

the cases are from Bihar, where nine districts contribute 65-70% of the countries disease burden.

- Declining trend of Lymphatic Filariasis seen in Jharkhand, Karnataka, Andhra Pradesh, Uttar Pradesh, West Bengal; Transmission Assessment Survey (TAS) carried out in select districts in West Bengal (4), Maharashtra (3), Assam (5) and Odisha (1). The microfilaria (Mf) rate has declined in the Mass Drug Administration (MDA) districts from 1.24% in 2004 to 0.29% in 2013.
- IEC/ BCC activities are not markedly visible in Himachal Pradesh, Uttar Pradesh and Rajasthan. In Andhra Pradesh, IEC activities were visible in facilities, but not in outreach sites or beyond facilities. IEC and use of mass media seen in Karnataka, Manipur and Odisha. In Maharashtra, month wise calendar of activities for the whole year was observed to reduce vector density.
- Shortage of human resource at all levels - LTs, entomologist, consultants, MPWs etc., was observed in Himachal Pradesh, Andhra Pradesh, Jharkhand, Madhya Pradesh Karnataka, Uttar Pradesh, Rajasthan, Odisha, Delhi and Maharashtra while most of the NE state -Assam, Meghalaya and Manipur reported reasonable HR position in place but surveillance, monitoring, drug supply and spray activities were found to be sub-optimal.
- ASHAs were trained and performing well in terms of referring suspected fever cases. Contractual MPWs are not performing in hilly areas due to inordinate delay in salary release (for last 2 years). However, Multi-tasking by Lab Technicians from various programmes is well utilized in West Bengal; Needs improvement in Jharkhand, Uttarakhand and all other remaining states

2. Revised National Tuberculosis Control Programme (RNTCP)

- Himachal Pradesh, Delhi, Meghalaya, Rajasthan, Jharkhand, Uttarakhand and West Bengal have shown good performance in terms of achieving RNTCP targets - Case Detection Rate-80/L/Y, cure rate 90% and sputum conversion rate 90%;
- Programmatic management of DR-TB and Paediatric TB was observed as per guidelines in Maharashtra, Delhi, Uttarakhand, Odisha and Chhattisgarh however, in Rajasthan, delay in identification and testing of suspected MDR TB reported. Maharashtra reported maximum load of DR-TB 4738 followed by UP 2976 and Rajasthan 2050 DR-TB cases in 2015. In Delhi, diabetic screening for all TB cases initiated.
- TB-HIV collaborative activities are progressing well in Maharashtra, Manipur, Andhra Pradesh, Uttar Pradesh and Odisha though slow progress was observed in Meghalaya, and Jharkhand. Assam reported proportionally 40% of all registered TB cases with known HIV status whereas Andhra Pradesh reported 98% in 2014.
- Cartridge Based Nucleic Acid Amplification Test (CBNAAT) was initiated in Delhi for testing of presumptive TB cases among homeless children, marginalised high risk groups such as truckers and prison inmates. CBNAAT were established in all visited states for rapid diagnosis of MDR-TB.
- Lab registers at Designated Microscopic Centre (DMCs) and TB register at Treatment Unit (TU) are being maintained in Delhi, Meghalaya, Manipur, and Uttarakhand.

Adequate consumables and equipment with AMC coverage seen in Delhi, Meghalaya and Manipur.

- Overall drug availability at the district and sub-district level is satisfactory except for Inj. Streptomycin in Meghalaya.
- Maharashtra, Jharkhand, Chhattisgarh, Manipur, Madhya Pradesh, Uttarakhand, Meghalaya, Assam and Odisha reported regular entry of data in NIKSHAY system. However, many PHCs find it difficult to enter data in NIKSHAY due to inadequate IT infrastructure like desktops and internet connectivity, in addition intermittent electricity supply in these areas. Chhattisgarh, Rajasthan and Delhi desired to have refresher training in NIKSHAY system.
- Involvement of ASHA/Mitanin/Sahiya seen in Meghalaya, Jharkhand, Chhattisgarh, Manipur and Punjab; Needs improvement in Delhi. IEC activities of the Programme are observed at District and sub-district level in Delhi, need improvement in Uttarakhand.
- Shortage of human resource at all levels – LTs, STLS, STS etc., was observed in Andhra Pradesh, Delhi, Jharkhand, Manipur, Odisha, Himachal Pradesh and Rajasthan; Situation is better in Meghalaya and Uttarakhand. Mobility support for STS/STLS lacking in Meghalaya and Manipur.

3. Integrated Diseases Surveillance Programme (IDSP)

- Surveillance units are established and functional across all the states and districts. State like Odisha use state surveillance unit as state health control room during emergencies like floods, cyclone and heatwave etc.
- Reporting of S, P, and L form varies from state to state that ranges from 10% reporting of S Form in Uttar Pradesh to 100% reporting of L Forms in West Bengal and Assam. Adequate IT infrastructure is available across all the state but maintenance of hardware is a concern in almost all states.
- IDSP system aided in detecting early warning signals of impending outbreaks and helped in initiating an effective response in a timely manner in all visited states. Almost all states have responded early to outbreak by initiating control measures. However, percentage of samples from outbreak sent to laboratory varies from state to state and needs improvement.
- Public health laboratories developed in Dholpur, Rajasthan, Churachandpur in Manipur, Purba Medinipur in West Bengal, Beed and Nashik in Maharashtra, and Mohali in Punjab under NHM for diagnosis of epidemic prone diseases. Similarly, district priority labs were strengthened in almost all visited states to support outbreak investigations and undertake laboratory confirmation of diseases on a routine basis.
- Inadequate human resource (epidemiologist, microbiologist etc.) for IDSP reported in Delhi, Jharkhand, Madhya Pradesh, West Bengal and Maharashtra. States like Uttar Pradesh, Uttarakhand and West Bengal reported need for training/ reorientation of IDSP staff at different levels – from filling formats, analysing IDSP data to responding to outbreaks in the districts.

4. National Leprosy Eradication Programme (NLEP)

- Of the 18 states, three reported prevalence rate >1/10,000 (Delhi (1.26), Chhattisgarh (2.14) and Odisha (1.23)). Remaining 15 state reported prevalence rate less than one per 10,000 (<1/10,000).
- States like Delhi, UP, MP, Jharkhand, West Bengal and Odisha reported ASHAs involvement in suspecting and follow-up treatment. State like Himachal Pradesh and Manipur reported limited involvement of ASHAs due to lack of awareness and sensitization programmes. Uttarakhand reported delay in incentives payment to ASHAs for suspecting and treatment completion ASHAs have been recently introduced in Himachal Pradesh
- Karnataka, Chhattisgarh, MP, UP and West Bengal reported adequate drug stock. Similarly, adequate MCR footwear supply reported in Odisha, West Bengal and Karnataka however Uttar Pradesh state reported inadequate supply of MCR footwear.
- SPARSH program has been launched in Chhattisgarh to find hidden leprosy cases in community through active surveillance in high endemic blocks. Similarly, Intensive Case Detection Drives (ICDD) and Block Level Community Campaign (BLCC) have been carried out in Odisha to detect early leprosy case and put them under treatment.
- State reports indicate leprosy associated stigma in Manipur and Odisha that resulted in delay in case detection. Reconstructive Surgeries referred and conducted in Karnataka [134], UP [10], Manipur [1] and Odisha [307].
- Intensive IEC/BCC campaign taken up for reduction of stigma and discrimination in Karnataka, Chhattisgarh, Uttarakhand, Assam, Manipur and Odisha.

5. National Programme for Control of Blindness (NPCB)

- National programme for control of blindness is implemented in all the 18 states covered under 9th CRM. Blindness control programme demonstrated sustainable partnership with private not-for-profit organizations in achieving the programme targets.
- Madhya Pradesh, Uttarakhand, Meghalaya, West Bengal and Odisha reported that most of cataract surgery load is borne by NGOs and private healthcare facilities. There are total 19 regional institute of ophthalmology functioning under NPCB and 248 eye banks in India.
- Adequate number of human resource available in Himachal Pradesh and Haryana. However, high vacancies reported from Delhi, Madhya Pradesh and Odisha under NPCB programme.
- School children are being screened for refractive errors and free spectacles are being provided in Himachal Pradesh, Andhra Pradesh, Chhattisgarh, Jharkhand, Madhya Pradesh, Uttarakhand and Odisha.
- Maharashtra has initiated tele-ophthalmology programme for the benefit of tribal population in Gadchiroli, Nandurbar and Amravati districts. Similarly, Odisha started

mobile tele-ophthalmic unit at MKCG MCH Berhampur to provide eye care services in the interior parts of the district.

6. National Programme for prevention and control of cancer, diabetes, cardiovascular diseases and stroke (NPCDCS)

- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) program has been rolled out in Delhi, Himachal Pradesh, Chhattisgarh, Haryana, Uttar Pradesh, Manipur, Jharkhand, Madhya Pradesh, Uttarakhand, Assam, Maharashtra, Punjab, West Bengal and Odisha. However the programme has yet to fully take off in Meghalaya and Rajasthan.
- In Himachal Pradesh, glucometers, gluco-strips and lancets have been provided in PHCs and sub-centre level. The Tele-stroke project is one of the best practices of Himachal Pradesh under NPCDCS. State like Punjab reported to have launched educational campaigns for cancer and tobacco control and funds from Chief Minister's office were being used for supporting treatment of cancer patients. Hospital based cancer registries exist in PGIMER, Chandigarh and Medical College Hospitals in Amritsar and MoU for establishing population based Registry with Tata Memorial Centre was being processed (Mansa district).
- In Manipur, West Bengal and Delhi, district NCD cells are not in place and NCD clinics, Cardiac care Units and Cancer care facilities are not established in District Hospitals due to various administrative and technical reasons.
- In Jharkhand, number of persons screened for diabetes and hypertension is 1.1 lakh and proportion of those suspected for diabetes (>140) and Hypertension (>90) is 12.61% and 10.38% respectively.
- Partial coverage of services was observed in sub-district hospitals within implementing district under NPCDCS program. In addition, inadequate funding for IEC activities was reported. Many of the sanctioned post under NPCDCS are vacant in almost all states.
- Non availability of training manuals/ modules on NCD for different categories of staffs was observed. No provision for Day Care Chemotherapy at district hospitals and non-availability of treatment protocol for cancer, diabetes, hypertension, stroke and drug policy were also noticed

Status of other programmes

- Himachal Pradesh state reported issues in procuring salt testing kits under NIDDCP programme. Other NCD programmes like tobacco control, oral health, healthcare of elderly and mental health programme are functioning well in the state.
- In Rajasthan, no activity observed in the visited district regarding other NCD programmes such as NOHP, NPCDCS, NPHCE, NPPCF, NMHP, NIDDCP and Palliative care.
- State tobacco control cell were constituted in all visited states with a state nodal officer. The programme was launched in 29 states covering 58 districts in a phased manner. Support was extended for setting up state as well as district cells. However, in Phase –II, only district cells were supported.

- Mental health services are provided in Imphal East and Imphal West. National Programme for Prevention of Deafness is implemented across all the districts of Manipur.
- Geriatric clinics under National Programme for Health Care of Elderly found to be functional at visited CHCs in Jharkhand.
- A total of 14 districts are covered under National Programme for Prevention and Control of Fluorosis programme and a total of 16 districts are covered under National Tobacco Control Programme in Madhya Pradesh.
- Maharashtra state stands out in organizing mental health clinic with psychiatrist, psychiatric social worker, and occupational therapist and other staff nurse was observed at district hospital, Bhandara, Maharashtra. Regular mental health camps are being conducted in the community.
- Palliative care Programme is implemented in eight districts of Maharashtra. License was obtained for 32 hospitals in eight districts for the storage of critical drug Morphine.

Recommendations under NVBDCP

1. Necessary steps must be taken to ensure maintenance of ABER at >10% and adopt national framework for malaria elimination across all the states. State needs to ensure induction and refresher trainings including treatment protocols as per the latest guidelines at regular interval to all levels of staff involved in implementation of NVBDCP Programme.
2. Develop comprehensive plan at the state and district level for implementation of vector-borne disease control programme in respective State. Formulate and enact bye-laws for public health in urban areas to control and monitor mosquito breeding sites particularly focusing on new construction areas. Involve other line departments (water and sanitation) and stakeholders in implementation of NVBDCP programmes at the state, district and sub-district level.
3. Health supervisors and ASHA workers should be involved more actively in creating awareness among the community. Revised incentive for ASHAs needs to be provided as per the NVBDCP guidelines. Ensure involvement of local bodies such as VHSNCs and PRI/ULB for source reduction at community level in campaign mode to reduce the risk of transmission - the key strategy for prevention.
4. All vacant posts (District Malaria Officers, Microbiologists, Pathologists, Surveillance officers, Entomologists, Data managers and Malaria inspectors etc.,) need to be filled up on priority basis for effective implementation of the programme. Integrate National Health Programmes including NVBDCP with general health system in view of HR shortage.
5. Ensure good quality and coverage of Indoor Residual Spray (IRS) through close Monitoring and supervision, particularly in high-prevalent areas.
6. Dengue deaths should be audited by Dengue Death Audit Committee. State level review meeting should be organized to review the disease situation and preparedness of the respective state. Dengue cases should be confirmed by standard (ELISA) method as per latest NVBDCP guidelines for management of Dengue.

7. Entomological activities for malaria and dengue must be strengthened, along with more frequent and regular supportive supervision/monitoring visits from state and divisional/zonal teams. Active and passive surveillance need to be strengthened. State Surveillance hospital labs need to be made operational through filling vacancies and providing necessary logistics.

8. Community sensitization to be strengthened in JE/AES endemic states to avoid delay in response. Strengthen CCU through required supplies (oxygen etc.). IEC/ BCC material is likely to be effective when displayed at prominent public places and mechanisms set up to hold discussions and get feedback on the IEC from different stakeholders to further modify the iEC strategy.

Recommendations under RNTCP

1. Ensure early diagnosis and improved access to quality treatment for all diagnosed TB cases including MDR-TB and monitor progress to achieve RNTCP targets -case detection rate, treatment completion rate and failure rate etc.

2. States should ensure complete registration of TB cases through NIKSHAY at District and sub-district levels. It should be made real time data entry system and all practicing doctors needs to be registered under NIKSHAY.

3. State needs to ensure the involvement of private healthcare providers in reporting TB cases and strengthen monitoring, supervision and programme operations at the District and Sub-district level to improve the quality outcomes and to achieve the desired targets.

4. Induction and refresher training needs to be provided at all level staff (MOs, STS, STLS and LTs) on regular interval. The health supervisors/ASHA should be actively involved as DOTS providers and community be sensitized through VHSNCs.

5. State should encourage involvement of NGOs/ voluntary organizations/ individuals (community champions) to increase awareness of the Programme and involvement as DOTS providers.

6. Cross referrals of TB-HIV needs to be strengthened as per guidelines and all retreatment cases should be monitored till the end of treatment. Referral and follow up of MDR-TB cases should be accorded high priority

7. States should recruit sanctioned contractual positions under RNTCP for the benefit of the programme. Programme needs to ensure timely release of contractual staff payment and revised mobility incentives (two wheelers) for STS and STLS.

Recommendations under IDSP

1. Block and district needs to use IDSP data for better planning and implementation of disease control programme. IDSP data needs to be reviewed on monthly basis at block and district level to improve data quality.

2. State needs to ensure recruitment of all sanctioned positions like epidemiologist, entomologists, DEOs etc. and make sure district surveillance officer functions without any additional responsibilities.

3. Ensure annual maintenance of available IT infrastructure and need to improve the quality reporting of S, P and L form across all states. Ensure establishment/ functioning of district public health laboratories in respective states.
4. State needs to ensure regular training / orientation of staff including medical officers on various components of IDSP at state, district and sub-district level.
5. District needs to improve sample collection from outbreaks and sent to laboratories to improve the quality of control measures.

Recommendations under NLEP

1. State needs to ensure dedicated manpower at district and block level for management of disability prevention and medical rehabilitation under NLEP programme.
2. Make sure active surveillance through involvement of general health care services like ANM/MPHW for early case detection and treatment. Create awareness on leprosy through various modes of IEC/BCC to reduce stigma and acceptance of leprosy services.
3. Focus on early diagnosis during VHND by ANM/MPHW/ASHA. More ICCD/BLCC activities need to be carried out in high burden states.
4. Engage more civil societies for supporting Reconstructive Surgeries (RCS) and ensure district wise early tracking of eligible RCS cases. Strengthen services at leprosy colonies.

B. NON-COMMUNICABLE DISEASE CONTROL PROGRAMMES

Recommendations under National Programme for Control of Blindness

1. State should rationally deploy ophthalmic surgeon mainly against vacancy at district hospital level. State needs to ensure recruitment of ophthalmic assistants, Optometrist or hiring services through NGOs.
2. Ensure construction of eye OT at medical colleges on fast track mode and adhere to available guidelines for carrying out cataract surgery in government institutes.
3. Expedite engagement with NGOs/hiring services for early screening for cataract, engaging ophthalmologists, screening of school children, screening for diabetic retinopathy.

Recommendations under NPCDCS and other NCD programmes

1. State needs to fill up vacancies under various non-communicable disease programs and provide regular free drugs & diagnostics as per guidelines under these programs.
2. Progress in setting up of NCD clinics and functioning of existing clinics should be strictly monitored as per recommended norms and guidelines and capacity of states be developed in this regard.

3. State needs to train appropriately available manpower to fill the gap of psychiatrist, clinical psychologist, and psychiatric social worker under national mental health programmes.
4. Ensure regular review of program performance at state and district level and engage suitable NGOs (not-for-profit) organization to draw core competencies and implement various NCD programmes.

STATE FINDINGS

ANDHRA PRADESH

- API > 1 reported from three districts Vizianagaram (1.17), Vishakhapatnam (1.87) and East Godawari (1.00). Remaining 10 districts of the state having API<1 needs sub-centre wise stratification for pre-elimination of Malaria as per NVBDCP guidelines.
- District TB officer position is vacant in Anantapur district since last 7 years and needs to be filled up expeditiously.
- A systematic process of review and monitoring system is in place for IDSP. Intensive IEC activities were taken up to deal with dengue out-break. Dengue outbreak in Anantapur district has been tackled successfully in the year 2015.
- Targets set for NPCB are being achieved by the State. Cataract operation mainly done by IOL implantation. Screening for refractive errors of school children is also done effectively.

ASSAM

- Health infrastructure at periphery/ sub-district/ district level is inadequate to treat the encephalitic patients. However, fogging, impregnated bed-nets and awareness camp are being carried out. Standard treatment guidelines for management of cases are available at all the facilities visited.
- Registration under NIKSHAY is around 95-100%; but data is not being fully utilised for monitoring.
- The public health lab has been strengthened under IDSP at District level. Reporting from private sector needs to be aligned with IDSP. Feedback to the block and PHCs for taking appropriate action needs to improve.
- District Leprosy Officer is not available in visited district. No record of leprosy stock maintained at Dergaon CHC. PHCs are acting as MDT collection centres and there is under staffing in the NLEP. IEC activities under NLEP were observed in almost all the facilities visited.

CHHATTISGARH

- Active involvement of *Mitanins* was observedat village level. Coverage of MDA drug distribution is optimal and Mf survey carried out in selected districts in the state. Coverage of indoor residual spray -room and house is reported to be low (53%)

- Active involvement of Mitanins was observed in TB suspect identification and referral for sputum examination.
- State reported more than 90% of syndromic and presumptive surveillance forms under IDSP. State reported prompt response to outbreak to control them.
- SPARSH program was launched to find out hidden leprosy cases in community through active surveillance in high endemic blocks. Observed referral of disability cases for RCS with good IEC at each level in state. State needs to ensure timely availability of steroids at PHCs for management of lepra reaction.
- School going children in the periphery are being screened for refractive errors and provided spectacles. Good response was reported for eye donation in urban areas in the state.

DELHI

- All guidelines related to dengue management and prevention were circulated to all the government and private hospitals, dispensaries, private practitioners and other stake holders. No staff available under NVBDCP programme at state programme office, Delhi.
- Eleven out of twelve medical colleges are involved under RNTCP. TB-HIV co-location centres were reported in 92% of facilities. Diabetic screening for all TB patients initiated from January 2015. However, low Referrals reported from government dispensaries.
- State and district surveillance units have investigated total 23 outbreaks related to water/vector borne disease in FY2015. Preparedness for H1N1 has been completed at all facilities and was visible during the field visit. Of the 51 sanctioned positions, 25 positions are vacant under IDSP at state level.
- ASHAs are actively engaged in Leprosy survey and around 100 new cases of leprosy have been reported in Delhi and many of them are from adjoining states. Disease prevalence shows decreasing trend.
- Data entry positions in all 11 districts are vacant and 20 out of 28 clinical positions are vacant under NPCB program at state level. Delhi state preformed 511 cataract operations out of which 124 carried out by NGO in 2014-15 under NPCB.

HARYANA

- Recurring outbreaks of Dengue haemorrhagic fever, Chikungunya and Japanese Encephalitis have been reported from Haryana. Under-reporting of some vector borne diseases is a cause of concern (E.g. malaria cases) and slides are not being adequately preserved for cross checking.
- The TB success rate is 88% and default rate is 6% in Cat -1, 12% in Cat-2 and 6.4% in Paediatric TB. There are huge variations across all these indicators in the districts. DOTS therapy is being provided without direct observation and the records of treatment and drug stocks are incomplete.
- Regular reporting of IDSP forms was observed and regular feedback is being sent to the districts, which is descriptive rather than analytical nature.

- State leprosy prevalence is low however, it differ across all the districts with one high endemic district (Panipat). Case detection rate of leprosy has shown increasing trend (from 1.37 in 2010-2011 to 2.33 in 2014-2015) and treatment completion rate is at 95% in the state.
- Under the NPCB, 13 dedicated OTs are working in the State. During FY 2014-15, of the total target, 65.05% of cataract operations has been achieved out of which 28.98% were in government hospitals and remaining 71.01% in private hospitals.

HIMACHAL PRADESH

- Active and passive surveillance is being carried out at the district and sub-district levels under NVBDCP. However the quality of peripheral smears needs improvement. The ABER is consistently < 10% for the past five years.
- Discrepancy has been observed in the data physically available at the district level and that entered in NIKSHAY (in Hamirpur District). At some facilities, the staff is facing issues with the NIKSHAY software (TU Barsar, TU Sujanpur in Hamirpur District). The Registration of TB patients under NIKSHAY is being done only at the district level in Sirmaur.
- V- SAT had been installed in all the 15 surveillance sites in the state (12 Districts, 2 Medical Colleges & 1 State Headquarter) under IDSP programme but these installations are non-functional due to hardware issues.
- Due to low leprosy case load, the leprosy workers (in Hamirpur District) are involved in dispensing medicines to the patients, and the involvement of ASHA's and other health workers is very limited in awareness and sensitization activities.
- Adequate human resource available under NPCB. Screening of school children and distribution of free spectacles are being done regularly. However, free spectacles should also be provided to older people for near-work, as per the provision of the Programme.

JHARKHAND

- Microfilaria survey is carried out through Night Blood Survey by teams of Sahiya (ASHA) / ANM, BHW under supervision of Malaria Technical Supervisor (MTS). It was observed that there is a lack of information on vector in the Falciparum areas for proper and effective insecticidal spray operation.
- DOTs centres are run by ANM/ RNP/ Sahiya /AWW.
- IDSP positions are vacant at districts level -Epidemiologist (14), Districts Data Manager (16), and District Data Entry Operator (15). Outbreak reports submitted within a stipulated time and action initiated immediately. Samples were collected from 14 out of 20 outbreaks sites in the state.
- There are 11 Districts out of 24, which are yet to achieve leprosy elimination status. The state is utilizing the services of all healthcare workers for assisting in Leprosy related services on 3rd Saturday of each month. Payment of incentive to Sahiya is regular.

- Against screening target of 4,76,190 school children, 2,64,158 (55.47%) achieved under NPCB. During the year 5160 children were detected with refractive error and supplied 2327 (11.64%) free glass as against target of 20,000.

KARNATAKA

- Inter-sectoral coordination meetings organized to review the implementation of Malaria & other Vector Borne Disease Control by involving corporation members, NGOs, private practitioners and media. Web based Malaria App was launched in Mangalore city with the support from health department.
- Under RNTCP, Koppal district shown an annual cure rate of 75 percent. The annual NSP Default Rate for the district is 9 percent.
- Nine Model district laboratories have been identified to strengthen laboratory services under IDSP. 6 out of 9 labs were registered with Shankar Nethralaya, Chennai for External Quality Assurance. State Rapid Response Teams have participated in 9 outbreaks as compared to 3 in 2014.
- At the state level, 97% disabled persons availed treatment under NLEP, 3017 MCR footwear distributed and around 134 reconstructive surgeries were conducted during 2014-15. Around 26 High endemic blocks were identified in FY 2014-15 reduced from 31 blocks in previous year.
- Under NPCB, the Koppal district shown decreasing trend of cataract operations, which is a cause of concern.

MADHYA PRADESH

- Many of the planned trainings under NVBDCP are pending in the state. State is not aware about the processes for putting indents for IgM kits – these are supplied free of cost by GoI. Around 30% of expenditure reported as against allocated fund under NVBDCP in the state.
- Most of the Designated Microscopic Centres are co-located with HIV testing centres in the state. Available staff is adequately trained on DOTS and PMDT however, there are several vacancies reported in the state.
- Janani Call Centre and IDSP have been integrated for daily reporting of outbreak and monitoring at State and district level. Of the sanctioned 218 posts, 136 are recruited and remaining 81 positions are vacant.
- ANCDR of leprosy has increased from 7.79 in 2010-11 to 9.02 in 2014-15 due to active search and surveillance. The number of new cases detection has also increased consistently from 5708 in 2010-11 to 6921 in 2014-15. Visited districts seem to be achieving treatment completion rates.
- Regular camps organised to conduct cataract surgeries. School children were assessed and free spectacles distributed. There are several vacancies observed and much of the surgery load is borne by private facilities.

MAHARASHTRA

- Around 275 Guppy fish hatcheries established under biological vector control and these guppy fish distributed across 2,402 mosquito breeding places. Special dengue

awareness campaign and container search was conducted with the help of 40,000 school children. Around 13,000 LLIN were distributed in Gadchiroli with support from corporate social responsibility fund.

- CSR fund supported in providing nutritional supplementation to MDR/XDR TB Patients in Mumbai.
- There are total 10 Referral Labs under IDSP all recommended tests are done in these Labs. Of the sanctioned, around 30% of positions are vacant these include epidemiologists and data managers etc. It was observed that due to lack of coordination between MOs and pharmacist most of the P form incompletely reported in the state.
- 15 out of 35 districts reported high leprosy prevalence rate. Grad II disability reduced to 2.6% from 4.34% (2014-15) and child cases reduced to 11.32% from 12.46% (2014-15).
- Tele-ophthalmology was initiated in difficult and hard to reach areas. Around 765 refractive Index and 1005 fundus eye screenings were conducted through tele-ophthalmology in Nandurbar, Amravati (Melghat), Sindhudurg & Gadchiroli Districts.

MANIPUR

- Community bed nets were treated with deltamethrin insecticide in the endemic areas of Churachandpur. Non-payment of incentive to ASHA has caused limited involvement in the surveillance and treatment of malaria.
- Adequate drugs are available under RNTCP at districts and treatment unit level for first line as well Second line drugs. Delay was reported in releasing RNTCP contractual staff salary for the past nine months.
- Out of S, P and L forms only P form was found to be implemented in the PHCs and CHCs. Data was analysed only at state and not at district and sub-district level. There is no Public Health Laboratory in the state except one District Priority Laboratory at Churachandpur which is not yet fully functional due to lack of man power.
- Number of new leprosy case detected at the state level shown declining trend from 26 in 2010 to 17 in 2014. Grade II disability among new cases has come down to 6% in 2014-15 from 19% in 2010-11. It was observed in the field that there was lack of orientation on Leprosy among the Health Workers and ASHAs.
- Regional Institute of Ophthalmology, tele-ophthalmology facility and eye bank are not available in the state. However, Mobile Ophthalmic Units are operational. Jawaharlal Nehru Institute of Medical Sciences (JNIMS) and CMOU caters to the needs of eye surgeries.

MEGHALAYA

- Blood sample of JE suspects are collected and sent to NEIGRIHMS Shillong that led to delay in receiving diagnostic report of the suspected patient. Around 37 persons received JE vaccine and no case of Dengue, Chikungunya and Filariasis reported from the state.

- Adequate TB drugs available at the district and sub district level except Injection Streptomycin. In PHC Shanjpung, RNTCP Treatment Cards were not signed by MO.
- There are 29 reporting units under IDSP and around 80% to 84% are submitting presumptive, syndromic and laboratory format respectively. Human samples are send to Pasteur Institute, Shillong for examination.
- IDSP officer act as in-charge for NLEP programme in visited districts. It was observed that three leprosy cases were put on treatment with inadequate drugs (only 1 MDT box available).
- Ophthalmology department is well equipped at district hospital but non-functional due to lack of eye surgeon for the past three years. One eye surgeon from outside visits the hospital for two days per month.

ODISHA

- Engagement of volunteers along with Gaon Kalyan Samitis and PRI members was seen in source reduction of vectors. Free diagnosis, treatments including platelet transfusion were available in the state. ASHAs possess good technical knowledge on malaria testing and treatment. RDT and ACT were found to be adequately available with ASHA.However, quality of surveillance and issues related to supply of long lasting Insecticide Nets specially in tribal areas have contributed to increase in malaria cases in the region
- State has rolled out RNTCP tribal action plan in 11 notified tribal districts catering to 22.47% of tribal population of the State. Various IEC activities rolled out to disseminate TB messages to the community. Delivery of quality DOTS services through ASHA network. However, delay in ASHA payment was observed in the state.
- State and district surveillance unit are functional with trained IT personnel. Ortho-toluidine & H2S test kits provided to the district and sub district level for routine monitoring of water quality. Steps are being taken for involvement of private providers at major cities in disease surveillance activities.
- Leprosy prevalence rate vary from district to district. Of 31 districts, 4 districts reported >3 prevalence rate per 10,000 population. Around 45.5 % of all new cases detected during 2014-15 are being referred by ASHAs.
- One Mobile Tele-Ophthalmic Unit has been installed at MKCG MCH, Berhampur to provide eye service at the interior area. Around 131 Vision Centres have been installed at CHC level with Ophthalmic Assistant.

PUNJAB

- Supplies of chloroquine and primaquine were available at health facilities, while artemisinin combination therapy is required far less often (low falciparum load) and is available at the district headquarters. Both dengue and malaria are notifiable diseases in the state. RNTCP functioning satisfactorily in District Hoshiarpur
- The state and district have designated Surveillance Units with epidemiologist, data manager & data entry operator. There are 5 Referral Labs at Government Medical

College and District Priority Lab at Mohali is functioning well. Total 45 outbreaks were reported and were investigated in the year 2015.

- The. State government has launched educational campaigns for cancer and tobacco control and funds from Chief Minister's office were being used for supporting treatment of cancer patients. Hospital based cancer registries exist in PGIMER, Chandigarh and Medical College Hospitals in Amritsar and Mou for establishing population based Registry with Tata Memorial Centre was being processed (Mansa district)

RAJASTHAN

- There is minimal involvement of ASHAs, ANMs and PRIs in Disease Control Programmes in general and particularly in NVBDCP. Many of the para-medical and medical staff are not aware of National Drug Policy (NDP) 2013 for treatment of malaria. Presumptive treatment is still continuing which has been removed from NDP.
- Delay in timely identification and testing of MDR TB suspects and retreatment of TB cases not followed till the end. Involvement of private sector for TB notification and supervision of their treatment is poor.
- District public health lab established and functional in Dholpur. Surveillance data is not being used effectively for generating forecast reports. Interactive Terminal room (1 at Jaipur & 6 in medical colleges) is non-functional in the state.
- DCMHO is the nodal officer for NLEP. Of the total cases, 91% MB and 75% of PB cases completed the treatment in Bikaner district. There is no child leprosy case reported in the district.
- NPCB achieved the target of 67.7% cataract surgeries in Bikaner district. 485 surgeries including 430 IOL achieved in Dholpur district however, the data indicates that in Dholpur, inadequate number of BPL families benefitted from NPCB.

UTTAR PRADESH

- Low ABER (1%), and slide positivity rate (0.1% in Sitapur and 0.6 in Jalaun) was observed. In Sitapur, DH, CHC and PHCs were not involved in malaria slide. The involvement of ANM and ASHA workers are relatively low and active surveillance is not operational in the districts.
- Number of TB suspects to be screened was close to the target and HIV/TB collaboration activities are taking place in the visited district.
- Reporting of P and L forms is close to 100%, whereas for the S forms it is <10% at state and district level (both visited districts). The available data was being analysed at district level.
- The Annual New Case Detection Rate (ANCDR) of Leprosy over past 5 years shows declining trend in UP from 12.78 in 2010-11 to 10.35 in 2014-15. However at District Sitapur reasonably high ANCDR of >20 reported. Treatment completion rate reported to be 100% in urban and 98.1% in rural areas.

UTTARAKHAND

- Contingency plan for epidemic preparedness was found ready for Dengue and Chikungunya diseases. District Action Plan was in place for Malaria control. Both the districts had District Surveillance Units and Rapid Response Teams. Test kits were available for Dengue in both the districts. Clinical guidelines for management of dengue/DHS/DHF/DSS cases were available.
- TB cases treated by private practitioners were being notified. Monitoring and supervision activities as well as DOTS by Community providers were lacking. For TB Care and Control in the State, collaboration with ITBP Hospital Dehradun and Military Hospital Dehradun had been undertaken
- Data analysis had been done at the district level, which is an improvement; however, it is still not being done at sub-district level in Nainital District even though infrastructure and Data Entry Operators are available. IDSP data is not being used for better planning and implementation of various disease control programmes at District and State level.
- Uttarakhand is a low endemic state and has achieved elimination of leprosy in March, 2005. ANCDR of Nainital District is 15.51/100000. Implementation was good with adequate MDT medicines.
- Eye camps were organized for cataract surgery at health facilities where functional operation theatres are available. NGOs and private sector are playing very active role in conducting cataract surgeries in both the districts. Vitamin A supply is available. School children are being screened for refractive errors and free spectacles are being provided, if required.

WEST BENGAL

- Long-Lasting Insecticide-treated Nets (LLIN) distribution to pregnant mothers has shown a significant impact in reducing malaria transmission in Cooch-Behar. Inter-sectoral coordination between health and municipal bodies, public health engineering and local self-governments is weak.
- TB notification is sub optimal in municipal areas and from the private sector in Purba Medinipur district. Notification into the web-based reporting system NIKSHAY is sub-optimal especially from urban centres where private practitioners are clustered. Paediatric case detection is inadequate in Purba Medinipur.
- The Rapid Response Team is in place but there is lack of visibility and utilization of data to detect any impending outbreaks. Emergency preparedness for outbreaks were not evident. There is very poor Programme review at the District Level as observed in District Cooch Behar.
- The prevalence rate of Leprosy has declined in 8 out of 12 blocks of District Cooch Behar and 9 out of 12 blocks in the districts have already achieved elimination goals. All registers are well maintained. At sub-center level, treatment cards & MDT kits were available with ANM. Follow up of cases under treatment was being done.
- In Cooch Behar, the NPCB program is inadequately implemented due to lack of human resource. No camps have been conducted this fiscal year. In contrast, Purba Medinipur over achieved targets, though non-government sector is performing more surgeries than the government sector.

TOR 4
Human Resources for Health

OBJECTIVES:

1. To review the adequacy of HR against requirement, challenges, steps taken to increase sanctioned posts, creation of Public health cadre.
2. To assess the capacity of training institutions, utilization, accreditation if any, training and mechanism for skill up gradation of both regular contractual staff, progress on HRIS competency based skill assessments.
3. To review existing HR policies for rational deployment of skilled staff, methods for conducting rational and transparent postings and transfers, web-based counseling and mechanisms for performance assessment of regular and contractual.

NATIONAL OVERVIEW

Availability and Adequacy

Since its inception, NHM has made a significant contribution towards addressing shortages in Human Resources for Health (HRH) with the supplementation of almost two lakh additional medical, nursing and para-medical personnelon contractual basis. This includes an estimated 75,000 ANMs, over 40,000 staff nurses, about 17,000 paramedics, 16,000 programme management staff, almost 25,000 AYUSH doctors, over 7,000 medical officers, 6,000 AYUSH paramedics and approximately 3,300 specialists (Source: NHM – State wise progress as on 30.06.2015). This has helped address some HR gaps, yet significant vacancies still remain in spite of these efforts. This is especially true for specialists - around two-thirds of sanctioned posts for specialists are currently lying vacant across the public health system.

Some states have been adopting innovative recruitment methods and alternative approaches to expedite HR intake e.g. walk-in interviews and campus recruitments. Skill based competency assessment tests have also been included as part of recruitment procedures in some states for ensuring the quality of HR selected.

TRAINING AND CAPACITY BUILDING

States conduct numerous staff trainings under various national health programmes but lack of training needs assessments of functionaries to ascertain HR skill gaps and limited functionality of SIHFWs (state nodal agency for trainings) remains a challenge. Significant faculty shortages exist at in-service training centers in many states which compromises their ability to train adequate numbers of in-service staff members.

WORKFORCE MANAGEMENT

HR policies (including postings and transfers), where present, are not generally comprehensive and not being properly implemented in some states; Karnataka is an example of a state with a robust postings and transfer policy in place.

Adequate recruitment and retention of health workers in remote and rural areas remains a problem. Delays in recruitments owing to lengthy and complicated procedures have been adding to HR shortages in states. To address the shortage of HR, financial and non-financial incentives have been provided in some states. The CRMC model of Chhattisgarh has shown some success.

Some states have made better progress than others in the development of HRMIS. However, this needs strengthening, along with the establishment of adequately staffed HR cells at state and district level.

Tamil Nadu has improved health outcomes by maintaining a robust Public Health Cadre.

NHM has made significant contribution towards addressing both the shortage and skills gaps of the contractual workforce. Despite this, unless concerted efforts are made to improve recruitment and retention through improved and worker-friendly HR policies and practices, the impact on improving Human Resources for Health will remain limited.

KEY FINDINGS

AVAILABILITY AND ADEQUACY

- Recruitment processes have been streamlined with the constitution of specially empowered recruitment boards in Assam, Haryana, West Bengal and Maharashtra and the introduction of recruitment counseling in Odisha. These measures have helped fast-track recruitment processes and increased availability of HR in these states.
- Skill based competency assessment has been incorporated in workforce recruitment processes in states like Chhattisgarh which ensures that adequately skilled HR is recruited.
- Significant shortages of HR, especially specialists, have been observed in most states, including Andhra Pradesh, Chhattisgarh, Delhi, Haryana, Jharkhand, Madhya Pradesh, Rajasthan, Uttarakhand and West Bengal. While some states have attempted to address these HR gaps through the deployment of additional contractual staff,

others like Uttar Pradesh and Karnataka report non-availability of adequate health professionals who can be employed even on contractual basis.

- Measures to improve retention such as provision of hard areas allowances, relaxations for PG education, performance based incentives and rural service linked promotions have been adopted in Madhya Pradesh, Chhattisgarh, Uttarakhand, Uttar Pradesh, Punjab and Odisha. However, Uttar Pradesh reported limited effectiveness of monetary incentives in improving HR retention.

TRAINING AND CAPACITY BUILDING

- Training Calendars have been developed but they are largely not based on Training Needs Assessment. Ideally, these should be part of a comprehensive Training Management Information System (TMIS), which states are yet to develop.
- Skill based competency tests have been successfully used for baseline skill assessment and addressing skill gaps through specific corrective trainings in Haryana, Odisha and Rajasthan.
- Multiskilling/multitasking of LTs working under different programmes and their deployment at the facilities offering integrated lab services is a welcome initiative undertaken by the state of Odisha. Other states would do well to emulate this example of good practice.
- Significant faculty shortages exist at training centers such as SIHFWs (including for in-service training) in many states including Chhattisgarh and Delhi.
- Odisha has introduced the facility for online applications to ANM/GNM courses. This helps to streamline the admission procedure and reduce delays.
- Post training utilization of skilled human resources remains a challenge due to lack of rational posting policies in many states.

WORKFORCE MANAGEMENT

- Good practices of robust postings and transfer policies exist in states like Karnataka. The recently introduced HR policy in Karnataka has helped streamline workforce management practices considerably. In the absence of systematic transfer policies, there has been difficulty in ensuring rational and transparent transfers in Andhra Pradesh, Himachal Pradesh, Manipur and Rajasthan.
- Performance appraisal systems have been developed in Delhi, Jharkhand, Karnataka, Madhya Pradesh and Punjab but are used for renewal of annual contractual engagements only in Delhi and Punjab.
- Introduction of Mid-level health care providers like Rural Health Practitioners in Assam and Rural Medical Assistants in Chhattisgarh have helped significantly in strengthening primary healthcare delivery in peripheral areas.
- Online Human Resource Management Information Systems (HRMIS) have been developed in Assam, Chhattisgarh, Jharkhand, Karnataka and Maharashtra but its functionality is limited to post training deployment of staff. In Assam, however, application of HRMIS is being expanded to cover recruitments, postings, transfers,

promotions and salary/incentive disbursement though this is currently in the testing phase. In Haryana and Delhi, HRMIS is in the implementation phase. For states, which are yet to initiate setting-up HR-MIS, it represents a missed opportunity to improve workforce management.

- States like Assam have made efforts towards rationalization of skilled Health Professionals at the FRUs to make them functional.
- Dedicated HR Cells for handling HR management functions have been formed in Assam, Jharkhand, Chhattisgarh, Madhya Pradesh, Maharashtra and Uttarakhand; while one is being established in Karnataka.

RECOMMENDATIONS

Availability and Adequacy

1. Considering the shortage of specialist skill providers, alternative strategies for generating specialist skilled care providers are required that may include multiskilling of doctors in Emergency Obstetric Care (EmOC) and Life Saving Anesthetic Skills (LSAS) and their effective utilization through a robust supportive system. The established system in Maharashtra of year's training in specialist skills at College of Physicians and Surgeons has been helpful in generating specialist skill providers in the state, and with the state authorities taking up this initiative to have the Maharashtra Medical Council recognize the trained providers as specialists, this model of good practice should be considered for emulation in other states too.
2. Specially empowered recruitment boards, as present in some states, should also be constituted in other states which experience lengthy delays in recruitment. In addition, the centre has empanelled external HR agencies to support states with large-scale NHM recruitments. Skill based competency assessments should also form the part of selection procedure for ensuring selection of quality HR.
3. States should adopt flexible and innovative mechanisms to engage specialists to address vacancies and ensure quality secondary care. In this regard, states will find the recent MoHFW guidance note on strengthening specialist support in public health facilities helpful.
4. Considering the increasing bed strengths in some facilities in Andhra Pradesh and Assam, states will need to review and revise the number of sanctioned positions in facilities.

Training and Capacity Building

1. Training Need assessment should be linked with HR skill gaps for functionaries at all levels from facility to the state level and training plans developed accordingly. Training data should be managed through a Training Management Information System (TMIS) - linked to a functional Human Resource Management Information System (HRMIS).
2. The shortage of faculty at training institutes such as SIHFWs needed to be addressed to ensure that high quality training can be imparted to in-service candidates for health systems strengthening.

3. States also need to formulate plans for post training deployment and supportive supervision in order to ensure that the skills imparted are practiced correctly.
4. Skill based competency tests complemented with corrective trainings to address identified skill gaps would help the states in delivering quality care.
5. To ensure maximum efficiency of health functionaries, consideration may be given to developing comprehensive integrated in-service training for paramedical staff (e.g. lab technicians and counsellors) so that they can multi-task effectively across various national health programmes, where ever appropriate.

Workforce Management

1. States need to strengthen existing HR policies for contractual staff to make them more comprehensive and ensure better implementation as observed in the state of Karnataka.
2. In view of evolving and changing public health needs, recruitment rules should be reviewed periodically to create new posts as required.
3. The ministry provides support to states willing to strengthen/establish a public health cadre by extending technical support and financial incentives through NHM conditionalities – states may like to utilize this.
4. There is a need to establish robust performance appraisal systems, which takes into account employees' performance and also helps in decision-making with regard to salary increments and renewal of contractual engagements.
5. Performance appraisal systems may also be linked with incentives to improve morale and boost efficiency of the staff. The prototype given in the MoHFW's 'Guidebook for enhancing the performance of MPW (M)' may be referred to design performance management linked with incentives of all grades of staff.
6. Web enabled HR and Training Management Information Systems may be helpful in planning of HR, trainings and promotions and postings and transfers of employees. Such systems are required to be scaled up and strengthened across states. Establishing and strengthening dedicated HR cells for streamlining workforce management practices should be a priority for all states.

STATE FINDINGS

ANDHRA PRADESH

a. Availability and Adequacy

- Substantial vacancies of human resources especially specialists observed in facilities and Medical Colleges. Over one-fifth (22.5%) of the teaching staff posts are vacant in medical colleges. Despite shortages, existing staff shows high commitment but this will not be sustainable unless shortages are addressed.
- The slow progress of recruitment in regular posts has meant that HR availability is not commensurate with the rising bed strength in public health facilities.

b. Training and Capacity Building

- Training appears to be low priority - Training calendars though present did not incorporate a review of training needs assessment.
- No database to capture information and track deployment of trained service providers.
- There are no supervisory or monitoring visits during or after training or follow-up of trained staff.
- The state has not been left with any nodal Public Health Training Institute at the state level after the state's bifurcation, though the Regional training institute in Vizag (one of the 3 Regional Training Centers) has been identified as the new state level training institute.
- Irrational post training deployment of staff is an area of concern.
- Workforce Management
- There is no evidence of a systematic transfer policy in the state and the existing procedure lacks transparency.
- There is no plan for supportive supervision or monitoring at different levels in the State.
- Work charter and ToR have been defined for all cadres of HR but there is no system for performance monitoring or appraisal of contractual and regular staff in the state.
- Skill based competency tests for recruitment has not yet been implemented at any level.
- Absence of performance management system for both regular and contractual staff has been a challenge.
- There is no Public Health cadre in the state.

ASSAM

a Availability and Adequacy

- There is acute shortage of doctors (including specialists) in the state – 25 percent of the sanctioned posts for MOs and Specialists are vacant.
- There is a specially nominated selection committee for the recruitment of various positions under NHM. Waiting lists are valid for one year from the date of publication of results.

b Training & Capacity Building

- SIHFW, the only state level public health training institute has been closed due to the discontinuation of HR positions by the state. This has adversely affected training and resulted in an inability to prepare Training Need Assessment, develop a systematic training calendar and create a training database.

- There is a need to provide integrated training and utilize trained staff (LTs, Counselors, Surveillance workers, District Media experts, etc.) across all programmes.

b. Workforce Management

- State NHM office has issued orders for rational deployment of EmOC/LSAS trained doctors at the FRUs and monthly monitoring of their performance.
- There is a HRD cell at state level for management of HR issues.
- Performance appraisal committee evaluates performance of all the staff vis-a-vis their job responsibilities. Based on the grades assigned to the staff, renewal of contracts is done.
- State has an online HRMIS, which captures HR data at the state, district and block level. The HRMIS is utilized in recruitment, postings, transfers, promotions and salary/incentives disbursement.
- Deployment of Rural Health Practitioners (RHPs) has helped in strengthening health service delivery at the Sub-centers.
- State has disseminated the Operational Guidelines for enhancing performance of MPWs (F).
- The state plans to establish Public Health cadre and a proposal has been submitted for approval to the relevant authorities.
- Equal opportunities are provided to in-service contractual staff in Programme Management Units for selection to higher positions through open interviews.

CHHATTISGARH

a. Availability and Adequacy

- The lengthy processes of recruitment, poor perception of salaries and compromised management environments have been a deterrent to MOs and Specialists towards joining the service.
- To address the shortage of MOs, AYUSH Medical Officers and Rural Medical Assistants (RMA) are deployed at PHCs by the state. The creation and regularization of RMA positions has been very helpful in augmenting human resources for health in the state. However, shortages of skilled care providers especially specialists and general doctors still exists in the state.
- Outsourcing of staff has been put in place and has shown reasonable success evidenced by the recruitment of nearly 440 tribal-reserved posts of nurses and doctors, which were earlier vacant due to the low turnout of tribal candidates. This has specially been the case at the Sick Neonatal Care Units (SNCUs)

b. Training and Capacity Building

- SIHFW faces acute shortage of staff with 21 of 27 posts lying vacant.
- Lack of adequate mobility support for the District Training Coordinator and concerned staff have resulted in difficulty in undertaking monitoring of trainings.

- No systematic training calendar or database developed in the state.
- Very limited RMNCH+A training has been provided in the last year against the targets set.
- Over 500 Mitanins have been trained in ANM courses through special provisions for Mitanins introduced by the state so far but their deployment in the system needs to be scaled up.
- As the existing gaps in ANM vacancies have been filled, the state is in the process of phasing out ANMTCs and orders have been issued to shut down all 75 Private ANMTCs in the state.

c Workforce Management

- The financial and non-financial incentives introduced through the CRMC incentives scheme has been helpful in the improving the retention of health workers, including those of specialists, general MOs, EmOC and LSAS trained MOs, nurses, ANMs and RMAs in the difficult, most difficult and inaccessible areas as defined by the state.
- Skill based competency assessments have been adopted for the recruitment of doctors, nurses and allied health professionals.
- There is a dedicated HR cell at the state level – this is under the charge of a specific Deputy Director.
- The HRMIS framework has been set up but its functionality is currently limited and it has no linkage to postings and transfers or to training.
- Promotion rules for staff have not been revised for a while and need updating.
- Various clinical/leadership positions such as Block Medical Officers are currently operational on an ad-hoc basis; these need to be regularized.

DELHI

a Availability and Adequacy

- Shortage of human resources exists in the state. Nearly one-fifth of the sanctioned posts for Medical Officers and Specialists and one-fourth of nursing posts are vacant.
- Lack of mechanisms to undertake decentralized recruitments is causing a delay in filling up new positions.

b Training and Capacity Building

- Trainings are being conducted at the 4 identified training centers at state level and at 4 district training centers. Training database is not being maintained in the state.
- Significant HR gaps at the Health and Family Welfare Training Centre (HFWTC) have resulted in low training achievement. This needs addressing.

c Workforce Management

- Job Description as well as the TOR has been developed for each position.

- Performance Appraisal of all contractual staff is done quarterly on predefined formats. Renewal of the contractual engagements is also linked with the performance appraisal.
- State is under the process of establishing Human Resource Information System (HRIS). Currently there is no comprehensive HR information source at a single place.
- There is also a need to address the issue of rational deployment in the state.
- The state does not have a public health cadre.

HARYANA

a Availability and Adequacy

- Significant shortages of Specialists and Medical Officers existing in the state. Deputation arrangements are being made on a temporary basis to address the HR gaps at higher level facilities.

b Training and Capacity Building

- The introduction of skill based competency assessment for ANMs and staff nurses is a welcome initiative, though there is a need for further refresher trainings for skill upgradation of ANMs and staff nurses.

c Workforce Management

- Irrational deployment of human resources was observed at the facilities visited- Shortage of pharmacists has been leading to an increase in workload for Staff Nurses who were found managing stores at some of the facilities.
- There has been delay in payment of salaries for last 3 months for contractual staff.
- Skill based competency assessment has been done for most of the ANMs and Staff nurses and training is being imparted accordingly.
- Implementation of HRMIS software is underway: web-enabled portal has been designed for capturing HR data and data entry has been initiated in the state.

HIMACHAL PRADESH

a Availability and Adequacy

- Despite several measures undertaken to increase HR, there is an acute shortage of specialists particularly at the regional hospitals and FRUs. Besides, half of the LT posts are vacant in the state.

b Training and Capacity Building

- An annual training calendar is maintained.
- Implementation of Training Management Information System (TMIS) has been completed in 7 districts.

- Progress of SBA and RMNCHA counselors training has been delayed due to limited supply of mannequins and training materials required for the training.
- There is considerable presence of private sector in nursing institutions in the state (30 private GNM schools and 2 private ANM schools). The state is yet to initiate mechanisms to assess the training quality of these institutes
- Workforce Management
- Although the state has a policy for regulating transfers of government employees, the staff reported instances of irrational transfers.
- There is no HR cell to undertake management functions for contractual and regular Human Resources.
- State has been using Personal Management Information System (PMIS) for capturing HR data.
- No dedicated public health cadre in the state. However, consultations have been held for constitution of public health cadre in the state.

JHARKHAND

a Availability and Adequacy

- Significant vacancies of regular and contractual staff including technical and non-technical staff exist in the state.
- Shortage of MOs is affecting the functionality of PHCs in the state,, leading to high patient load at the FRUs/CHCs.
- The absence of regular recruitment procedures for MPW (Male) has resulted in a scarcity of these functionaries in the state. The numbers of LHV posts are also limited.

b Training and Capacity Building

- The training plan is being prepared at the state level but proper training needs assessment has not been carried out.
- Training related data will soon be uploaded on to a Training Management Information System (TMIS).

c Workforce Management

- The state has formulated HR norms for recruitment, remuneration, promotions & postings; these have been in place since 2011.
- Performance appraisal system has been developed recently but its application is limited.
- There is no mechanism for performance monitoring and associated disbursement of performance-based incentives.
- An HR Cell is in place for management of contractual workforce in the state.
- Competency based skill tests of paramedical staff, programme management units, administrative and nursing staff are being conducted for recruitment.

- Human Resource Information System (HRIS) has been developed but hand holding of state officials is required.

KARNATAKA

c Availability and Adequacy

- There has been an increase in availability of HR among all categories since 2005 but gaps still remain - especially for specialists and medical officers.
- To address gaps of skilled care providers, state has decentralized recruitment of specialists and doctors at the facility level.

b Training and Capacity Building

- Planning for training is done up to the district level by nodal officials but there is no system for training need assessment at the facility level.
- Training Management Information System (TMIS) has been implemented in the state and all the information regarding training planned, monthly calendar, batch size etc. are uploaded in the TMIS software.

c Workforce Management

- HR policy is in place for regulation of transfers of medical officers and other staff, which also has provisions for compulsory posting in rural areas and rational posting of specialists.
- Rational deployment of Staff Nurses at higher caseload facilities and delivery points is done based on caseload assessment at these facilities.
- Establishment of a state HR cell is in progress while at the district level, nodal officials have been assigned to handle HR issues for both regular as well as contractual staff.
- Human Resource Management System (HRMS) captures all the information related to regular and contractual staff on online database. Web-based system for disbursing salary has also started for regular employees.
- The state is in the process of developing a Public Health Cadre.

MADHYA PRADESH

a Availability and Adequacy

- A substantial shortage of specialists exists in the state with up to 84% vacancies in some specialties. The situation is somewhat better in the case of staff nurses and ANMs.
- The State Public Service Commission is the recruitment agency for regular MOs. The average time taken for completion of the recruitment round is 8-10 months; this results in a delay in filling up vacancies.
- To address the shortage of MOs, state has initiated the process of campus recruitment but evaluation of this initiative is yet to be done.

Training and Capacity Building

- Training calendars were found well prepared for the trainings approved under PIP.
- There is no HRMIS or TMIS functional in the state to capture and update HR and training related information systematically online. Trainings approved in the PIP are currently captured and maintained in a separate training calendar.

Workforce Management

- The state has defined criteria for posting through its recently introduced transfer policy. The state has also developed a proposal for career progression of NHM staff as well.
- The state has initiated rationalization of Accountants and LTs and their deployment is being carried out across various programmes.
- Further efforts need to be made for the rational deployment and utilization of LSAS and EmOC doctors.
- Performance based incentives to the staff have been helpful in expanding the reach of Maternal and Child health services to distant facilities.
- Performance appraisal system is in place but not being utilized for determining salary increments of the NHM staff.
- Skill based competency assessment tests to be adopted for future recruitment of Nurses and ANMs.
- There is a HR cell at state level to look after HR functions in the state.
- The state has constituted a technical resource group to establish a Public Health cadre in the state.

MAHARASHTRA

a Availability and Adequacy

- The state continues to take advantage of the 'College of Physicians and Surgeons' model by creating a pool of specialists, awarding locally recognized PG diplomas in various specialties and making state provisions for recruiting them in to specialist positions.

b Training & Capacity Building

- For coordination of trainings, there are 7 HFWTCs at regional level and a state level institute, the Public Health Institute Nagpur, where a Skill Lab has been recently developed.
- Skill based competency assessment tests of in-service ANMs, LHVs and Staff Nurses have been completed and corresponding training needs have been identified.

c Workforce Management

- Public health leadership positions have been identified at the district level with the District Health Officer dedicatedly looking after public health functions.

- The TOR and work charter is well defined for all clinical, paramedical and administrative staff.
- The state is in the process of rational deployment of EmOC/LSAS trained doctors and 335 staff have been redeployed at facilities relevant to their skill upgradation and training..
- There is a HR cell established at the state level for the management of HR functions.
- Web-enabled HR MIS is available in the state but there are issues regarding regular reporting of HR data.
- While the norm is to deploy AYUSH MOs at PHCs as the second MO, but in many 24x7 PHCs they are the only MO in position and consequently over burdened.
- State has also developed a web-based performance monitoring system for performance tracking of the skilled care providers using 5 parameters - Clinical, Family Planning, MCH, Software reporting and RNTCP/NVBDCP.
- Biometric attendance monitoring system has significantly addressed the problem of absenteeism in the state.

MANIPUR

a Availability and Adequacy

- 16 % of the sanctioned posts of doctors at PHCs are vacant (16 %) Source: RHS 2015. Of the 11 sanctioned posts of specialists under NHM, 9 are vacant in the state. In some of the districts, even the key public health leadership posts at district level are vacant leading to disruption in programme implementation

b Training & Capacity Building

- The state has five BSc Nursing colleges (two public; three private), nine GNM schools (all private) and nine ANM schools (three public and six private)
- SBA training has been provided to 80 AYUSH doctors but information on the extent of their utilization is limited

c Workforce Management

- Recruitment process is lengthy and complicated, and recruitment of any post is subject to approval at the cabinet level.
- There is no HR policy in the State. Transfers seem frequent with no clarity on a transparent transfer policy.
- No performance-based incentives are given in the state.
- The state does not have an HR Cell but a nodal official of the rank of Deputy Director have been designated to handle HR functions at the state level.
- The state has not yet introduced competency based skill tests for recruitment of skilled care providers.

- The state does not have a full-fledged HR MIS but a list of regular and contractual staff is available online, though this is not dynamic and therefore its utility is limited.

MEGHALAYA

a Availability and Adequacy

- Various specialist services were not being provided at facilities due to shortage of specialists in the state.

b Training & Capacity Building

- All service providers at the Delivery Points need to be trained in SBA since non-SBA providers conduct most of the deliveries in the state currently.

c Workforce Management

- There is no clear/formal postings and transfers policy in the state.
- Online HR MIS or Training MIS is yet to be implemented in the state.
- Performance appraisal process has not been implemented at any level.

ODISHA

a Availability and Adequacy

- Although there has been an increase in sanctioned posts of human resources, the state still faces shortage of specialists at the District Hospitals.
- In absence of MOs, AYUSH MOs and Pharmacists are managing various PHCs in the state.
- Seat intake in the existing 3 Government Medical Colleges has been increased by over 40 percent in the current year (2015-16)

b Training & Capacity Building

- State plans to establish training information/archive centre and repository at state and district level as State Training and Education Centre (STEC) and DTEC respectively. Online Training Management Information system (TMIS) has been developed in 2013 and is being utilized for planning of trainings in the state.
- With the support of NHM, the state has launched a web-enabled facility for application to nursing courses in state government nursing institutes with the help of manpower from NHM programme management units.
- In order to encourage students from vulnerable communities to undertake nursing courses, the state offers scholarship facility to candidates from Scheduled Caste and tribal populations.

c Workforce Management

- Deployment of the newly appointed staff under NHM is being done at high caseload facilities in remote districts on a priority basis.

- Multiskilling of the LTs have been done and the trained LTs have now been placed at labs offering integrated lab services in various District, Sub-District Hospitals and CHCs.
- Decentralized recruitment procedures, conditional promotions subject to completion of minimum service tenures, hard area allowances and relaxation of maximum eligible age are some of the strategies adopted to increase HR availability in the state particularly at the difficult areas.
- Despite the constitution of a dedicated 'transfers committee' for rationalizing postings of EmOC and LSAS providers, more than half of the trained EmOC and LSAS providers yet to be placed at designated FRUs.
- The proposal for introduction of a Public Health cadre is awaiting cabinet approval.
- State uses a detailed performance assessment system with predefined performance based key deliverables. The system is being further revised.
- Temporary skill stations have been setup at District Hospitals and assessors trained to undertake skill assessment based recruitment of the ANMs and Staff Nurses. In addition, competency assessment of existing ANMs has been completed and those identified with skill gaps provided mentoring support through the trained AYUSH MOs or LHVs.
- The state has recently replaced several absconding doctors with the adhoc appointment of other doctors.

PUNJAB

a Availability and Adequacy

- State has increased the number of sanctioned posts for doctors, nurses, ANMs, etc. as per IPH Standards. But despite these measures, the state has not been able to address HR shortages adequately. This is specially felt in peripheral areas due to the state's initiative of strengthening District & Sub-district Hospitals by shifting staff from the periphery to these larger facilities.

b Training & Capacity Building

- Four skill labs are being established in the state for the purpose of conducting skill based trainings.
- Local training needs should also be taken into account for updating the state training calendar. The training data is not updated regularly on any online database like TMIS.
- Training progress has not been adequate especially for LSAS, FIMNCI and SNCU training.

c Workforce Management

- Caseload at delivery points is being monitored through the HMIS to decide the rational posting of staff.
- Supervisory staff conducts performance appraisal annually and increments granted on the basis of these appraisals. This includes pre-identified key performance deliverables such as C-Sections and normal deliveries.

RAJASTHAN

a Availability and Adequacy

- Significant vacancies of Specialists, Nursing and Paramedical staff– 66 % vacancies of Specialists, 48 % vacancies of pharmacists, 44 %vacancies of LTs, 31 % vacancies of Nurses exist in the state currently. (RHS 2015) There are large number of vacancies (around 38% in Dholpur and 29% in Bikaner) in various posts.

b Training & Capacity Building

- Adhering to the timelines in the training calendar has been a challenge.
- There is a need to train more care-providers in SBA, RI, IMNCI and PPIUCD.
- Skill assessment of nursing staff in High Priority Districts has been conducted on a pilot basis and the state intends to link this with the Training Management Information System (TMIS).
- There is no performance assessment/review mechanism for identifying individual training needs and planning need-based training for various functionaries.

c Workforce Management

- Hard area allowances and performance-based incentives are provided in the state, but there is limited awareness about this among staff.
- There is no HR Cell in the state. However, nodal officials have been assigned to handle HR functions at state and district level.
- There is no definite policy for transfers and rational deployment of personnel.
- There is no specific Public Health Cadre in the state

UTTAR PRADESH

a Availability and Adequacy

- Significant vacancies exist across the majority of facilities in the state - especially for contractual specialists and medical officers.
- In addition, recruitment of regular staff is witnessing considerable delays due to litigations in the courts.
- Training & Capacity Building
- Health professionals expressed a lack of planning and opportunities for continued education.
- In some instances, work overload due to shortages made it difficult to avail leave for continued professional development or refresher in-service training

b Workforce Management

- The disparity in salaries between contractual and regular specialists is an issue.
- Monetary incentives are provided in the state but are reported to be insufficient to effectively retain specialists.

- There is no Human Resource Management Information System (HRMIS) to capture and maintain regular and contractual HR data online

UTTARAKHAND

a Availability and Adequacy

- More than half of the sanctioned posts of specialists and doctors are vacant in the state.
- Many of the CHC-FRUs were not functional because of lack of Gynecologists (or EmOC trained MOs) and Anesthetists (or LSAS trained MOs).
- Unequal distribution of LTs was observed across facilities - some had only one LT while others have multiple LTs - each working under different programmes.

b Training & Capacity Building

- The state has two functional Regional Training Institutes (Haldwani & Dehradun) and the Institute at Haldwani is being upgraded as a SIHFW.

c Workforce Management

- In order to retain doctors in rural areas, the state offers differential salary packages and reservation in PG courses for doctors serving in rural areas.
- The Department has recently setup an HR Cell for workforce management.
- Implementation of HRMIS in underway in the state and the HR data is being captured in a phase-wise manner.

WEST BENGAL

a Availability and Adequacy

- There is a shortage of human resources especially Medical Officers and Specialists - particularly at the secondary care facilities. To cater to the increased workload, deputation arrangements have been made on a temporary basis.
- The state has constituted a Medical Recruitment Board for fast tracking the recruitment of Medical officers and specialists.
- Around three-fourth of the sanctioned posts of MPW (M) are lying vacant in the state. (RHS 2015)
- At some places, LTs were found working only for single programmes under which they have been hired. The need for multitasking and integration of LTs was felt.
- There is a need to revise the sanctioned vacancies for staff such that the number of sanctioned posts is commensurate with the rising bed strength of health facilities.

b Training & Capacity Building

- The quality of SBA and NSSK training needs improvement.
- There were many labor rooms functioning without any NSSK and/or SBA trained staff nurses.

c Workforce Management

- Inequitable work distribution between contractual and regular ANMs was observed at Sub-centers.
- Handholding for ANMs and ASHAs is done through LHVs at the peripheral level.

TOR 5
Community Processes and Convergence

OBJECTIVES

1. To review the adequacy of ASHAs in terms of requirement, numbers, selection and training, ASHA support structure, availability and adequacy of ASHA Drug Kits, constitution and meetings of VHSNC and RKS.
2. To oversee integration of support structure for VHSNC and ASHA, effectiveness of support structure, regularity and quality of feedback, strategies and experiences of ICT tool for communication and incentive payment mechanism, and convergence between ICDS, education department, water and sanitation and rural development.
3. To review the involvement of VHSNCs in village level planning for health, level of involvement of Panchayati Raj Institutions/PRI utilization in VHSNC, use of RKS Untied Funds, sources of fund generation, differential allocation of Untied funds.

NATIONAL OVERVIEW

The year 2015 marks a decade of the ASHA programme. In this section we provide a brief overview of the entire programme, including the states that were visited. Over this period, the ASHA programme has evolved significantly. ASHAs act as an effective bridge between health services and community and are able to influence health seeking behaviours of the community in areas of maternal and newborn care, child care and communicable diseases. Their strong commitment and agency has been appreciated and documented in various evaluation and review reports. As the programme matures, the role of the ASHAs needs to expand such that she becomes an integral part of delivery of comprehensive primary health care, for effective continuum of care. With the launch of the ASHA programme in urban areas, much more emphasis is required on strengthening her ability to reach the marginalized for improved access and equity, through regular training and on the job mentoring.

About 8.56 Lakh ASHAs are in position against the target of 9.52 Lakh in rural areas and 37,617 out of 63,459 in urban areas across 35 states / UTs. States are at various stages of completing the four rounds of Modules 6 and 7. About 81% ASHAs have been trained in Round 1, 67% in Round 2, 44% in Round 3 and 11% in Round 4

of Module 6 &7. However, limited availability of functional HBNC equipment kits and drugs with ASHAs remains an unresolved challenge and affects her functionality in many areas.

The supportive institutional network for community processes at state level and below has expanded rapidly in the past few years, as states have increasingly become cognizant of the necessity of a strong support structure. However larger investments are required to strengthen the capacity of support structure to ensure effective supervision, performance monitoring and mentoring.

Incentive payment mechanisms have been streamlined and almost all states have started making payments either in cheque or bank transfer mode but delays in payments specifically for incentives linked with activities of NVBDCP, RNTCP and NLEP, are common and remain unresolved. In addition to the performance based incentives linked with various activities, some states have also introduced fixed monthly honoraria for ASHAs or matching the incentives earned by ASHAs as top up in the states of– Sikkim, Kerala, Rajasthan, Haryana, West Bengal, Chattisgarh, Tripura, Karnataka and Meghalaya. Provision of social security to ASHAs in the form of medical and life insurance funded by state budgets increases state ownership and enables provide motivation for the ASHA. These have been initiated in the states of Assam, Chhattisgarh, Jharkhand, Bihar, Delhi, Odisha and Sikkim. Since the launch of revised Guidelines on Community Processes in 2013, grievance redressal committees have been set up at district level in states of Bihar, Jharkhand, Maharashtra, Odisha, Uttrakhand, Jammu & Kashmir, Madhya Pradesh, Uttar Pradesh, Arunachal Pradesh, Tripura, Manipur, Haryana and Sikkim. Despite this progress in instituting mechanisms for grievance redressal, additional efforts are needed to strengthen action and effectively operationalize these mechanisms.

In order to expand career opportunities for ASHAs, states such as Chhattisgarh, Jharkhand, Madhya Pradesh, Uttrakhand, Jammu & Kashmir, Maharashtra, Arunachal Pradesh, Assam and Tripura have made provisions for preferential admission to ASHAs for enrolment in ANM / GNM schools. Maharashtra has well entrenched system of Community Health Volunteers in Greater Mumbai.

To enhance competency and professional credibility of ASHAs, the certification of ASHAs through an assessment of her knowledge and skills has been launched by MoHFW in collaboration with National Institute of Open Schooling (NIOS). As part of this process, the curriculum of ASHAs will be standardized, training sites and trainers will be accredited, and ASHAs will be certified. States nearing completion of Round 4 training of ASHAs, are preparing for the process of certification of ASHAs and accreditation of trainers and training sites.

Nearly 5 Lakh VHNSCs have been constituted across the country. However, the functionality of VHSNCs varies across states depending on the status of reconstitution of VHSNCs as per the revised guidelines, timely fund flow, training of VHSNC members and capacities of ASHAs and ASHA facilitators to play a lead role in VHSNCs. (Refer Annexure -1)

KEY FINDINGS

ASHA

- Of the three North Eastern states (Assam, Manipur and Meghalaya) and the seven high focus states (Chhattisgarh, Jharkhand, MP, Odisha, Punjab, Rajasthan, UP and UK), visited in the Ninth CRM< Chhattisgarh and Jharkhand have had the ASHA programme in place before the launch of the National Rural Health Mission (and now the National Health Mission- NHM) in 2005. Seven of the eight non-high focus states (AP, Delhi, Haryana, Karnataka, Maharashtra, Punjab and West Bengal) have had an ASHA programme since 2009, except for the state of Himachal Pradesh which has begun selecting and training ASHA only a year ago.
- The findings from across the states are mixed, which is not unexpected in a programme of this scale and given the size and diversity of the country. Overall there is an emerging picture of a mature programme with established systems for some components. All reports indicate an increasing ownership of the ASHA by the health system. The role of the ASHA as a facilitator continues to be dominant as noted in previous CRM reports. Increasing home visits by ASHAs are reported. In Punjab, the report states that the ASHA "has acquired visibility and stature". In several states increases in outpatient cases, immunization coverage and institutional deliveries are being attributed to the ASHA. The reports of the ninth CRM emphasize the increasing reach of the ASHA to vulnerable households from Uttar Pradesh, Punjab, Maharashtra, and Assam. Some state reports however, caution that the ASHAs community moorings appear to have become tenuous, indicating that the village level platforms such as the VHSNC and MAS need strengthening, that inter-sectoral convergence needs to be stronger, and that the role of the ASHA as a mobilizer needs to be better emphasized.
- **ASHA Selection and Training:** In terms of ASHA selection, except for four states - West Bengal, Karnataka, Delhi and Uttar Pradesh, selection is over 95%. Yet there are inter district discrepancies, particularly in the high priority districts. In Koppal district of Karnataka, there is a vacancy of 34%. In the Char areas of Assam there is a shortage of 293 ASHA, apparently as a result of being disallowed in the PIP. In Manipur's Thoubal district a shortfall of 55 ASHA is reported, 11% in Nabrangpur, Odisha, and about 26% in Bikaner district in Rajasthan.
- Under the NUHM, except for Uttar Pradesh and West Bengal which have not yet begin selecting ASHAs, most other states are in the process of ASHA selection. Induction training for ASHAs has begun in seven states - Andhra Pradesh, Jharkhand, Chhattisgarh, Madhya Pradesh, Meghalaya, Manipur and Punjab. About ten states -Andhra Pradesh, Chhattisgarh, Assam, Madhya Pradesh, Jharkhand, Rajasthan, Meghalaya, Manipur, Odisha and Punjab have constituted Mahila Arogya Samiti and of them Chhattisgarh, Odisha, MP, Jharkhand and Manipur have initiated training of Mahila Arogya Samitis. The key challenge is that states are yet to use and adapt the learning from NRHM to strengthen the role of the urban ASHA. A second issue is that the incentive amount for ASHA in urban areas, needs reconsideration, as there are anecdotal reports of difficulty in recruiting ASHA or higher anticipated drop-outs owing to other available options. The third is the limited clarity about the role of Mahila Arogya Samiti in urban areas. Vulnerability Mapping has begun

only in Odisha and Assam. In Karnataka and Maharashtra, the state is faced with the challenge of converting link workers into ASHAs as they are getting a fixed monthly remuneration.

- **Attrition of ASHA:** Annual attrition rate ranges from a low of 0.6 percent in Assam to nearly 11% in Punjab. Most of this attrition is on account of being elected as Panchayat representative, a testimony to her empowerment and credibility. Some states are slow in filling this gap, leading to missed households, reduced coverage and an increasing burden of work on existing ASHA, who is handed over charge for indefinite periods of the neighbouring village where there is an ASHA vacancy.

- **Training:** The training in Module 6 and 7 and induction modules for newly recruited ASHA are underway in the states. States are making steady progress in the training, although the pace is slow in some states- particularly UP, Haryana and Assam. In Sitapur District of Uttar Pradesh, ASHAs reported not having been trained for over three years and training has just been re-initiated.

- Two important causes across states appears to be - trainer attrition and lack of fund releases, although this is a problem at district and sub district level. This is an area of concern particularly since states are required to be readying for accreditation of training sites, trainer and ASHAs as part of certification by the National Institute of Open Schooling.

- In West Bengal and Odisha, the reports suggest a direct correlation between robust training systems and effective trainers to the knowledge levels among ASHAs. This has been facilitated in both states by a strong, full time support mechanism that has provided leadership and handholding support to the districts. Weak training systems and trainer attrition was reported from Meghalaya, Uttar Pradesh and Rajasthan, thus slowing down the process even further. In Delhi the report states that competing priorities of the state trainers (who are full time employees of the health department and service providers) delays the pace of training. The issue of non literate ASHA and the lack of appropriate training material as an impediment to training has been reported from Andhra Pradesh, Jharkhand, Madhya Pradesh, and is also corroborated by other field reports. Chhattisgarh appears to have overcome this issue by ensuring high quality ASHA facilitators who interact frequently with the Mitanin in the field and ensure that the requisite skills and knowledge are in place by reinforcement over a long period of time.

- **ASHA Functionality:** A high degree of functionality is reported on areas such as immunization, mobilizing mothers for antenatal care, and motivating them for institutional delivery. ASHAs are also active during the VHND as observed in Maharashtra and Uttar Pradesh. There is a gradual improvement in the diagnosis, referral and follow up of sick and Low Birth weight newborns, reported from Madhya Pradesh, Maharashtra and Delhi. In Maharashtra, progress has been made in the use of follow up cards for babies that are discharged from the SNCU. ASHAs also appear to be cognizant of danger signs and make active referrals to SNCU. Knowledge levels were reported to be good in states with effective and stable training mechanism such as West Bengal and Odisha, and in the non high focus states such as Maharashtra, Andhra Pradesh and Delhi, where literacy levels of ASHA are higher. Reports from Jharkhand, Haryana, Assam, Rajasthan, Meghalaya, Manipur and Uttarakhand, point

to limited skills of the ASHA that were met, especially in areas related to provision of new born care, nutrition counselling, ability to track children with malnutrition and counselling on family planning. (Refer Annexure-2)

- **Drug and Equipment kit:** Another major area of concern that is evident from the reports across all 18 states is the lack of a consistent mechanism to refill the ASHAs drug kit or to replace broken components of the equipment kit. Any effort to discuss the effectiveness of the ASHA is rendered null by the lack of these two critical support mechanisms. This not only minimizes the effectiveness of the ASHA in tasks such as pregnancy diagnosis and early pregnancy registration, distribution of OCPs/Condoms, ORS, but also places the credibility of the ASHA at stake.

- **Support Structures:** The correlation between effective support structures to performance is significant. In UP, the report specifically mentions increase in pace, momentum and improved quality of training after the establishment of a state support structure. This is also the case in Odisha and Maharashtra. In Maharashtra, Odisha, and Chhattisgarh there are reports of state programme officers undertaking regular field visits. In Chhattisgarh, the presence of an effective support system at state and block and sub block levels suggest a high functionality of not just the ASHA but also VHSNC and PRI engagement. Most states have a support structure as specified in the guidelines and at most levels. The effectiveness of the support mechanism is hampered in Rajasthan, Madhya Pradesh, Meghalaya, Uttarakhand, Haryana, by one/all of the following factors: high number of vacancies, poor orientation/training, lack of mobility support, the allocation of the work of data entry to ASHA facilitators and Block Community Mobilizers for an increasing numbers of forms that the ASHAs are filling, and little handholding from the state level. The nature of support and mentoring provided to the ASHA is compromised on a poor understanding of support staff, (where they are in place) towards their tasks of ASHA and CP programme support. The consequence of lack of mentoring is visible in the field particularly related to home visits being made by the ASHA- which are not supervised for content, accuracy or completeness. In UP, the ASHA facilitator also serves as an ASHA further compromising her role of mentoring. Review meetings of district mobilizers or block mobilizers are not held regularly across most states, exceptions being Chhattisgarh, Odisha and Meghalaya

- **Coordination at village/VHND/Sub centre level:** ASHA-ANM-AWW coordination is reported to be strong across states. The early tensions of the earlier years where there was lack of clarity on tasks, particularly incentive related tasks and claims over JSY and family planning entitlements seems to have abated. This has facilitated a platform for the coordinated action. As fertility levels decline, particularly in the non-high focus states, and as ASHA themselves have expressed, this is an opportune time to revisit the tasks of the ASHA in such contexts. The AAA platform seen in the state of Uttar Pradesh, as a form of convergence at the level of the sub centre has potential to serve as a site for coordinated service delivery, population enumeration and screening. The experience of the state of Punjab with engaging ASHA in screening for cancers and the role of the ASHA in measuring blood pressure and testing for blood glucose at the Gram Arogya Kendras in the state of Madhya Pradesh both demonstrate interest, enthusiasm and appear to address a community need, pointing to a role shift for ASHAs in these states. However skill based training is crucial for creating new tasks for ASHA.

- **Performance Monitoring:** Of the 18 states visited, thirteen states (MP, Delhi, Jharkhand, Manipur, Maharashtra, Meghalaya, Odisha, Punjab, Chhattisgarh, Assam, Karnataka, Haryana, Uttrakhand are using the performance monitoring tool and developing mechanisms for identifying drop-out ASHAs. The tool however is also intended to support ASHA who are not able to perform on the ten key tasks that are the basis of the indicators. Reports indicate that this is not happening, and is linked to the limited awareness and time of support staff in doing so. We also have reports that non functional ASHA are removed, but the vacancies created are yet to be filled.

- **Payment:** The average payment received by ASHA ranges from Rs. 1200 in Himachal Pradesh to Rs. 4500 in Uttar Pradesh. States such as Haryana, Karnataka, Meghalaya, Uttrakhand, West Bengal and Chhattisgarh also provide an additional honorarium from state funds. An area of concern is that despite opening of bank accounts and initiatives taken to streamline payments, delays are being reported across states. This is particularly true of programmes such as NLEP, NVBDCP and RNTCP. A notable exception is Odisha. In Rajasthan and Karnataka, the introduction of ASHA Soft has ensured timely and accurate payment to the ASHAs. Another emerging area of concern is that while approvals were obtained for a set of activities ranging from 23 in Rajasthan to 41 in Odisha, ASHA are not aware of the fact that incentives are associated with several tasks that they undertake. Engaging ASHA in campaigns with the promise of additional incentives and then not paying them needs to be flagged as a breach of trust to local implementers and policy makers alike. From Maharashtra there are reports of ASHAs being engaged by other line departments for expanding the reach of their programmes to the grass-root level. The routine and recurring monthly payments are being paid to the ASHA in only ten states - Assam, Himachal Pradesh, Jharkhand, Karnataka, Maharashtra, Odisha, Punjab, Rajasthan and Uttar Pradesh, Uttrakhand. In Himachal Pradesh, which has recently initiated the programme the state has demonstrated exemplary performance in ensuring that all ASHA payments had been made up to September 2015.

- Several states have instituted non-monetary incentives for the ASHA. These include: mobile phones, torches, bicycles, welfare measures, (social security, death compensation), but reports from Assam and Odisha, indicate that ASHA are not aware of such entitlements. They also have no avenue to complain about the fact that the equipment provided is in a state of disrepair. In Manipur ASHA have been provided with cycles, but several are not using it, and state has yet to review underlying reason and reconsider the policy. This is related to the nature of support and the level of monitoring and supportive supervision.

- **ASHA Gruha/Rest houses:** are not uniformly in place. We have reports of either complete absence or of poorly maintained rest houses that are a barrier to the ASHA accompanying women to institutions. Reports of bad behaviour by facility staff to ASHA has surfaced in several reports.

- **Grievance redressal:** is reported as being in place from several states but no state reports indicates effectiveness.

- Non approval of some of the critical components in PIP 2015-16 has affected the pace and desired outcomes of the programme at field level. Eg- mobility support for district community mobilizers in Meghalaya and additional 241 ASHAs in Char areas of Assam were not approved in FY 2015-16, affecting the quality of mentoring

support and coverage of ASHAs in hard to reach areas in Meghalaya and Assam respectively.

VHSNC

- Reports from most states reflect low priority in effectively utilising VHSNCs, and limited success in using them as the key institution for social mobilisation, as the 'platform for community action', as envisaged in the original NRHM design. New VHSNC guidelines, which envisage their reconstitution and expansion for making them more effective, have not been implemented in most states. There is also a general trend across the states of smaller amounts and irregular releases of untied funds, (attributed partly, to low expenditure patterns in past years)..
- VHSNCs are in place in all states visited in 9th CRM (except Delhi) and were in adequate numbers as per their targets except in Assam, where a gap of 8% is noted at state level. This gap was higher in Dibrugarh district of Assam (20%) while reports from Sirmaur district of Himachal Pradesh also indicate 13% gap.
- Among the states visited, AP, HP and UP, have constituted VHSNCs at the Gram Panchayat level. West Bengal, is one state with its own variation, where VHSNCs have been formed at the level of Gram Sansad which has one or more revenue villages. Another variation is noted in Assam were VHSNCs have been formed at the level of ASHAs i.e, One VHSNC per ASHA but funds are received as per revenue villages. In all other states VHSNCs are constituted at the level of revenue village.
- Most state reports underscore the absence of any service users and general community among VHSNC memebrs, Ex officio members like ANM, AWW, ASHA and PRI representatives dominate the membership.
- Madhya Pradesh, Karnataka, Manipur, Meghalaya and Punjab, are states where restructuring of VHSNCs has been reported to have been done, as per the new GOI guidelines while it is underway in Uttrakhand
- In Assam VHSCs are yet to be renamed to include Nutrition in the nomenclature and also in the core focus of its work,.
- With regards to membership status of ASHAs in VHSNCs, ASHA are member secretary and joint signatory in most states except AP, Haryana, HP Maharashtra, Odisha and UP. In Haryana, Maharashtra and Odisha this role has been delegated to AWWs while in HP and UP ANMs are the joint signatories.
- Odisha is the only state that has diverse mix of members which is conducive for convergence v.i.z, elf Employed Mechanics, President/ secretary of the SHGs, President of the Pani Panchayat, representative of a well functioning Yuvak Sangha or other CBOs etc. Good participation of PRI in VHSNCs were evident in Maharashtra.
- Good functionality is reported from a few states like Andhra Pradesh, Chhattisgarh, Maharashtra and Odisha. State of Maharashtra has put in place innovative systems such as allocation of untied funds as per population, i.e., Rs 5000 for up to 500 population villages, Rs. 8000 for 501 to 1500 population and Rs. 30,000 to bigger villages with more than 10000 population.
- In Chhattisgarh VHSNCs monitor health and social determinants in their regular monthly meetings and make action plan every month, identifying 2-3 key priority gaps.

- Low levels functionality of VHSNCs with Irregular meetings or poor quality of monthly meetings emerges as common findings in remaining states. Level of awareness among the members and their competencies in organising the affairs of VHSNC was found as one weak area across most states (except Chhattisgarh, MP and Odisha). This can be directly attributed to absence of any investment in training of VHSNC members since last 2-3 years.
- An interesting finding from Assam shows that despite no formal training of VHSNC members, they were aware of their roles and used the platform of VHND to meet beneficiaries to advise them on nutrition.
- Problems related to fund flow regarding the untied funds of VHSNCs were seen in states of HP and Assam (no fund release in 2015-16); late release of funds in Maharashtra, partial release of funds (Rs. 7500 in Punjab and Rs. 1000 in UK in 2015-16)
- Maharashtra has put in place a process of fund allocation to VHSNCs based on the population size, as detailed out earlier.
- In Uttrakhand, some ASHAs met reported spending upto Rs. 750 of their own funds to open the new VHNSC accounts as part of the reconstitution process.
- Preparation of monthly Village Health Plan by VHSNC is reported from Chhattisgarh and annual plan from Odisha, which is revised based on the need for addition of any new activity. These need based activities are often mass cleanliness drives, sensitization on prevention and management of malaria, dengue & diarrhoea, observation of various important days related to health etc.
- In other states, the pattern of expenditure shows substantial proportion of funds being spent on cleanliness and hygiene, sanitation and health related activities. Apart from these activities, provision of financial support for arranging transport and for medicines and healthcare for poor families, in some cases is reported. In some states like, Punjab, purchase of medicines is seen as a recurrent item of expenditure from VHSNC funds, across the village visited.
- In one particular example of context specific innovation, VHSNCs in Uttrakhand, have a system of Doli (a kind of Palanquin) made from the untied funds, which is made available for transporting patients upto nearest road-head in difficult areas. In Manipur, major portion of untied funds are being spent in paying the incentives to ASHAs for organising VHNDs and in paying for refreshments for VHNDs, leaving little for other community led action.

ROGI KALYAN SAMITI (RKS)

- RKS was found functional in most states, but levels of functionality vary across states on account of low levels of awareness among RKS members, about their roles and their limited involvement in functioning. Lack of orientation programmes and ad hoc support systems are the key reasons for this problem.
- Participation of PRI and NGO representations in functioning of RKS was found to be limited in all states. Across most states, meetings of RKS are not held regularly, and in some states meetings of RKS were found to held only once in the whole year (as seen in one district of Uttarakhand – Dehradun, Meghalaya and West

Bengal). Regular meetings with proper records were reported only from states of Maharashtra and Manipur.

- Most state reports mention levying of charges for certain services and diagnostics (with provision for exemptions for BPL patients in most of the cases) on behalf of the RKS. But it emerges that there is lack of a clear policy on use of RKS funds.
- Issues of poor fund utilization and poor record maintenance emerge as a common finding across states except in Maharashtra and AP (till the recent court case which has stalled the untied fund in AP).
- Enhanced administrative focus on RKS, after recent attention by political and administrative leadership, and RKS meetings are being done on regular basis in Delhi.
- In Haryana, as per the new rule of the Societies Registration Act, every member has to pay an annual fee of Rs. 1100 for five years, and this has created problems in renewals of the registration of RKSs (called Swasthya Kalyan Samiti in the state).
- Deviations from the guidelines were also seen regarding joint signatories of RKS account. In state of Meghalaya, where PHC Accountant and ANM were joint signatories of the SC's untied funds account. In WB no member from civil society was in RKS. In a major aberration, the money collected from registration and other charges was being deposited not in RKS, but in the state treasury account of the hospital in the state of Maharashtra. In Madhya Pradesh large sum of funds has been raised for RKS from sale of shops built in the health facilities, but there was lack of clarity about use of funds and proper records were not being maintained.

CONVERGENCE

- Strong institutional convergence between VHSNCs and Gram Panchayats, is not seen on the ground in most of the states. Even in states where VHSNCs have been formed at the level of Gram Panchayat, this convergence is not reported to be any better than in other states. Eg- Himachal Pradesh, one such state, reports that despite PRI representatives being well represented in VHSNCs, RKS & District Health Society, their participation in the meetings and understanding of their roles, is not satisfactory, which is probably linked to lack of any orientation or capacity building for them.
- Only in the states of Maharashtra and Chhattisgarh is PRI participation in VHSNCs found to be adequate.
- In most states functional convergence was seen at the community and village level, but problems exist in convergence between departments at the district and state levels.

COMMUNITY ACTION FOR HEALTH (CAH)

- Only ten states (out of the total 18 states visited) report any programme on the ground or any progress on the planned CAH interventions.
- Maharahstra has a strong programme on the ground, started in the initial phase, in 2007. It currently covers 600 villages in 13 districts, and has an elaborate set of

processes on the ground, including well attended Jan Samvads (Public Hearings) and generation of report cards with positive outcomes related to local health system issues.

- In Chhattisgarh, VHSNCs monitor 27 indicators on health, nutrition and sanitation every month. Annual *Swasth Panchayat Sammelans* are held in blocks as Public Dialogue events. This process is also linked with Swasth Gram Award Scheme, in which, Gram Panchayats are ranked on a set of health, nutrition and other social indicators,
- Odisha has introduced CAH in 13 districts. The state uses a community enquiry tool (Soochna Patrika) for community based monitoring and decentralized health planning, focused on major health indicators. It also conducts a Gaon Kalyan Samiti mini convention at sub-block level, where a review of the progress on indicators of mother and child service delivery gaps was done by the Sector Supervisor (a designated nodal person from the block). Training of VHSNC members is also being done under CAH.
- Punjab implemented the CAH interventions in two districts in 2014-15, covering 2 blocks, 6 PHCs & 30 villages from each district) where two District level Jan Samvads were held. In 2015-16, state has planned to implement CAH in 11 districts.
- In Madhya Pradesh, CAH programme intervention was sanctioned for 5 districts in 2013-14, but the process could not take off, as implementing NGOs could not be selected. In 2015-16 it is now being implemented through MGCA members in same 5 districts (3 blocks, 15 PHCs & 45 villages in each district). Trainings at Block, PHC, and VHSNC levels are under process.
- In many other states where CAH activity is in the initial phases of planning, reconstitution of State AGCA has been done. In most of the cases a few members from the national AGCA have also been co-opted.
- The states of Delhi, Meghalaya Uttarakhand, Assam and Rajasthan have initiated the process for implementing CAH, but there is not much progress reported.
- The state of Uttar Pradesh appears to have made significant progress in establishing support structures on the ground and is attempting to streamline training functions. At the other end of the spectrum is the state of Haryana where past gains appear to have dissipated, with little action seen on Community Processes including RKS, and IEC. States which demonstrate good performance on the ground include Odisha, Maharashtra, West Bengal, Punjab, Chhattisgarh and Himachal. States such as Madhya Pradesh, Delhi, Assam, Uttarakhand, Manipur, Meghalaya, Karnataka, Andhra Pradesh, Rajasthan, despite adequate financial and human resources in place, need to recover lost ground and put in more intensive efforts to strengthen the programme and perform to their potential. In these states the ASHA exercises agency and performs to the best of her ability but overall systemic weaknesses undermine her efforts.

RECOMMENDATIONS:

1. The ASHA programme has been underway for nearly ten years in over half the states visited, and about seven years in the remainder. Programme evolution cannot

take place unless existing support mechanisms have been strengthened. Existing vacancies must be filled and training of support staff must be instituted immediately. If necessary, the functioning and leadership provided by the state ASHA resource centres and DCMs must be assessed and appropriate modifications made.

2. Consider incentives for good team performance- i.e. if, in a block all training for ASHA is complete based on the existing calendar, all ASHA receive monthly payments, all new-borns are visited, and ASHA refresher training is held, then the BCM and ASHA Facilitator would get an additional incentive- either in the form of cash or a non monetary awards such as recognition at the state level, exposure visit, training at state or national level, or points towards promotion.

3. Strengthening the ASHA training systems, especially as states move towards ASHA certification is also important. While the choice of trainers (full time, on deputation) is a state issue, one recommendation would be to explore the use of Block Mobilizers, ANM and ASHA facilitators as trainers so that the roles of support, on the job mentoring and training are combined. Chhattisgarh has demonstrated that this is possible. The additional compensation for training would also serve to increase the salary package for these cadres.

4. Streamlining payments is a critical priority. The ASHA is a volunteer worker, and there is no other means of tangibly compensating her effort which in many cases is hardly commensurate to the effort she is making. It appears that some gains made between 2011 and 2014 have been reversed. Particularly, payments for disease control programmes need to be expedited. Introduction of new campaigns with ASHA being promised an incentive must be monitored to assess if payments were actually made.

5. The strong coordination between the team of the ASHA-ANM_AWW needs to be taken advantage of and newer tasks need to be added based on workload assessment and accompanied by training and capacity building. This needs to be a well planned exercise, and must be contextualized to local needs.

6. Poor skills of the ASHA in nutrition, family planning and newborn care are reported from some states, and these have also been noted in previous CRM visits. The states must take urgent action to resolve this. The first step is to orient support structures including ANM in these skills in a two day workshop. Thereafter, over a three month period, states must ensure that every AF/ANM spends two days with the ASHA focusing on key skills and then following up to ensure that gaps are corrected. The Role of the ASHA in MP and Punjab, in acting on non communicable diseases needs to be studied, and a future course of action on the mechanisms to engage the ASHA as a possible member of the Primary Health Care team needs to be decided. One way of improving ASHA skills is to develop mobile based application to reinforce key messages and also to develop applications for support structures of the ASHA to enable performance tracking and supportive supervision .The REMIND model from the state of Uttar Pradesh is a good example.

7. The issue of dis-allowing elements of PIP in the community processes components is partly on account of variations in interpretation of existing CP guidelines. The existing CP guidelines need to be revised to reflect current learning from the states.

8. The process of restructuring of VHSNCs needs to be expedited, and key role of ASHAs in mobilising and facilitating VHSNCs should be mandated as per the new guidelines and enabling inclusions of key individuals. Training of VHSNC members needs to be undertaken on a priority basis. There is need for stronger integration of ASHA support structures to support and manage VHSNCs realigning the TORs of block and district level ASHA coordinators to given equal focus to supporting VHSNCs is important.
9. More active and sustained involvement of PRI members in supporting VHSNCs and RKS needs to be promoted in all states, through advocacy with Ministry of Panchayati Raj Institutions.
10. Reconstitution of RKSs as per the new guidelines needs to be undertaken on priority basis, followed by capacity building of RKS members focusing on community participation and fund management. Financial management systems of RKSs need a review from state level and prompt corrective action to improve transparency and governance.
11. Enhanced role of district and block level panchayat structures in supporting and monitoring health programmes on the ground, especially involving their standing committees, will enhance effective convergence. Implementation of Community Action for Health, should be speeded up, and integrated with the CP interventions.
12. States needs to strengthen or establish State ASHA/CP Mentoring Group and engage with effective and credible NGOs to serve as resources for all components of community processes including Community Action for Health.

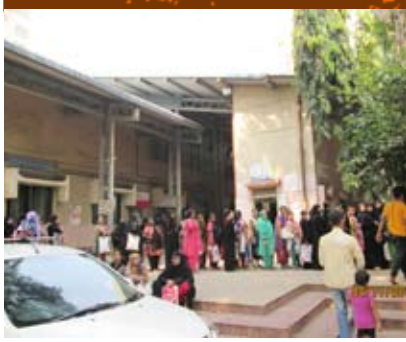
STATE FINDINGS

ANDHRA PRADESH

- ASHAs are well recognized by the community and supported by PRI members.
- ASHA are involved in all NHM activities including disease control programs except for promoting PPIUCD as they are yet to be trained in PPUICD.
- Quality of ASHA training is good as reflected in knowledge levels of ASHAs.
- District community mobilizers are in position in six out of total 13 districts in the state. At block and sub block level, existing staff supports the programme. Induction training of support staff has been completed.
- ASHAs are aware about marginalized families and provide special attention to such families by visiting them more often and spending extra time with them.
- HBNC kits have been provided to ASHAs over last two years but use of kits was found to be limited.
- Payment of ASHA incentives is online but delays were noticed.
- Grievances redressal committee formed in 9 districts and process is underway in other four districts.
- Recent order of reconstitution of Hospital Development Society (HDS) as per GOI guidelines has been challenged in court, affecting fund utilization. Participation

of NGOs and PRI members is low in HDS activities. Lack of transparency if fund utilization was also noted.

- VHSNCs functional as per guidelines with ASHAs taking lead role in involving community specially PRI representatives. Meetings are regular with meeting minutes and action points being well documented but VHSNCs have not received funds for the current financial year



ASSAM

- Attrition rate of ASHAs is low (0.6%) with major reasons being better career opportunities. Of the 251 dropout ASHAs, 16 were selected as ASHA Supervisor, 5 as BCM, 76 as AWW and 78 as PRI.
- State team shared the shortage of 241 in one of the districts (Char area), but the state's proposal for their selection has not been approved by MOHFW.
- ASHAs in the riverside islands are reaching up to the marginalized population with good support from boat clinics which provides ANC, immunization and basic family planning services
- ASHAs functionality was good in areas of ANC and immunization but gaps were observed in counseling for family planning, ensuring growth monitoring and WIFS.
- Incentive payment in Golaghat was timely but in Dibrugarh delays were common. Average incentive earned by ASHAs was reported to be about Rs. 4500/- pm.
- ASHAs have started receiving routine and recurring incentives, except in *SDCH* Bokakhat, Golaghat district where ASHAs and even block officials were not aware about this incentive.
- ASHAs shared facing problems during hospital visit because of non availability of rest rooms.
- State has reserved 10% seats in Basic course for ANM and age relaxation of up to 45 yrs is made. Till now 92 ASHA have been enrolled in the basic ANM courses
- The State has introduced a medical and life insurance scheme - ASHA Kiron, and so far 292 Medical reimbursements and 113 death compensations have been paid but many ASHAs met were unaware about the scheme.
- ASHAs of Kamarbandha Ali PHC shared that they were given bi-cycle, mobile phone, umbrella and radio in 2009, of which only the mobile is in working condition.
- VHSNC members are yet to receive formal training however they are aware about monthly meetings and untied funds. They attend VHNDs to interact with beneficiaries to advise them on nutrition etc.
- RKS are constituted in adhoc manner and details of constituted RKS were not available at any facility. RKS is viewed as part of finances with no programme person managing RKS at state level.

CHHATTISGARH

- Most Mitanins met, were found to be motivated, well informed and capable of counselling women/mothers. They were viewed by community as a critical link with the health system.

- Attrition rate is low - around 1.3% and the major causes included selection in ANM course or promotion into Mitanin Facilitator role or death/ migration and family pressure.
- State has strong support structures for Mitanins, at all levels – sub block, block, district and state. Excellent integration of AWW and Mitanins was also evident at field level.
- Most Mitanins are conducting Rapid Diagnostic tests and HBNC visits. *Mitanins* are involved in village level planning and also facilitate the *Fulwari* scheme (on child nutrition and health in tribal blocks)
- Mitanins have been provided a communication kit including a flipbook designed for home visits
- Findings regarding availability of drugs were mixed, as some Mitanins had all drugs while few Mitanins had expired medicines.
- The state has introduced various measures to support mitanins –Mitanin Samman Diwas by PRIs to honor Mitanins at village level, 40% reservation for *Mitanins* in Govt ANM schools since 2011 (about 1700 Mitanins are enrolled), social security scheme through Mitanin "Kalyan Kosh".
- Mitanins payments are irregular as most Mitanins interviewed have not received incentives for more than a year. These delays are mainly due to payment procedure routed through PRI members. To address this, District Collector of Rajinandgaon has reversed the decision to route funds through PRIs.
- Mitanin is member secretary/convener of VHSNC and handholding of the committees is through the Mitanin Support Structure.
- On an average, 80% of VHSNCs are conducting monthly meeting in any given month and around 71% of VHSNCs are preparing village plans. VHSNCs also record and discuss deaths in the village along with the community reported causes of deaths.
- Community Based Monitoring activities are undertaken in all 146 blocks and VHSNCs monitor 27 indicators on health, nutrition and sanitation and record it in their Monitoring registers monthly.
- Inter sectoral convergence was found poor even on VHND days.

DELHI

- Selection process is managed by the ASHA sub unit, but community participation in selection process was not observed during district visits.
- State has an online system for monitoring of ASHA programme. However, the actual use of data for taking programmatic decisions was not seen at district and field level.
- High attrition rate of 8-10% was noted on account of better opportunities and low incentives.
- Slow training pace in case of induction module and Module-6 &7 (round3). Main reason for delay is competing priorities of trainers (from health dept) which pushes training on a back seat.

- Trainers were found to be knowledgeable in subject topics but skills on issues like vulnerability mapping, reaching the unreached and household visits were found to be weak.
- Since PHCs are quite accessible, ASHAs are only given basic set of drugs and supplies, - Paracetamol, IFA, de-worming tablets, Betadine, condoms, OCPs, pregnancy testing kits and ECPs.
- ASHAs had good knowledge levels and were active on promotion of spacing methods like PPIUCD and OCPs.
- Average monthly incentive is around Rs. 3000-3500 pm. Payments are made through online transfer but delays of up to two months were common.
- State has facilitated enrollment of ASHAs in NIOS for equivalency programmes.
- State has taken initiatives to make RKS more effective recently. A district level RKS with MLA as chairperson is formed which will coordinate management of funds and oversight functions. S/he would collect feedback from local volunteers and community, and include them into the agenda and discussions of RKS meetings.

HARYANA

- Shortfall of ASHAs was noted in both districts. District visits indicate that selection of new ASHAs has been stopped in the state.
- Slow pace of ASHA training is evident as Rounds 3 and 4 training of Module 6 & 7 are yet to start. Delay was attributed to budget constraints.
- Drug kit was available with ASHAs but in one of the visited districts, kit was distributed on the first day of the CRM visit (2nd Nov. 2015)
- Despite PFMS based ASHA incentives payment delays were observed as most ASHAs have not received payment since July 2015.
- Additional incentives from state funds - of Rs. 500 pm as fixed monthly honorarium and a top up of 50 percent incentives earned through NRHM incentives. Though ASHAs were aware about this incentive but they are yet to receive this incentive.
- ASHAs are functional on all technical and referral activities
- About 202 ASHAs have undertaken ANM/GNM course without any support from State.
- In order to discourage home deliveries, state has mandated Dais, ANMs and ASHA not to attend to such cases. This excludes the most marginalized.
- Convergence with other department like WCD was very limited except for specific functions such as village health nutrition days where ASHA, AWW and ANM work closely.
- State is facing a problem due to new rules of the Society Registration Act in the state that requires each member of society to pay Rs 1100 as annual fee for five years, which they are reluctant to pay and there is no provision within the budget.
- VHSNC was found very weak on the ground. The involvement and role of ASHAs in their functioning as well as in community level mobilization was not very active.

HIMACHAL PRADESH

- ASHA programme was launched in HP in the year 2014 and so far, 7539 ASHAs have been selected against the target of 7752 (estimated at population density of 1 per 800).
- Participation of community in ASHA selection is limited to representation of PRI member in selection committee without any community level consultations and gram sabha involvement.
- Training of ASHAs in the Induction module has been completed for 7446 ASHAs (98%) but training of Module 6 & 7 is yet to begin.
- Post training support at field level for ASHAs is weak though Female Health workers (ANMs) play the role of ASHA facilitators.
- Availability of drug kits is not uniform i.e, drug kits were available with ASHAs in Sirmaur while in Hamirpur district no drugs were available with ASHAs.
- Functionality of ASHAs in RCH activities like referral transport arrangement and VHND, distribution of contraceptives etc, is good. Community interactions indicated that the role of the ASHA is well appreciated in the community as they bridge the gap between health department and community.
- State has mandated that ASHA payments should be done by 10th of every month through online transfer/RTGS. However payment is delayed by 3-4 months on account of time taken for verification of claims. In district Sirmaur, ASHAs have received payments only till September 2015
- Average monthly incentive of ASHAs is Rs. 1200 which includes Rs. 1000/month for routine and recurring activities.
- At state level, one nodal officer manages the ASHA programme while at district level, process of recruitment of ASHA Coordinators is underway.
- State has made efforts at policy level for effective operationalization of VHSNCs and issued detailed guidelines for facilitating operationalization. But VHSNCs were found to be non-functional on the ground. Coordination and flow of funds between the two departments (Panchayat and Health) were also cited as roadblocks.
- Good convergence was reported with Department of Education with regard to WIFS implementation. However, convergence with ICDS, water and sanitation and rural development requires further strengthening.

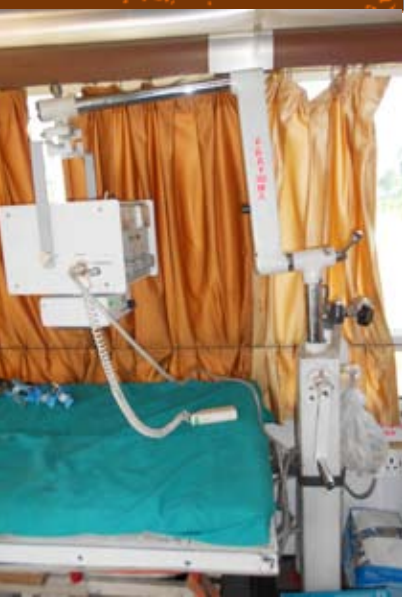
JHARKHAND

- Sahiyas were motivated and enthusiastic and took pride in their work.
- State has laid special emphasis on hard to reach areas in selecting Sahiyas for effective coverage of such areas. Attrition rate of ASHA is low i.e, around 2.5%.
- Support structure for Sahiyas has been set up at all four levels i.e, state, district, block and sub block level and have also been trained in supportive supervision.
- Training pace is satisfactory and the skills of the Sahiyas were found to be good.

- Drug and HBNC kits have been provided to all Sahiyas. However availability of medicines with Sahiya was variable as they only had Paracetamol & Amoxicillin syrup, ORS packets and nischay kit.
- Delays of 3-5 months in payment of incentives were common in Lohardaga while in Dhanbad delays are up to 2 years. Delays are larger for incentives of NVBDCP, RNTCP, NLEP etc and IDCF activities.
- There is no ASHA Grievance Redressal Mechanism in place at state/district/block levels.
- Sahiya Help Desks (76) were initially set up in district hospitals and Community Health Centers in Left Wing Extremist (LWE) districts in FY 2011-12. Helps desks later scaled up to 24 district hospitals and have been withdrawn from CHCs.
- Participatory Learning and Action (PLA) has been implemented in all 24 districts.
- One challenge highlighted by Sahiyas was the need of ASHA Ghar when they bring delivery cases to health facility during night hours.
- State has conducted training of VHSNC members, but their impact on the VHSNC processes is not clearly visible. VHSNC meetings are still not regular. Though ASHAs are member secretary of VHSNC, ANM still retains control on VHSNC funds while in some cases AWW was not a VHSNC member

KARNATAKA

- ASHAs are vibrant, active and have a good understanding of National Health Programmes including disease control programmes. They are effective in mobilization and conducting home visits.
- There is huge gap of 27% in ASHA selection against the target. Gap of about 16 % and 34 % was noted in Dakshin Kannada and Koppal districts respectively.
- Payment of incentives is through RTGS but delays were observed. Payments of some components have been pending since Dec-2013 and were attributed to drop out of ASHAs by state officials. However, the recent introduction of ASHA NIDHI Soft has facilitated prompt payment.
- State also provides matching grants equal to NHM incentives earned by ASHAs. Average monthly incentive in Dakshin Kannada -Rs.2000-2500.
- Over the last two years Sukshema Project (under KHPT) has been started in eight High Priority Districts under which ASHAs have been provided with key chain and calendar for family focused counseling
- Non availability of ASHA rest rooms, even in health facilities with high case load is an issue.
- 10% seats of the ANM's course have been reserved for ASHAs for providing her career progression; however none of ASHAs were aware of such a provision.
- Grievance redressal system has been put in place but ASHAs not aware about such a process



- VHSNC meetings are not being convened on regular basis and there is no proper documentation maintained. Except for ASHA; no other VHSNC member is oriented about VHSNC activities.
- Meetings of ARS (RKS) are not conducted regularly and documentation of expenditure is not done properly. Almost 50 % of ARS funds are being used for procurement of drugs and consumables.

MADHYA PRADESH

- Over the last year 6% ASHAs dropped out of the programme (including nonfunctional ASHAs) and additional 3% were identified inactive based on low incentives earned in ASHA software.
- Momentum of training has reduced over last year as only 26% ASHAs are trained in round 3 and 5% in round 4. High dropout rate of state and district trainers also affected the pace of training.
- State has established 49,846 Gram Arogya Kendra (GAK) to bring primary health care services at the door-step of community. ASHAs play an important role at GAK where she spends 2 hrs. (6daysaweek)12 Noon to 2PM per day. ASHAs reported to be happy in this new role at GAK.
- ASHAs are skilled in using weighing machine and thermometer and are trained in measuring BP by the digital BP instrument and testing Hb through Sahli's method since the launch of GAK.
- Availability of drugs with ASHAs has improved because of GAK system as she has access to 16 drugs kept at GAK and HBNC equipment kit was also available with ASHAs.
- Payment process is streamlined with no delays in incentive payments.
- ASHA restrooms are in place in 42 districts and are being set up in an additional 6 districts.
- Supportive supervision visits by the District and Block support teams are hampered by lack of dedicated mobility expenses. Additional tasks such as data entry for MCTS and HMIS consumes substantial time and affects their main task of supporting ASHAs.
- Interaction of ASHA facilitators with ASHAs was found to be limited to verifying HBNC forms rather than providing mentoring support to ASHAs.
- The mechanisms of review and support systems for ASHA Support Cadres are quite weak.
- State had merged ASHA Grievance Redressal (GR) Committees with Mentoring Group for Community Action (MGCA)in all districts but the system is yet to become operational.
- State has a policy of 10% reservation for ASHAs in ANM schools and 120 ASHAs have been benefitted. State also supports ASHAs who want to upgrade their educational levels.

- State has an effort for institutional convergence at community level by integrating three village level committees namely – Mahila Swasthya Khata (of ICDS), VWSC (of Water and Sanitation programme) and VHSNC as' Gram Sabha Swasthya Gram Tadarth Samiti (GSSGTS). Funds of the three committees remain in separate accounts, with separate cash books, their meetings are held separately, but the members remain the same.
- Overall progamme and financial management of RKS is quite ad-hoc. RKS meetings were irregular, and documentation was incomplete on funds and expenditure. Irregularities in records and funds management with regard to construction and sale of shops on hospital land are a major lapse.

MAHARASHTRA

- ASHAs were found to be knowledgeable, skillful, committed and functional on all the expected areas of service delivery.
- Bhandara has about 785 villages with human habitations but since selection is based on population, about 70 ASHAs cover more than one village, indicating inadequacy of targets set for ASHA.
- Attrition rate of ASHAs is low (3%) during last financial year. Migration & better employment opportunities were quoted as main reasons of dropout
- Pace of training of ASHAs in Module 6 &7 is slow. Training Round 2 and 3 of Module 6 &7 are yet to be completed in the state.
- Despite completion of training of ASHAs in round 1 of Module 6 & 7, only 59% ASHAs have received HBNC kits (35,000 out of 59,118).
- State has set up support structures at all four levels which have been trained in performance monitoring and five days orientation in Module 6 & 7. However ability of Block Facilitators and BCMs to use these reports for providing on field mentoring to ASHAs was found to be limited in Bhandara.
- State has started data entry of HBNC forms for all ASHAs but this data is not used for analysis. However this has shifted focus of block facilitators on forms filling rather than mentoring ASHAs.
- No delays observed in payment of incentives for RCH activities were reported but huge delays were reported for incentives under NVBDCP and RNTCP. Average monthly incentive of ASHAs is around Rs. 1531 pm at state level.
- Provision for enrolment of ASHAs in ANM/GNM course was introduced in 2013 and so far 140 ASHAs have completed the courses. A recent order issued stating that ASHAs should resign after joining these courses has dampened the motivation of ASHAs to enroll in such courses.
- ASHAs are very active on HBNC related tasks. Bhandara district Officials, credited ASHAs for saving lives of 64 high risk newborns between April – September, 2015. ASHAs are also active in directly observed Iron Therapy for Anaemia prevention among pregnant women and Sickle Cell programme.
- State has a good Non communicable disease programme at secondary level facilities but with no community linkages. ASHAs in Bhandara were keen to take up new skills and tasks.

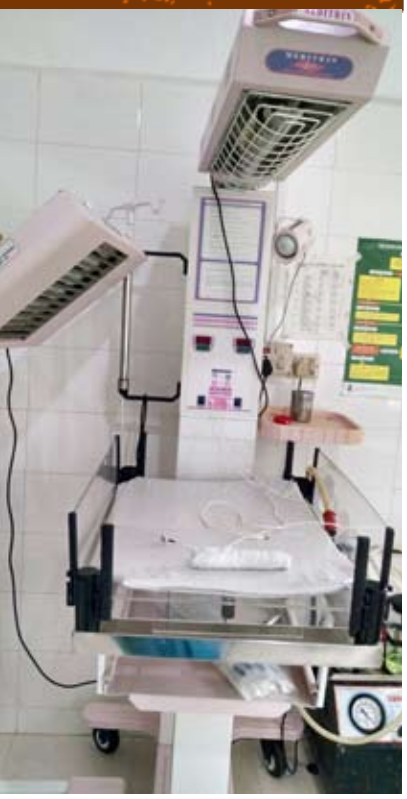
- Disbursal of VHSNC untied funds is done on basis of population of the village.
- RKS were found functional with regular meetings and over 75% fund utilization (except at District hospitals). However issues regarding fund management were noted as funds generated under RKS were being transferred to treasury since 2014.
- Participation of PRI members in VHSNC/ RKS, and governance of Health Department, was good.
- Good convergence was seen with WCD and Education department for VHND and RBSK.

MANIPUR

- Overall, ASHAs are active helping in organizing VHND/ supporting immunization and institutional delivery, management of childhood illness and RNTCP.
- ASHA Performance Monitoring on basis of ten indicators has been instituted but timely compilation of report, its analysis and identifying the gaps/ problems are an issue.
- Skills of ASHAs in the area of identifying danger signs during pregnancy, breastfeeding, nutrition counseling and HBNC were found to be poor in some areas.
- State has set up support structures at all four levels however lack of regular capacity building and provision of mobility support affects their functionality. Skills of ASHA facilitators for providing on the job mentoring were found to be limited.
- Incentives payments are made via online transfer but delays were common. Backlog of incentive payments since April 2015 was reported on account of lack of funds. At CHC Kaching, HBNC incentive has not been paid since January 2015
- State has provided cycle, mobile phone, umbrella, raincoats, radio etc to ASHAs. Most ASHAs met in both districts reported that they do not use the cycle but Mobile phones and radio are being optimally used by ASHAs. Maintenance cost of cycle is being provided by VHSNC from untied fund.
- Drug kits have not been given to ASHA. ASHAs reported collecting essential drugs, condoms, pills etc. from nearby health facility whenever required.
- HNBC kit provided to all ASHAs about three years back, ASHA of Salungpham Sub Center in Thoubal district reported most of the equipment of the kit are not in functional state now.
- ASHA grievance redressal system has been set up in every health facility but ASHAs were not aware about the process of registering a grievance. ASHA Rest rooms are available only in district hospitals.
- The RKS formed as per guidelines were found in place at every health facility and were functional (two tier structure - Governing Body and Executive Body). The Executive Body meets every month while General Body meeting is held quarterly.
- The quality of processes of RKS; minutes of meetings and participation of members is variable, and overall governance issues were noted.
- Level of engagement of PRI representatives in VHSNC, RKS, and District Health Society is weak, and convergence is limited.

MEGHALAYA

- Although training of Module 6 &7 shows good progress, attrition rate of trainers and high number of absentees during different rounds is an area of concern. Induction training for new ASHAs is yet to be initiated and delay was on account of non availability of modules in local languages.
- ASHAs are functional on task related to promotion of institutional delivery, HBNC visits, Immunization, NVBDCP & RNTCP but limited functionality was reported in the area of family planning counselling.
- HBNC visits have improved since implementation but quality of visits is a concern as state has not been able to replace the non functional items in HBNC kit since the 1st round of training i.e. 2011-12
- Low attrition rate of 3% was reported but slow pace of selecting new ASHAs is an issue in few districts.
- Drug kit is provided to all trained ASHAs once but stock outs were noted.
- State has support structures at three levels (state/district/sub block level) and has a mechanism of regular review of support structures at all levels.
- State was sanctioned Rs. 4 lakh for General Grievance redressal cell but it is yet to become operational.
- Across the state and two districts visited, ASHA receive incentive range from Rs. 250 to 1500. In South West Garo Hills ASHAs were not aware of all their incentive entitlements.
- Delays of incentive payments were seen. Despite 70% ASHAs having bank a/c, payment is still made in cash inWest Jaintia Hills District.
- Routine and recurring incentives have been introduced in 2014-15 but payments are still pending.
- ASHA Ghar/ASHA transit homes not available in majority of the health facilities.
- State has ASHA Benefit Scheme - matching amount of incentive is given from state funds.
- Effective convergence was seen on the ground between ANM, ASHA, AWW during VHND but convergence between departments stills remains a challenge at state and district level.
- State has involved representatives of the traditional Village Council in the VHSNCs, Rogi Kalyan Samiti and District Health Society. VHSNC has been constituted as per new guidelines, but, level of participation of these community representatives was low.
- VHSNC meetings are held once or twice in a year and in most cases role of PRI member is limited to facilitating space for meeting. Functionality of VHSNC is largely dependent on participation of ASHA.



ODISHA

- State has selected 95.4% ASHAs but a gap of 12 % was reported in High Priority Districts. Dropout rate was only 0.9%, with major reasons being selection in other jobs and death.
- In addition to training modules provided from MoHFW, state specific trainings are also carried out as refreshers training on different thematic areas. Skills of trainers were found to be excellent.
- Knowledge of ASHAs on ANC, Institutional delivery, HBNC, Immunization and Family Planning is good but skills of using HBNC equipment ARI timer, thermometer and weighing scales needs improvement.
- Drugs and HBNC kit were available with all ASHAs. Medicines are replenished during monthly sector meeting but HBNC equipment is given once. ASHAs were well versed with the use of medicines.
- Average incentive earned by ASHA is Rs. 2099/- (April 2015 to Sept 2015). Payment is made online through PFMS but incentives for activities under the RNTCP were reported to be delayed
- Awareness among ASHAs about all incentives especially family planning programme was low. Though state has vouchers for ASHA payments but ASHAs lacked clarity about the claim process for incentives specifically under disease control programs.
- State has created support structures at all levels except at block where existing block level functionaries - Block MOIC and the BPM are responsible for CP activities.
- ASHA Sathis are selected from the existing ASHAs and continue to work as ASHAs also. Despite the high work load ASHA Sathis are doing commendable work in supporting ASHAs. They receive a monthly honorarium of Rs. 2000/- along with performance based incentives.
- One of the criterions for Sathi selection is the incentives earned, this in practice excludes ASHAs covering small population and earning low amounts of incentives.
- CUG has been given to ASHAs with monthly Rs. 100/- for mobile phone recharge.
- ASHA Gruha are available at DH and high delivery load CHCs, which were found in good condition.
- Bi- cycles have been issued to ASHAs and ASHA Sathis and are seen as a medium of empowerment.
- Working area of ASHA is not coterminous with Anganwadi. Thus some Anganwadis have 3-4 ASHAs who have to share the incentive for VHND and immunization services.
- ASHAs are involved in awareness generation on Household toilets under Swaccha Bharat Abhiyan. She is also involved in Shakti Barta- Counseling on MCH under WCD.
- RKS are formed as per guidelines but regularity of meetings varied across state. RKS funds are used for hiring Specialist and services such as housekeeping, security, etc. RKS has large unspent balance.

- Quarterly GP level meeting is conducted with involvement of PRI, ICDS & Health Dept under the chairpersonship of GP Sarpanch to review and regular support Gaon Kalyan Samitis. State has provided printed registers to all GKS. Untied fund is utilized as per the need and approved village health plan. Funds are received by the VHSNCs in two instalments during the year.
- State Advisory Group for Community Action was constituted in 2012 and 19 meetings has been held. No meeting was reported since last one year. Community Action for Health is being scaled up to 13 districts. Capacity building have been organized for ex officio members of VHSNC but training of members other than the office bearers is missing

PUNJAB

- ASHAs have acquired both visibility and stature in the community. ANMs also recognize ASHA's role and are supporting ASHAs in the field.
- Total ASHA drop out in the 2014-15 are 493.The main reasons for drop out reported were - no support from families, selection as PRI members, non performing ASHAs etc.
- Performance Monitoring is regularly done and poor performing ASHAs are provided support for improvement. Field findings indicate ASHAs and ASHA facilitators are not aware about 10 indicators.
- About 20% seats are reserved for ASHAs in ANM course; four ASHAs are enrolled in ANM School.
- ASHAs were involved for early detection of cancer during Dec- Feb 2013-14 and referred many people to hospital, of which many were ruled out of having cancer. Inadequate training of ASHAs and improper referral support affected acceptance of this initiative.
- State has reconstituted VHSNCs as per the new guidelines, and has made provision for rotation of ASHAs as member secretary in villages, which have more than one ASHA.
- For better convergence, ICDS department is invited to the Anganwadi Centre every month, to participate in and review the immunization programme and VHND.
- RKS are dependent on Government grants as no fund generation is done. RKS funds are credited to main account of district hospital in Hoshiarpur instead of RKS accounts since 1.5 yrs.
- State has implemented CAH programme in two districts in 2014-15 and two Jan Sunwais were held in each district, with village and facility reports. CAH is to be expanded to 11 districts this year

RAJASTHAN

- Overall state has 94 % ASHA selection but major gaps were observed in Bikaner with 74 % selection.
- Launch of ASHA Soft has made payments of most incentives regular except for malaria programme.

- Replenishment of drugs for ASHAs is regular in Dholpur District but it was adhoc in Bikaner District.
- ASHAs functionality as mobilizer was found to be good but skills of ASHA in providing HBNC was found to be limited due to unavailability of equipment kit and lack of mentoring support.
- State has not invested in training of support staff of ASHA programme. Lack of routine monitoring of training and poor post training support emerged as major gaps in ASHA programme. Lack of clarity about roles of ASHA support structure was observed in both districts.
- Large number of vacancies exist at all level starting from district to sector level; District ASHA Coordinator post was vacant in Dholpur district, Block ASHA Facilitator vacancy is about 75 % in Dholpur, and 66 % in Bikaner and PHC Health Supervisor vacancy is about 62.9 % in Dholpur and 74 % in Bikaner.
- Most ASHAs met were focused on correctly filling the form for payment purposes rather than recoding the actual status of mother and new born.
- State does not have dedicated Grievance redressal mechanism for ASHA. State has "Rajasthan Sampark" for anyone to lodge a complaint but awareness regarding this was negligible among ASHAs.
- State has initiated a process of enrolling ASHAs for 10th and 12th std. through NIOS and so far 30 ASHAs have been nominated from all districts.
- Services provided during Village Health and Nutrition Day was more focused on clinical part of ANC and immunization. Counselling on Family planning and nutrition was not being done.
- Out of 43,440 VHSNCs, 2742 villages are having less than 100 population therefore untied funds are being transferred to 40698 VHSNCs. 36000 VHSNCs (88%) have opened account. Reconstitution of VHSNC committees has been done in both the districts but training of VHSNC members has not been initiated
- Though six districts were identified for CAH and constitution of state planning and monitoring committee is underway but there is no awareness about the process at the state level. State received approval of Rs. 30 L in ROP 2014-15 for CAH, which was utilized, on printing of RMRS (RKS) guidelines, VHSNC monthly calendar and printing of booklet for PRI members
- Rajasthan Medical Relief Society (RKS) has been constituted in most of the health facilities. However reconstitution as per new guidelines is yet to begin. Irregularity of meetings was observed in all facilities. There is a lack of knowledge among members about the process of using RMRS untied fund in Bikaner district. RMRS money is utilized for purchasing computer and other office expenses
- No convergence mechanism at District Health Society (for planning, monitoring and inclusion of left outs and drop outs) at ward level amongst ICDS, Health & FW, PHED, and Education.

UTTRAKHAND

- ASHAs are vibrant and motivated to work for community. Skills and knowledge level of ASHAs were found to be commendable. Irrespective of the difficult terrain

especially in hilly districts like Nainital, ASHAs are linking the services of NHM with the community efficiently.

- ASHAs are given weightage during selection of candidates for ANMs/GNM courses. State also have 15% reservation for ASHAs in Class 3 & 4 postings by the State government
- Delay in payment of incentives of up to 3-6 months was reported. Incentives for National Programmes like immunization, TB, RKSK, and NVBDCP are often delayed. Payment for Immunization has not been made to ASHAs since 2014 in Nainital and in Dehradun it has not been paid for this financial year. ASHAs reported making multiple visits to health facility get incentive.
- On an average, ASHA earns around Rs. 1000-2000 per month. A special bonus of Rs.5000/- is given to all the ASHAs since last two years.
- ASHA award system is also in place and the best performing ASHAs are being appreciated during Mahila Diwas
- ASHA bag with drug kits are available in the field, but stock outs of Iron, Paracetamol, and Pregnancy Kit were noted. Limited drugs are provided to ASHAs once in a year which get exhausted within 2 months of supply. No systematic process of drug kit refilling is in place and ASHAs were not aware about the possibility of refilling of drug kits from SCs and PHCs.
- HBNC kit was available with ASHAs but thermometers were not functional since the time of supply.
- All ASHAs have been provided with an overcoat and an ASHA Dairy.
- ASHA programme is supported through NGOs at district level. In Nainital district the support staff was paid cumulatively at intervals of six months and in Dehradun at quarterly intervals.
- High expenses are incurred by ASHAs for transport in difficult areas for attending meetings - in Chakrata CHC ASHAs from remote villages spend Rs.120/- to travel 80 Km by jeep
- *"ASHA Ghar'*, were not established uniformly, wherever they exist, they were in poor condition.
- State has set up mechanisms for grievance redressal but it was not fully operational. Many ASHAs reported bad behavior of hospital staff towards them during hospital visits.
- Reconstitution of VHSNCs as per GOI guidelines is underway in state and so far 48% have been reconstituted. VHSNCs have received Rs. 1000 per VHSNC in FY 2015-16. ASHAs reported spending Rs. 750 to open the account for newly reconstituted VHSNC. Doli are arranged by VHSNC funds for transporting pregnant women in hilly parts of Nainital district.
- Functioning of RKS was good in Naintial but sub optimal in Dehradun. There is a need to strengthen RKS fund management process.
- State Advisory Group on CAH has been formed and initiative is to be launched in six districts

UTTAR PRADESH

- In the last two years, the programme has made significant progress in several processes critical to the ASHA programme – training, payments, and support structures.
- At state level there is a gap of nearly 20% in ASHA selection. Both districts have a shortfall of nearly 25%. Gaps are highest in poor performing blocks which require intensive community interaction.
- In Sitapur district most ASHA are in place since 2007, indicating low attrition. In Jalaun, attrition rate is high - 9.2%. which could be because of stronger data base and performance monitoring.
- Training has picked up momentum, with over half of the ASHA being trained in Round 1 and 42% being trained in Round 2. In contrast, in Sitapur less than 10% have received Round 1 training. Reasons for the slow pace appear to be frequent administrative changes, preoccupation with other components resulting in little attention to the programme.
- Role of ASHAs in Sitapur was limited to mobilization for immunization, institutional delivery and for family planning; whereas in Jalaun ASHAs were actively involved in HBNC, providing ORS, Zinc, Paracetamol, and Contraceptives.
- ASHAs had plentiful supplies of ORS, Zinc, Vitamin A&D capsules, OCPs, Condoms, Nischay kits and Emergency Contraception. ASHAs have been provided with drugs without proper training
- ASHA payment systems are streamlined, with all ASHA met having bank accounts. Average amount earned by ASHAs in Sitapur is Rs. 2200 per month, while some ASHA reported over Rs. 3000 per month. In Sitapur ASHAs were not earning incentives for disease control programmes.
- ASHAs reach into marginalized homes was good. Families from marginalized communities were satisfied with the interaction of the ASHA and acknowledged that she visited pregnant women and children and escorted them to the health facility.
- ASHA Grievance Redressal mechanism is in place at the block level. State resource centre which has hitherto been receiving complaints from ASHAs, reported far fewer phone calls from ASHA, as these are resolved at the block levels. In Jalaun, misbehavior by health official emerged as main complaint. About 36 of 40 grievances were resolved within 21 days of complaint.
- Support staff is largely in place and trained in supportive supervision and mentoring. In both districts, the role of the District Community Processes Mobilizer (DCPM) encompasses more than that of Community Processes, leaving him for little time to undertake mentoring and review of block mobilizers and the Sangini.
- In both districts, the Sanginis continue to perform ASHA related tasks, leaving her with little time to mentor the ASHA in her cluster, and compromises her work on both fronts.
- Given the slow pace of training, ASHA performance monitoring has not been initiated in the state. In Jalaun Block wise monitoring and grading of ASHA activities is done on a regular basis.

- State has recently developed a Village Health information Register (VHIR) which the ASHA are being trained to fill at "Triple A" platform. AAA platform is a monthly meeting of the ANM-ASHA and AWW which is currently limited to developing due lists for immunization and antenatal cases.
- There are several missed opportunities for convergence. In Sitapur AWW were maintaining weight registers filled from a recent campaign of the State Nutrition Mission. About 46 children out of 143 were identified as malnourished but this information was not shared with ANM/ ASHAs for action.
- VHSNC have been constituted at gram panchayat level and ASHAs are member secretary but ANMs are the designated joint signatories of VHSNC account. VHSNCs were found to be largely inactive.
- RKS was functional at DH Jalaun but irregular meetings and poor functionality was noted at block and sub block level and in Sitapur. There appears to be lack of governance and possibility of fiscal mis-appropriation in the absence of oversight and lack of PRI participation.

WEST BENGAL

- State has 76.3% (46,585) ASHAs in position out of approved 61,000 as on August 31, 2015 (the sanctioned numbers are based on 2001 census) highlighting huge gap in selection.
- Out of these, 89.7% have already completed 3rd round of Module 6 &7 and 66% have completed refresher training.
- 18 District Area Facilitators (DAF) against the target of 25 are in place and 87 out of 6666 Block Area Facilitators (BAF) have been selected.
- About 23 Disha Help Desks are present in 8 Districts but none were present in the visited districts
- State has a radio Talk Show – a live phone in radio programme held on Wednesdays for training and sensitization on new guidelines and information.
- Knowledge and skill in the context of modules 6 & 7 is good among most ASHAs. They are effective in conveying ANC and PNC advice about nutrition, high risk signs and conducting HBNC visits.
- Drug & HBNC kits have been widely distributed.
- ASHA gets a fixed honorarium from State fund (Rs. 1500/-) and average incentive of Rs. 1995/- and is being received 3 – 6 weeks later after proper verification.
- There is no process of meeting of ASHAs above SHC level and for support structure at any levels
- ASHA help desk (DISHA) is yet to be operationalized but a sitting room with attached toilet facility is arranged for ASHAs at DH in Purba Midnapur, though it is not found in other health facilities.
- Analysis of performance is done by the DAF and details of poor-performing ASHAs (based on incentives) are sent to BMOH who after discussion can issue show-cause

notice to the ASHA about the low performance. In Cooch Behar, there was one such case under process.

- After PRI elections in 2013, VHSNCs are in the process of being re-constitution. VHSNCs are formed at the Gram Sansad level (covering one or more revenue villages). Till March 2015, **10,747** (out of 49,141) VHSNCs have been formed and **3,129** VHSNCs have opened bank accounts.
- RKS have been formed in all health facilities, regularity of meetings varies, in Cooch Behar, they rarely meet more than once a year and several of the RKS have not met since 2013-14. RKS meetings are clubbed with other meeting. There is little clarity on the specific RKS activities and expenditures.
- The process for community action for health is not yet begun in the state.

TOR 6
Information & Knowledge

OBJECTIVE:

1. To review the use of various Public Health Information Systems and any duplication among them, use of HMIS and MCTS data, mechanism for data quality review, training on HMIS and MCTS, data reporting status of urban and private facilities into HMIS and MCTS web portal and its updation.
2. To oversee availability of IT infrastructure like computer, internet connection etc., alternative mechanisms for data uploading, availability of RCH registers and use of MCTS for generation of ANM work plans.
3. To review the implementation of telemedicine of m-health solution if any, use of data from civil registration system, progress towards health call centre if any.

NATIONAL OVERVIEW

Health Management Information System (HMIS) was reformed in 2008 under National Rural Health Mission which continued under National Health Mission. The facility-wise data entry, which started in 2010 in HMIS Web Portal, has now stabilized. As of now around 90% of facilities are reporting data into HMIS Portal.

HIMS Web Portal- Data Reporting Status (2014-15)		
Facility Type	**Total Active Facilities**	**% Regular Reporting**
SC	157075	92.3
PHC	28971	82.4
CHC	8438	68.7
SDH	2283	82.8
DH	1126	90.0
Total	197893	89.7

Mother & Child Tracking System (MCTS) was initiated in 2010 for tracking of pregnant women and children, assuring service delivery and referral support for complicated/ high risk cases. The key distinguished feature of MCTS is generation of work-plans and due lists for ANMs which works as job aid in organizing service delivery. There are 2,06,815 facilities registered in MCTS and out of this around 94% of facilities are regularly reporting data into MCTS.

The scope of MCTS since then has gone far beyond and it is now being used for birth certificate generation, tracking of HIV positive women and for payments to ASHAs for activities carried out by them under RCH. However the MCTS system still suffers from limited data entry during subsequent visits of mothers and children. This impacts data quality, reliability and use. Initiatives such as USSD were put in place to support ANMs for data reporting using Mobile Phones. In addition call centres services (both central and state) were used to verify information and support ANMs/ASHA with care delivery.

The states were supported for assuring adequate ICT infrastructure in the facilities and for training and capacity building of human resources engaged in data collection, reporting, analysis and use.

Various new IT initiatives have been taken-up both by center and states. This was largely done by the states to support local information needs and by center to promote information availability for new programs and for integration of various information systems (National Identification Number for Health Facilities, Metadata and Data Standards, Electronic Health Record Standards etc). However the impact of these is yet to be seen.

KEY FINDINGS

1. HMIS & MCTS

- Facility-wise data entry across all states has stabilized in HMIS Web Portal and monthly facility performance data is readily available with a click of button. In MCTS- all states are utilizing MCTS for tracking mother and children. However the data completeness is a major concern among all CRM states.
- Users across Hindi speaking states have expressed concern regarding non-availability of formats, reports, work-plans in Hindi language both in HMIS & MCTS.
- Reporting from private hospitals is still a concern in all states. The data from urban institutions have started coming into HMIS web portal except in West Bengal.
- RCH registers are available in all states except Maharashtra. However their full fledged utilization has not initiated in Himachal Pradesh, Uttarakhand, Rajasthan and Madhya Pradesh. In Delhi ANMs reported to have difficulty in filling these registers due to its complexity. In Chhattisgarh and Andhra Pradesh Tablet-based applications (based on RCH registers) were introduced in pilot phase for data entry at the point of care.
- Use of USSD services for data reporting using mobile phones in MCTS needs further push in all States. Partial use was reported in Delhi, MP and Punjab. Only West Bengal has reported advance stages of implementation of USSD services. However

in remaining states the implementation has not yet started and in most cases ANMs are not aware about incentives linked with USSD reporting. Few states such as Delhi and UP reported technical glitches in utilizing USSD services.

- Central as well as state Call Centers are verifying records of mother and children and spreading awareness about various government health schemes.
- The use of data for program planning and monitoring is good at state and district-level. However almost all states reported to have poor data utilization below district especially at facility level. Often the data quality issues are identifiable and correctable at facility level itself but due to lack of skills the health workers are not able to manage these issues. Institutional process for data review, feedback and verification is not established in all states except Odisha.
- Training and capacity building with respect to use of information is largely weak at sub-district level in all CRM states. The induction training programs for new joinees are often delayed with limited to no focus on data analysis and use across states.

2. HEALTH ICT INFRASTRUCTURE

- Adequate ICT infrastructure (computer, internet, printers etc) is available in all States except hilly states such as Manipur, Meghalaya and Uttarakhand where serious connectivity issues were observed.
- In addition, remote and far-flung areas of Chhattisgarh, UP and Odisha have reported poor net connectivity. Assam and UP reported frequent power cuts and voltage fluctuation as major cause of concern.

New Health Informatics Initiatives

- All States have reported usage of local health information systems in addition to HMIS and MCTS to address local health data/ administrative needs. Among these majority of states have started Drug Vaccine Logistic System (Assam, Chhattisgarh, Delhi, Odisha, Punjab, Rajasthan, West Bengal); Human Resource Management Information System (Jharkhand, Assam, Chhattisgarh, Himachal Pradesh, Madhya Pradesh, Maharashtra, Odisha, Punjab, Rajasthan, Uttarakhand); Hospital Information System (Himachal Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Odisha, Punjab, Rajasthan, West Bengal); Telemedicine (Assam-Tele-radiology, Himachal Pradesh, Maharashtra, Punjab); and GIS applications (Assam, Chhattisgarh, Haryana, Jharkhand, Odisha).
- All of these systems are operating in silos and no data can be exchanged among these systems. This leads to two major problems- one, there is lot of duplications in terms of data collected by these different systems and second, patient records are kept in many information systems in pieces which cannot be accessed from one point to assure continuity of care.
- Many of the ICT initiatives taken in the states do not sustain over a period of time either due to lack of support (both technical and capacity building) or they are so rigid in design that they do not accommodate the changing needs of the users.
- Training and capacity building efforts are sporadic and training on one system does not take into account the data and information available in another system. This

leads to lack of integrated analysis and use of data available in these systems by program managers.

RECOMMENDATIONS

1. HMIS & MCTS

- Since facility-based data entry has stabilized in HMIS and has started stabilizing in MCTS there is a greater need to integrate both these systems to ensure that there is no duplication in-terms of reporting among these systems.
- Institutional mechanisms for data verification, authorization, analysis and use needs to be established in all states. Provision of reporting formats of HMIS and MCTS reporting in local language need to be made.
- Technical issues regarding usage of USSD (Unstructured Supplementary Service Data) needs to be addressed and adequate awareness needs to be promoted to improve reporting through USSD. The scope of USSD services may be expanded to promote single point entry by ANM in only one form, which can provide data to all information systems using data standards.
- Integrated training program and training calendar needs to be developed for various levels of users to promote data utilization.

2. Health ICT Infrastructure

- Additional resources can be allocated to districts/ blocks where internet connectivity is still an area of concern.

3. New Health Informatics Initiatives

- There is a need to develop integrated e-health architecture with health information exchanges to integrate available information systems at the States. Use of Aadhar/Unique Identifier should be promoted across systems to ensure identity management. Private sector needs to be persuaded to report data into HMIS.
- Information Systems which contain patient records need to follow MDDS and EHR standards so that patient records can be ported from one system to another to ensure continuity of care.
- To support program managers for planning, monitoring and management of various programs- integrated dashboards needs to be created at state level where data from all relevant systems can be put in analysed (indicator) form to support decision making.
- Guidelines need to be put in place as to how long manual record needs to be maintained in the facilities.

STATE FINDINGS

ANDHRA PRADESH

a. HMIS & MCTS

- All districts are reporting facility-wise data into HMIS Web-Portal.
- RCH registers are available in all health facilities and used for tracking pregnant women and children.
- HMIS data quality has improved over the years however still some of the Sub-canters are following area- wise reporting norm, resulting in duplication of data.
- HMIS data for deliveries are reported only from delivery points in the states resulting in high proportion of unreported deliveries against expected number of institutional deliveries. Data from private health facilities are not being captured adequately. Approximately 50 % of deliveries were not captured in HMIS in comparison to estimated deliveries for FY 2014-15
- No trainings were conducted for the newly appointed MOs/other staff for recoding/ reporting of data & data quality. The state has identified a designated person for data reporting/verification at all facilities.

b. Health ICT Infrastructure

- IT infrastructure is adequate and fully operational in all health facilities; which has helped in improved reporting in the state.

c. New Health Informatics Initiatives

- Use of Tablets by ANMs for data entry into MCTS has improved timely data reporting.

ASSAM

a. HMIS & MCTS

- The state has achieved 100% Facility wise data reporting in HMIS Web Portal two years ago.
- The RCH registers are being used to track and record mother and child data in all facilities except some tea garden/ private hospitals.
- Multiple reports are sent from the sub-centre to district leads to overburdening of staff in addition some of these reports have asked for the data which was not captured in the primary registers.
- The data managers and the accounts managers have received training for using HMIS, MCTS and PFMS systems.
- Phone calls are made to pregnant women and parents of children through Assam MCTS Call Centre. During interaction with the beneficiaries, due date of service is informed. Information about various health related schemes and facilities available

in the Government Hospitals are shared with the beneficiaries. Special calls are made to the High Risk Pregnant Women through Doctors posted in the Call Centre.

b. Health ICT Infrastructure

- Adequate IT infrastructure (Computer, Printer, Laptop, and Data Card) is available at facility level. Most of facilities were using data-cards for data reporting since BSNL broadband was not providing adequate internet speed.
- Majority of facilities reported frequent power cuts and voltage fluctuation as major concern.

c. New Health Informatics Initiatives

- State has developed "Health Services Monitoring information Systemto integrate all MIS information in a single platform.
- The state is also efficiently utilizing Human Resource Information System for managing all regular and contractual employee data-base.

CHHATTISGARH

a. HMIS & MCTS

- All the 27 districts are reporting facility-wise data on HMIS portal and Latitude-Longitude has been reported for more than 97% facilities.
- HMIS data is being used for State/ District level planning and for performance monitoring of districts and blocks.
- USSD services are not being used by ANM for updating of services delivered to beneficiary due to connectivity/technical issues and lack of skills.
- SAS VDD is not being used by the State though the license was provided to the State by MOHFW

b. Health ICT Infrastructure

- IT infrastructure and manpower are adequate for HMIS / MCTS in most of the visited facilities except for some data connectivity issues in certain facilities located in difficult to access areas.

c. New Health Informatics Initiatives

- There is a huge impetus to leverage Information Technology in health care in the State, 22 information systems dealing with various programs are being utilized in the state. Some of these information systems are Ministry driven while most of it is state specific as per need identified by the State Health System.
- Embedded design issues are affecting adoption of Tablet based RCH service reporting system (MITAN); piloted in urban areas in four districts.

DELHI

a. HMIS & MCTS

- Lack of coordination between various providers (i.e. Delhi Govt., MCD, ESI, CGHS, Railways, Army Defense, Jal-board, autonomous bodies) affects timely and complete reporting in HMIS.
- There are huge data entry gaps in MCTS in North Delhi district where only 34% of cases had data on all ANC parameters. ANMs reported difficulty in using registers due to its complexity.
- The use of HMIS & MCTS data by health service providers and health managers is poor and needs to be strengthened. The utilization is poorer at block and sub-block level.
- The USSD updation is not picking up in the state and only half of the ANMs (total 2000) have registered in the first two slots for USSD reporting.
- New integrated RCH registers proving to be difficult for entry as reported by ANMs.
- Due to lack of unique identifiers and mechanism to validate patient records- multiple providers are reporting same woman's data leading to duplication. Migratory population was a big challenge in all data entry and follow up actions.

b. Health ICT Infrastructure

- Network connectivity was not adequate across facilities. Data Entry Operators are relying on Internet Dongals for internet connectivity.
- It was observed that data was not reported from few facilities as the computers were out of order.

c. New Health Informatics Initiatives

- The In-house IT team has developed an Oracle based Software –"Nirantar". The purpose of this system is online indenting / procurement / payments / distribution / inventory management of drugs and other logistics.

HARYANA

a. HMIS & MCTS

- The state is reporting facility-wise data into HMIS Web Portal.
- There is discrepancy between different data sources. Although disaggregated data is available, it neither adequately utilized for understanding the root causes of several issues (e.g., access, equity, coverage by population groups) in the state nor become a basis for decision-making processes.

b. Health ICT Infrastructure

- State has five seater functional call center at state headquarter for verifying details of beneficiaries and feedback on health care services received. Approx. 500 calls are being made by these call agents and are also being supporting in resolving.

- Adequate ICT infrastructure is made available in the state across facilities.

c. New Health Informatics Initiatives

- Apart from central level online reporting and monitoring IT platforms, the state has progressed well in implementation of several IT initiatives. At present there are 12 information systems functioning in the state and catering to various program needs.
- The state has initiated an open source online GIS application and linked nine existing portals for map-based analysis of health data.
- Non-interoperability among online reporting portals leads to capturing of similar information across multiple portals which results in duplication of efforts.

HIMACHAL PRADESH

a. HMIS & MCTS

- All districts of Himachal Pradesh reporting facility wise data on HMIS portal from January 2014. In addition to HMIS Web Portal, state has local system- DHIS-2 wherein all the facility data is uploaded.
- In majority of facilities data was verified and signed by concerned official before entering into HMIS. However almost in all facilities visited old HMIS forms were in use. Due to this the data entered in the HMIS forms was not matching with the primary registers.
- Facility and block level functionaries were not oriented on the HMIS and MCTS as per norm and the data was not being utilized for program monitoring and supervision.
- In some of the facilities visited, it was found that the performance of nearby private facilities was being clubbed into the performance of the public facility.
- It was observed in Sirmaur district that details regarding Bank account number was not mentioned on MCP cards as well in MCTS portal
- Although ANMs were aware about USSD services, the same is not being used for updating services. Also, ANMs were not aware about the incentive they can garnish through updating records using USSD.

b. Health ICT Infrastructure

- Data entry takes place at CHC level in all districts where adequate IT infrastructure is made available.

c. New Health Informatics Initiatives

- Himachal Pradesh has introduced Hospital Information System (HIS) in all hospitals having more than 200 beds. Though the system has all modules, only registration and payments were found to be used in few hospitals.
- Recent initiative include launch of online blood bank management information system which keeps record of blood group wise availability of blood across various blood banks and provides access to the general public.

- State has tied up with Apollo Foundation and has launched telemedicine centres at Kaza and Keylong (Lahul & Spiti) to provide specialized consultations. The state is in process to expand the telemedicine network and has signed anMoU with M/S Piramal Swasthya across 25 CHCs with V-sat connectivity.
- State has initiated Acute Coronory Syndrome (ACS) registry and online SNCU. Further, the State is under process to initiating personnel management information system (PMIS) of State Government for the employees working under NHM as well.

JHARKHAND

a. HMIS & MCTS

- Facility wise HMIS data is reported in the Web Portal since 2011.Registers and formats are not properly maintained for both HMIS & MCTS.
- The MCTS data is captured through Mother and Child Protection Cards (MCP Cards) which is found incomplete and also not updated regularly.
- USSD (Unstructured Supplementary Service Data) is not used for up-dating of services provided by ANM/ASHA and incentive for updation of data through USSD as per the norms are not disbursed timely.
- The use of the available data from HMIS and MCTS at various levels is minimal; validation of data is a serious issue. Private health services are not captured under the existing HMIS reporting system.
- Work-plans are generated in few facilities. However this is not universal across all facilities. Details of mobile number of ANM/doctor are also missing from the database.

b. Health ICT Infrastructure

- Adequate ICT infrastructure is available across facilities for reporting HMIS and MCTS data.

c. New Health Informatics Initiatives

- In addition to National HMIS Web Portal and MCTS there are additional 11 health information systems functioning in the state.
- Human Resource Information System (iHRIS) project has been recently closed. Issue of handholding were evident in the state as complete data handover was not done by the development partner.

KARNATAKA

a. HMIS & MCTS

- The State is using HMIS data for review/planning purposes at district and state level. SAS WRS is used at state level for analyzing HMIS data. Regular data quality review meetings for HMIS and MCTS data are conducted at district and block level.

- There is widespread use of MCTS in the state- for issuing Birth Certificated through e-JanMa portal; for follow up of HIV infected Pregnant Women by Karnataka State AIDS prevention Society (KSAPS).
- In a few of the Sub center, the recent format for HMIS/ MCTS is not provided to the ANM.

b. Health ICT Infrastructure

- During monsoon few facilities reported power cuts and internet connectivity issues due to rainfall.

c. New Health Informatics Initiatives

- Three way conferencing call system named "Vatsalyvani" is used to connect beneficiaries, concerned Jr. Health Assistant Female and ASHA health worker through 104 Health helpline for promoting institutional deliveries and timely care.

MADHYA PRADESH

a. HMIS & MCTS

- HMIS and MCTS data is used for making presentations, formulating PIPs and attempting reviews and monitoring of programmes at state level.
- The M&E officers at sub-district level were not adequately trained to analyse and use data. There is mismatch in the MCTS format and the manual registration form available in the field.
- USSD services were rarely used by ANMs for updating of services delivered on MCTS. The incentive structure and poor connectivity at rural level probably contribute to the low pickup.
- RCH registers are available across facilities; however because of its recent implementation and lack of training, these have not been utilized so far.
- No HMIS/MCTS training has been received by some DEO since the last 2 years. Data formats were also unavailable at the facilities.

b. Health ICT Infrastructure

- The facilities across districts visited have adequate IT systems, connectivity, stationery, UPS and DEOs. There is lack of clarity as to upto how long manual record needs to be maintained in the facilities.

c. New Health Informatics Initiatives

- Madhya Pradesh has deployed seven MIS applications in addition to HMIS & MCTS. However there is considerable overlap between them. e.g. New born child is recorded in maternity wing MIS, SNCU MIS, NRC MIS in addition to MCTS and there is no interoperability among these systems, making a systematic review and analysis of continuity of care a major challenge.

MAHARASHTRA

a. HMIS & MCTS

- Facility-wise data is reported from all districts.
- RCH registers are not available in all the health facilities. At the HSC level, ANMs are maintaining 17 different types of registers.
- USSD system is not being implemented in visited the facility. District officials are using DIHS-2 Data for performance appraisal of all staffs of the health system.
- Health facilities like District Hospital/Medical College are located in urban places, but in HMIS they are mapped in rural area. Also need for training on SAS WRS was felt.
- Medical college and Municipal Corporation are not very familiar with online reporting on the HMIS web portal.
- Data from private health facilities are not being captured adequately. It is evident that more than 50% of deliveries are being conducted in private health facilities.

b. Health ICT Infrastructure

- IT infrastructure is adequate and fully operational in all health facilities.
- At Panchayat level, data entry volunteers of SANGRAM are involved in data entry for HMIS and MCTS.

c. New Health Informatics Initiatives

- There are 19 different MIS are being used in the State. However there is limited use of the data generated by these systems in the state.

MANIPUR

a. HMIS & MCTS

- Overall, 98% of the facilities are regularly reporting monthly in HMIS Web portal and 73% of the facilities are reporting data in MCTS application.
- RCH register is available in all facilities and ANM/Staff Nurses were trained to use this. However till now unformatted registers were in use across facilities.
- MCTS Work Plan (services due list) generation is not regular and not uniform across facilities. None of ANM, ASHA and beneficiaries received any call/feedback from District and State. But there were reported cases of receiving calls from MCTS Center Delhi.
- Training on USSD services given recently however no ANM, ASHA and other health functionaries are using it. No one in the state including beneficiary and service provider are receiving SMS about due services.

b. Health ICT Infrastructure

- Acute shortage of power and Internet connectivity and little skilled manpower obstructs the effective functioning of HMIS/ MCTS.

- Internet connectivity is provided in all health centres located in the valley districts; while in hilly district only four districts out of five and few blocks have been provided Internet connectivity.

c. New Health Informatics Initiatives

- State started implementation of Public Find Management System (PFMS). As of now 55% of the facilities are registered in PFMS for direct benefit transfer which is currently being done in three valley districts.
- Drug and Vaccine Distribution Management system has been approved for the State in Year 2015-16 RoP. State is under process of signing a MoU with CDAC.

MEGHALAYA

a. HMIS & MCTS

- Facility-wise reporting in HMIS formats is being done across all districts. The district health functionaries manage 100% reporting in HMIS.
- At facility level the state reported lack of adequate manpower for data entry and reporting. The situation becomes worse due to staff attrition and transfers. New staff is yet to receive training on HMIS and MCTS.
- Upon examination HMIS data was matching with the registers maintained at the facility. However the data of HMIS was not matching with the MCTS aggregate records. RCH registers are maintained at the facilities.
- USSD is currently not being used to report data. The State is in the process of distributing the CUG SIM cards to the ANM for using USSD services.
- Both centre and State level call centres are verifying the data entered into MCTS.
- The State has identified an agency for regular reporting from hard to reach area and for entering data on weekly basis.
- State officials did not receive any training on HMIS SAS WRS and it was not utilized.

b. Health ICT Infrastructure

- There are connectivity issues reported at the facility level which affects data entry into HMIS and MCTS applications.
- The State is in process of procuring computers for all PHCs/CHCs and installing VSAT for improving internet connectivity.

c. New Health Informatics Initiatives

- Other than HMIS and MCTS, there are other information systems / applications like, state specific application MHIS (Megha Health Insurance Scheme) application and NIKSHYA for Tuberculosis programme, SIMS for HIV/AIDS programme for across country are used for reporting of health programme data.

ODISHA

a. HMIS & MCTS

- State has established comprehensive mechanism for review of data quality of HMIS data. Feedback on data quality is given to districts, blocks and facilities on identified gaps.
- The HMIS data is also shared with the district collector on quarterly basis for reviewing the performance.
- The most recent training of all relevant staff was in March 2015 and consisted of a one-day zonal level review cum refresher training on HMIS and MCTS.
- Use of HMIS data at district and sub-district level is low due to lack of established process of data review and use.
- The State has leveraged MCTS during cyclone Hudhud in 2014 when data on pregnant women with expected delivery dates at the time was extracted and these women were contacted and transferred to health facilities for timely care.
- USSD based reporting has not been initiated in the state. The MCTS data is received from the sub-centre only once a month for updation. This limits the purpose of real-time data entry.
- Work Plans are generated and passed on to ANMs through Sector Supervisors but these reach late in many cases.
- ANMs are required to enter data on single events in multiple reporting formats. For example: child death is reported through IMNCI, HMIS, death line listing, Birth and Death register and MCTS database. The numbers across these systems do not match often. Methods to integrate data at the first point of its recording must be made at the Central level.

b. Health ICT Infrastructure

- Use of MCTS was severely limited in districts due to poor internet connectivity/ mobile network connectivity.
- BSNL provides very low bandwidth and additional service provider may be explored to address this issue.

c. New Health Informatics Initiatives

- In addition to the HMIS & MCTS there are 10 information systems in used in the state for various program purposes.
- The state has also developed a GIS application which uses data from these portals and helps in facility/program planning and management.
- Odisha was the first state to initiative PFMS-based ASHA payments. This has helped to streamline incentive payments to ASHAs.

PUNJAB

a. HMIS & MCTS

- All facilities in the State are reporting regularly on HMIS Web Portal except Harta Badla CHC and UPHC Islamabad.
- Private health facilities are reporting data only on few indicators such as total number of deliveries, type of live birth, number of live births and sex of the newborn.
- HMIS data is being used at State and District level for monitoring on monthly (high risk pregnancies, low birth weight babies and home deliveries) and quarterly basis (16 RMNCH+A indicators and outliers in HMIS data).
- All ANMs and LHVs have received training on USSD reporting and on RCH registers in the State.
- The data is verified later after entry into HMIS Web Portal.
- Work Plan is being used by ANMs for tracking the beneficiary and providing due services. Calls were being received from call center to ANMs and beneficiaries.

b. Health ICT Infrastructure

- Internet connectivity was found to be satisfactory in most of the facilities visited.
- Issue of logout of MCTS portal was reported in some facilities especially around 11:00 am-12:30 pm.
- After shifting of the mobile network to Idea issues were being faced by ANMs while accessing USSD services.

c. New Health Informatics Initiatives

- Telemedicine portal is being maintained by Punjab Health System Cooperation through C-DAC Mohali. During the visit it was observed that the telemedicine is used for consultation with doctors from Chandigarh, Faridkot, Amritsar and Patiala. OPD register and referral registers were maintained and proper follow up of case was being done.

RAJASTHAN

a. HMIS & MCTS

- Facility based HMIS reporting is good in the State. 93% of total health facilities (16,938 out of 18,189) in state are reporting on HMIS portal.
- Pregnancy, Child Tracking & Health Services Management System (PCTS) is State's own IT system for Mother and Child Tracking and line listing of beneficiaries. PCTS portal is integrated with MCTS; in addition it also generates aggregate HMIS reports. The portal is also linked with Swasthya Sandesh Seva for generating SMS Alerts to Citizen and Health Workers.
- Most of the errors observed in the facility reports were easily identifiable and correctable at the ANMs and DEOs levels. However they are not adequately trained to manage data quality issues on their own.
- RCH registers were not being maintained and updated based on the services delivered to beneficiaries.

- USSD services not available to ANMs for updating of services to be delivered to beneficiary registered on PCTS portal.
- ANMs in the facilities visited had not received any call from the MCTS Facilitation Centre (MCTFC) of MoHFW for validation of records and feedback. However, some ANMs/beneficiaries got the call from PCTS.
- Data Quality is not checked by supervisor before uploading on the web portal. Copies of reports submitted are not regularly maintained by all the facilities.
- HMIS & PCTS data was not being used effectively to review the status of RMNCH+A services and identify the gaps at the field level.

b. Health ICT Infrastructure

- PHCs, CHCs are equipped with computers, internet connectivity, DEOs/Information Assistants, but at places ASHA supervisors were given additional responsibilities for data entry on PCTS/HMIS.
- The facilities up to CHC level have proper IT infrastructure and are regularly reporting and uploading reports on HMIS Portal. Internet connectivity is weak in the remotest blocks of district.

c. New Health Informatics Initiatives

- State is using Multiple IT software and entries in these software are going on well in both the districts visited. In addition to HMIS Web Portal there are 11 other health information systems currently in use in State. The state is planning to launch six additional information systems to cater various program/administrative needs.
- ASHA Soft is State initiative and is functional in the State to ensure timely online payment to ASHAs, follow-up visits of HBNC and Audit of ASHA performance.
- A Whatsapp group of all the state level and district level officers/employees is connected with ASHA soft for continuous mentoring, monitoring and exchange of ideas.
- Arogya Online Project (e-Health) is State initiative to computerize the Hospitals in 15 Districts Hospitals (9 under RHSDP and 6 under NRHM) in the state.
- State has planned to initiate E-Upakaran software i.e. Equipment Management & Maintenance System (EMMS) for diagnostics inventory management. A lot of Data entering is done in E-Aushdhi at the level of DDC. But Stock outs are happening in the institutions visited.

UTTAR PRADESH

a. HMIS & MCTS

- Facility-wise data is reported in HMIS Web Portal. State had formed data audit team to check quality of HMIS data. For verification of data district level data validation committee are formed in all districts.
- RCH register is available at all rural facilities and Work Plans are generated on regular basis with the help of MCTS portal. The Work Plans generated in English are not helpful for the ANMs.

- State and Districts are using HMIS & MCTS data for monitoring, review and planning purposes. However the use of these systems is low at facility level.
- Rigorous trainings at Block and Facility level are required, which has not been started yet in most of the districts.
- The MCTS beneficiary ID number is not being entered in labor room register/MCP card at many facilities in Sitapur. MCTS reporting is low in several blocks.
- USSD training is imparted but is not being used by ANMs due to technical glitches.
- SAS VDD is not being used by the State, although WRS is being used for monitoring purpose by state data officials.

b. Health ICT Infrastructure

- Computer, internet, printers were present at block level however in few block and all below facilities these are not adequately available.

c. New Health Informatics Initiatives

- IT based activities like m-Sehat to convert ASHA VHIR into a mobile app is currently at nascent stages in both districts, Hausala Sajhedari & Pyari Bitiya are good initiatives taken by State, but needs regular review, monitoring, training and follow-up to ensure effective implementation.

UTTARAKHAND

a. HMIS & MCTS

- State is doing facility-wise data entry into HMIS Web Portal as of now 99.4% of facilities are reporting data regularly.
- The HMIS and MCTS data are not been used extensively for the monitoring purposes. Although, review meetings were held on at the facility level on the reporting data but the MO I/Cs were unaware of any reported outliers and validation errors.
- Facility-based performance audit was not adequate and needs to be strengthened. Use of HMIS for taking corrective actions needs more attention from the block, district & state level.
- The data mismatch of HMIS and MCTS was noticeable in both of the visited districts. Even in health facilities, some of the data items were not in sync with physical registers.
- The uploading of validated phone number of ANMs and ASHAs on MCTS portal is a major concern.
- USSD application has not been effectively implemented in the state. Out of the total registered health providers only 0.40% have subscribed on USSD for updating service delivery data. Out of these subscribed users, only 1.07% health providers are using USSD service for service delivery data updation.

b. Health ICT Infrastructure

- Most of the health facilities in state upto PHC level are equipped with IT infrastructure/ support i.e. computers and internet, although single computer is available for HMIS, MCTS and other general work which hampers the pace of work.

- Due to difficult terrain the internet connectivity remains an issue in many facilities situated at the middle and upper Himalayas.

c. New Health Informatics Initiatives

- The State is utilizing information system for human resource management.

WEST BENGAL

a. HMIS & MCTS

- Integrated RCH Register was being used in all the Sub Centers in the State. Incompleteness of the RCH registers was one of the key issues observed in the field. Recording in RCH register is yet to be started in the Urban Health facilities.
- Facility-wise data with 100% reporting is done in HMIS Web Portal in State. Urban Facilities are mapped in the portal however the data entry for urban facilities is yet to be initiated in the state.
- There are observations regarding lack of clarity in reporting certain data elements such as AYUSH OPDs where only Ayurveda OPDs are reported and not the Homeopathy.
- HMIS and MCTS data were used at different levels of health facilities. District Statistical Manager identifies and rates the poor and good performing facilities on various indicators.
- There are many quality issues such as incorrect reporting, double reporting, manual reporting are identified during visits.
- The team observed that the quality of training given to the Data Entry Operators is compromised. Only one day training cum orientation was organized for the DEOs, which was inadequate.
- The team observed that the Work Plans have been generated out of MCTS sub center-wise and not ANM-wise, which leads to partial updation of Work Plans.
- USSD has been taken up in the state well. As per the status provided 100% validation of the mobile numbers has been completed in the MCTS portal. However there are certain technical glitches reported such as unlocking of ANM mobile numbers.

b. Health ICT Infrastructure

- Computer, Internet etc were available at the block level across the districts visited by the CRM teams, but, computer was not functional in the ICTCs in the District Hospital- PurbaMedinipur.

c. New Health Informatics Initiatives

- The State has initiated five different IT enabled systems- SMIS for store management, HIPMS for Hospital Information Planning and management, OPD tracking System, MCS- Tracking system and)Online CE for registration of clinical establishment and licensing.

TOR 7
Health Care Financing

OBJECTIVES:

1. Review status of fund release and utilization, status of financial allocation to identified High Priority Districts, registration status of District Health Societies, RKS and constitution of VHSNCs, problems faced by facilities in utilizing NHM funds on time.
2. Oversee fund flow mechanisms, implementation of Public Financial Management System (PFMS), status on CAG and Concurrent Audits, Action Taken on report of Institute of Public Auditors of India (IPAI), RSBY and State specific health insurance scheme and its integration with NHM.
3. Review adequacy and effectiveness of finance management, capacity and training of finance personnel and delegation of financial and administrative Powers at all levels.

NATIONAL OVERVIEW

One of the most important goals of the NHM has been to increase public health expenditure on health targeted to reach 2 to 3% of the GDP from 0.9% in 2004-05. Though still short of the 2 % of GDP mark, public health expenditure has increased at a faster rate than the pre-NHM period. The Government expenditure on health as a share of GDP increased from about 0.9 per cent in 2004-05 to 1.2 per cent in 2013-14. From its inception in 2005-06 to October 2015 about Rs.1.44 Lakh Crore has been released under National Health Mission by the Union Ministry of Health. The utilization of funds was low initially but in the recent years fund utilization has improved in almost all the states. States have improved their capacity in financial management and in most states funds now reach the health facilities through electronic transfers. Through directly targeting provision of quality healthcare services at public health facilities and through public private partnerships where required, the NHM has improved access to healthcare services. It has also addressed high out of pocket expenditures on healthcare especially related to child birth through Janani Surakahsha Yojana (JSY) and Janani Sishu Surakasha Yojana (JSSK). In 2013-141, Delhi (Rs.1775) has reported a high per capita public health expenditure (PHE) followed by

1 PHE figures are from "Health Sector financing by centre and states/UTs in India (2013-14 to 2015-16).

Himachal Pradesh (Rs.1649). Low per capita PHE was reported in Uttar Pradesh (Rs.455) followed by Odisha (Rs. 466).

In 20142, annual per capita OOP on health care in India is reported as Rs. 2141. The average out of pocket expenditure (OOPE) on hospitalization is reported as Rs 17132. Disaggregated by type of facility, it is Rs. 5920 in a public facility and Rs. 24129 in a private facility. OOPE per childbirth in India in a public facility (Rs 1, 679) was lower than private facility (Rs 16, 436). The average OOPE on childbirth in public facility in rural areas has also reduced by 36% (from Rs. 1165 in 2004 to Rs. 749 in 2014 in real terms). A similar reduction of 5 % is observed in urban areas (from Rs. 994 in 2004 to Rs. 948 in 2014 in real terms)2. Further reduction of OOPE requires attention through improving implementation of patient transport services, free drugs and diagnostics initiative program and other programmatic deficiencies where ever observed.

KEY FINDINGS

FINANCE MANAGEMENT AND ADMINISTRATIVE CAPACITIES

- Financial and administrative power from State Health Society to District Health Society has been delegated in states.
- Human Resource (HR) gaps for Financial Management staff to be filled urgently. States like Andhra Pradesh, Odisha, Haryana, Rajasthan, Madhya Pradesh, Chhattisgarh, Uttarakhand and Uttar Pradesh have vacant positions for finance and accounts officers at various levels.
- Shortage of accounts staff, inadequately trained staff, lack of computers and internet impact the financial management in terms of delay in allocation of budget to facilities, release of funds to ASHAs and beneficiaries and preparing bank reconciliation statements.

PROCESS AND EASE OF FUND FLOW

- Some states are unable to meet the requirement to contribute their share of finances to NHM. There are also delays in fund transfer from Centre to state treasury and then to State Health Society. It has also been observed states like West Bengal, Delhi, and Haryana have not allocated additional funds to high priority districts.
- In almost all the states, funds are being transferred from state to the district level via electronic transfer (e-transfer). Direct beneficiary transfer (DBT) to the last facility and beneficiary has been implemented in most of the states. In Meghalaya, Chhattisgarh, Jharkhand, Andhra Pradesh and Punjab, cheque payment is still being made in some districts for JSY payments.

2 NHSRC's analysis from National Sample Survey Organization 71st round(2014)and NSSO 60th round (2004-05)

- Under utilization of funds observed in some states across all pools like Andhra Pradesh, Delhi, Jharkhand, Maharashtra, Meghalaya, Punjab and West Bengal. Poor utilization of funds under NUHM is observed in all states.

MEASURE OF ENSURING ACCOUNTABILITY

- Statutory and Concurrent audits are conducted regularly in most states, but timely submission of concurrent audit reports still remains a problem in states like Karnataka, Delhi and Punjab. There is a need to strengthen concurrent audit system for better internal control in all states.
- Most states accounted for and utilized interest earned on unspent balances as per guidelines. Interest earned at state and district levels are converted into grant and are being utilized on approved activities.

FINANCIAL MANAGEMENT AND MONITORING

- PFMS Registration of agencies has been completed only in the state of Maharashtra. The states of Andhra Pradesh, Assam, Haryana, West Bengal, Uttar Pradesh, Chhattisgarh, Rajasthan and Himachal Pradesh are in the process of completing the registration of agencies while Meghalaya and Manipur have completed less than 50 per cent registration.
- Expenditure filing has not been started through PFMS in states as majority of the states are facing difficulties while working with the PFMS software and have requested further training for the accounts staff.
- Monitoring of financial management needs to be strengthened across all the states. In most states, there is no system to determine and identify unclear payments
- Most states are maintaining books of accounts as per NHM guidelines. States like Andhra Pradesh, Meghalaya, Jharkhand, Uttarakhand, Haryana and Manipur still do not use Tally ERP 9 software for book keeping at all levels.
- In almost all states, physical progress is being reported along with financial progress in the Financial Monitoring Reports (FMR) at the District and Block level. However, it has not been observed in Meghalaya and Chhattisgarh.

TRENDS IN OUT OF POCKET PAYMENTS

- Most of the services are provided free of cost or at subsidized rates to below the poverty line (BPL) population. User fee are not charged from BPL households, pregnant women and children. Further in all states BPL patients still incur out of pocket expenditures due to unavailability of medicines, drugs and diagnostics at public facilities. In addition, patients spend on transportation despite free ambulances available in several states. States like Meghalaya, Assam are not implementing JSSK properly.
- Many states have implemented insurance programs like RSBY or the state specific health insurance which have reduced out of pocket payments (OOP) to an extent. However there is a need to improve the benefits offered and operational processes

so that no beneficiary is turned away from either empanelled public or private facility.

RECOMMENDATIONS

1. Timely release of funds from centre to state and state treasury to state health societies should be ensured for better utilization of funds.
2. States need to examine the reasons for underutilization of NHM funds in general and NUHM funds in specific and take necessary steps towards better utilization of these funds. Besides NUHM, other areas of low utilization for RNTCP, NTCP and training needs to be assessed and funds reallocated if needs have changed.
3. Necessary steps should be taken to fill finance and accounting positions in the states. Recruitment of accounts officers/ accountants at lower facility level or rationalizing posting of available officers to ensure proper book keeping at all levels is required.
4. Accounting staff at block level and below need to be trained in financial management. Strict adherence to book keeping/ accounting practice for accurate reporting of transactions is required.
5. Necessary steps should be taken to strengthen the monitoring of Financial Management at all levels. Monthly meeting of DPMs/DAMs along with CMHOs may be held for monitoring the physical and financial progress of the programmes. Visit calendar should be prepared and enforced.
6. Internal control system should be developed for passing bills of suppliers, contractors, vehicle hire, payment of security, purchase of medicines, etc. States should ensure timely submission of SOEs and UCs.
7. Implementation of DBT through PFMS should be prioritized. However, delays in Banks releasing the funds should be examined.
8. PHC/CHC Accountants and Block Programme Managers should monitor the unspent balance of VHSNCs.
9. Timely payment to JSY beneficiary needs to be monitored from DHS level. DBT though PFMS or Account payee cheque to be issued to JSY beneficiary should be implemented for payment.
10. Existing Tally ERP 9 software should be implemented at state and district level and new staff at lower levels to be trained in a timely way. Hard copy of financial report generated from Tally ERP 9 should be kept at all levels duly signed.
11. States should take steps to introduce free drugs and diagnostics schemes, strengthen patient transport systems and improve implementation of JSSK to reduce OOPE.

STATE FINDINGS

ANDHRA PRADESH

- State share contribution in financial year 2015-16 has not been fully transferred (shortfall of Rs. 113 Crore). Fund utilization needs to be improved especially in RCH (29% utilization), NUHM (15%) and RNTCP (17%) and NTCP (11%) components.

- Vacancies for Financial Management staff to be filled especially the post of State Account Manager and Block Accountants.
- The State has issued delegation of financial powers up to Sub centre level. Transfer of funds is proper to DHS/ CHC/PHC levels. E-transfer of funds is observed from District Society to all CHCs and PHCs. PFMS registration of 92% of agencies is completed. However it has been observed that JSY beneficiary's payment is being done through cheque in Visakhapatnam District. Also JSY payments are irregular and delayed due to shortage of funds.
- Tally ERP 9 are not working at State and District level as it needs renewal of license. Consolidated FMR was not prepared at the state level through Tally ERP9.
- The state has the NTR Vaidyaseva (formerly the Rajiv Aarogyasri) that provides cashless treatments for healthcare services to BPL households for certain diseases in empanelled public and private hospitals.

ASSAM

- Group Bank Account guidelines not implemented, wrong practices in maintenance of Bank Reconciliation Statements at all levels.
- Under JSSK activity, free drugs and diet not being provided to the patients.
- There is no compliance with Statutory Audit and Concurrent Audit reports. Monitoring visits should be followed to have better managements of financial records.
- All the payments towards ASHA incentive and JSY beneficiary are being paid through a/c payee cheque or e-transfer.
- 99% registration of Agencies on PFMS portal is complete. Expenditure filing through PFMS portal has not been initiated
- Patients make out of pocket payments for medicines, Blood etc. It is suggested that to minimize the out of pocket expenditure, further steps may be taken-care.

CHHATTISGARH

- Positions of account/finance staff are vacant and no systematic financial training at sub-district level is available.
- Funds are being released to the respective program accounts directly at all level without routing them through the main accounts.
- The State is yet to submit the Statutory Audit report for the FY 2014-15 to GoI.
- Records/books of accounts at District level are well-maintained but at the Block and PHC level the records were not maintained as per the prescribed NHM norms.
- Payment to JSY beneficiary is being made through A/C payee cheque at the time of discharge, no delay in JSY payment observed.
- Physical progress against the financial achievement is not being reported in the FMR in both of the DHS; SHS also reported partial physical progress report in FMR.
- The State has registered 69% of the agencies under PFMS.

DELHI

- The overall fund utilization is low in the state with only 14.37 per cent utilization.
- The mechanism of additional funding for high priority districts has not been implemented in the state. There is no system of responsive/ differential funding of untied funds.
- There is no cash book for NHM funds, no periodic reconciliation of NHM balances with bank, etc.
- The delay in fund release to SHS, after it is received by the state government, is about 100 days.
- All fund transfers to district and sub-district units are through electronic funds transfer system.
- The payment is released to the JSY beneficiaries using DBT under the PFMS system by the health facilities.
- The quality of audits, especially the concurrent audits, needs improvement.
- The RSBY which was initiated in the state is non- functional since the year 2013. The state has established 'Aam Aadmi Clinics' and 'Mohalla Clinics' in urban slums to provide healthcare at door step.

HARYANA

- There is a shortage of accounts assistants below the district level. On average one accounts assistant is maintaining the accounts for 3-4 PHC.
- There has been a delay in funds transfer from the state treasury to the SHS account.
- There is lack of funds and several activities are being withheld. Contractual staff is being curtailed and salaries and incentives are not being released.
- High priority districts are not receiving any additional funds from the state under NHM.
- Differential/ responsive funding of untied funds is being practiced effectively.
- The statutory audit for FY 2014-15 has been completed and the report has been submitted to MoHFW. Concurrent audits for 19 out of 21 districts in Haryana have been completed.
- State is using Tally ERP 9 customized software. The Tally ERP 9 customized software is not being used at PHC level.
- The current status of PFMS registration is 94 per cent. All the districts have started real time payment using PFMS. FMRs are not being generated. Operational issues of PFMS need to be addressed.

HIMACHAL PRADESH

- The State has utilized 60% of the funds released by GOI & State in the current financial year.

- High Priority Districts have received 30% more Budget under activities wherever applicable.
- There was no delay in the transfer of funds from the State Treasury to the State Health Society
- State should follow differential funding of untied funds as per GOI guidelines in all the facilities. State should monitor the activities on a monthly basis both release of funds and their utilization under the selected activities like untied funds, AMG and RKS funds
- State should register all agencies under PFMS. 550 agencies still are to be registered under PFMS.
- Proper books of accounts have been maintained on double entry system.
- JSY payments were being returned unpaid due to errors in the Central server thereby causing problems in reconciliation.
- Insurance scheme other than RSBY is being implemented in the state with extended coverage amount. However, it was observed there is OOP expenditure being incurred mostly on medicines.

JHARKHAND

- The state has been able to utilize only 17 per cent of the approved budget under NRHM-RCH Flexible Pool and 8 per cent approved budget of the NUHM.
- Transfer from state treasury to SHS bank account via Bankers cheque / Demand drafts took around 45- 60 days. From SHS the amount is transferred to programs account. E-transfers of funds fund is available up to HSC level.
- Interest earned against NRHM funds is not being accounted for at the sub-district level. All the institution need to account for the interest earned in the NHM bank accounts and use them for implementation of approved activities in the PIP.
- Books of accounts are maintained manually at most institutions, the other records such as ledgers, advance registers etc. were found incomplete. Only few blocks were reported to be using Tally software.
- Physical along with financial progress was reported in the Financial Monitoring Reports (FMR) at the District and Block level.
- The JSY beneficiary payment was mostly being done through a/c payee cheques with exception of some institutions where payment was done by DBT mode.
- RKS meetings are not being conducted on regular basis.

KARNATAKA

- A majority of funds are unspent. Low utilization of funds is observed in 2015-16 under some programs. RCH is 35%, NUHM is 5% and MFP is 19%
- Funds are released activity wise rather than pool wise leading to low pace of utilization and blocking of funds for a particular activity irrespective of the utilization.

- Expenditure incurred under many activities remains unreported. There is a need for strengthening of adequate monitoring.
- Updated books of accounts have been maintained, Bank Reconciliation is regularly prepared. Funds are released through e-transfer to lowest peripheries.
- Statutory Audit Report and Audited UCs for the F.Y.2014-15 are delayed. Concurrent Audit Mechanism needs to be strengthened.
- Planning mechanism is inadequate to foresee requirement of funds. Lack of adequate integrated planning at village/Taluka and PHC/CHCs leading to delays in fund release.
- Facilities charge user fee for APL households for registration and diagnostics. Services are provided for free to all BPL households, pregnant mothers and children under JSSK and JSY. None of the BPL households and mothers and children incurred any OOP at the facility. Beneficiaries of the insurance scheme also did not incur any OOP.
- State has its own insurance scheme for tertiary care operated through the Suvarna Aarogya Suraksha trust (SAST). The Vajpayee scheme covers 449 procedures and 60 follow-up packages for below poverty line households. Financial limit is Rupees 1.5 lakh per family in each fiscal year, extendable to additional amount of Rs.50000. The Rajiv Aarogya Bhagya Scheme for the population above the poverty line requiring sharing costs by the household up to 60% of cost of the treatment.

MADHYA PRADESH

- Tally ERP 9 has been implemented up to the block level. Pass books were not updated regularly at most of the health facilities visited.
- Bank Reconciliation Statement has not been prepared on a monthly basis below the district level. Suspense Account balances has still been lying not reconciled at the blocks even after finalization of the statutory audit for the relevant financial year.
- Cash book was available in all the facilities visited. However, the same has not been daily updated in almost all the facilities.
- The State follows the policy of centralized appointment of Concurrent Auditor for the state and district level. Appointment of Concurrent Auditor for the state level and at all the districts has been completed for 2015-16.
- JSY payment is being done through DBT. However, delay in payments to JSY beneficiaries has been observed in almost all the facilities.

MAHARASHTRA

- There is a pending central release from State Treasury to State Health Society.
- The State has low utilization levels under various pools/schemes.
- Customized Tally is in use by the State up to Block level to take care of all regular accounting activities.
- JSY beneficiary payment is being made through DBT system in 11 districts; the State shall start JSY beneficiary payment via PFMS portal shortly

- Agency registration has been completed on PFMS portal. Expenditure entry is not done as there is no PFMS training for DAM and BAM.
- ASHA is being paid via RTGS payment system; trainings have been conducted for payment to ASHA from PFMS portal and will be implemented soon and in some district payment to ASHA is being made via PFMS portal.
- Cash Book is maintained manually; the same is not as per the prescribed format and the FMR Codes are not written in the Cash Book.
- High OOP expenditure observed in cases when the expecting mother does not avail NHM services of ambulance, or it is in case of companions, etc.

MANIPUR

- Orientation/training for financial management and accounting procedures is needed. Regular supervision and hand-holding required for ensuring implementation of laid down processes in finance manual
- The NHM programme managers were not fully aware of any other programs outside part A (i.e. RCH, Immunization and Mission Flexi pool).
- JSY payment is being made to JSY beneficiaries in cash. In few cases e-transfers are made but mostly it is either bearer cheque or cash.
- 43 % agencies are registered on PFMS portal.
- Though RKS meetings are taking place, financial details of activities undertaken are not being shared with the members.
- There is high out of pocket expenses primarily on drugs, diagnostics, and transport.

MEGHALAYA

- High priority districts have been receiving more budget than other districts.
- Fund utilization is low with only 12% under RCH, 13% under HSS, 10% under NUHM, 8% under NDCPs, 7% under NCD pool against its approval of 2015-16.
- State has not reported physical data along with the financial data in FMR.
- PFMS registration is completed in only 41% agencies and SW Garo Hills has no registrations. DBT, payment of ASHA Incentives and expenditure filing has still not started.
- JSY payments significantly delayed (more than 1 year in some cases) and erratic in both the districts. Cheque payments are made and in some cases the payment made in cash which is against the NHM norms.
- Beneficiaries being paid cash compensation in lieu of diet and transport facility which is not recommended in the NHM guideline
- The problem of integration of accounts of other National Health Programs like NPCDCS and for other NCDs exists at the state, district and facility level.

ODISHA

- Vacancies have been noted in the finance and accounts positions (mainly at District and Block level under the position Addl. Director Finance at State level).
- No systematic orientation/training is provided to the finance and accounts staff at sub-district level leading to inadequate understanding of financial guidelines and weaker financial management at the block and lower level.
- The State has reported low expenditure under untied funds/AMG/RKS (14%) and under RCH Flexi pool reported expenditure is low. Low/Negligible expenditure has been reported by the state on core activities i.e. Maternal Health, Child Health, Family Planning Services, RKSK, RBSK, NUHM.
- Difficulty in using PFMS due to poor/ no internet connectivity in CHCs. Expenditure filing through PFMS has been started. No FMR has been generated through PFMS.
- Payment to JSY beneficiaries are being made through DBT/E-transfer. Delay up to one year has been observed in JSY incentive in PHC level. Presently no mechanism exits for monitoring/tracking of non-payment at facility level/district level.
- Under the insurance programs, timely settlement of the claims by the insurance companies under RSBY and BKKY is not happening. This needs to be taken up with the insurance companies for cost and care.

PUNJAB

- The State Government has large unutilized funds of the previous year.
- There is no problem in releasing the funds from Treasury as it takes around one month. For AYUSH, it takes more time to get the funds from the treasury.
- The flow of funds from state to district/sub-district level, PHC/sub-centre level is smooth and there is fully computerized system and proper records were maintained.
- JSY payments were made through cheques only during visit.
- In the state PFMS has been initiated and very soon all the facilities will be covered under PFMS.
- Concurrent and Statutory Auditors have been appointed as per the guidelines issued by NHM. Audited report for previous financial year has not been submitted by State Government. In context of RFP/TOR related to appointment of auditors, the present TOR is insufficient for transparency of the system and quality of services. Need to take up the matter with CAG and CVC to revise the TOR.

RAJASTHAN

- Post of Director Finance and many other are vacant. Continuous recruitment advised to fill-up vacancies.
- HPD has been issued 30 per cent more budget as compare to normal districts.
- Funds are transferred to the main bank account of SHS by cheque from treasury within 15-30 days, and from there, it is transferred to programs bank accounts.

- Below the CHC level the payment for JSY, is not credited through DBT and cheque clearance delay exists.
- PFMS registration was still pending in almost 30% institutions. Issues relating to this low registration should be taken up.
- Free medicines, free investigations, transportation for JSY, user fees for JSY, BPL & Senior Citizen, subsidized food for all patients and relatives is implemented.
- Mukyamantri Subhlaxmi Yojana is running for promoting female births. Also Mukyamantri Jeevan Raksha Kosh scheme is running for free medical services of BPL families. The OOPE has been mainly for transportation.

UTTAR PRADESH

- There are some vacant position in state for financial Staff, grant reconciliation has not been done by Block with Districts, Under all programmes of NHM advances to other agencies are pending settlement for more than one year
- More funds are being allocated to HPDs and trained staff is working in HPDs.
- Activity-wise fund utilization is monitored through the FMR submitted by the district. Activities with good performance and bad performance are being identified and instruction is being issued to CMOs for making appropriate action.
- Funds from state treasury to State Health Society bank accounts are being transferred through NEFT/RTGS
- 83% of agencies have been registered on PFMS portal.
- Payment to JSY beneficiary is being made on DBT through the PFMS portal. There is a delay in payment of JSY is due to non-availability of bank accounts of JSY beneficiary.

UTTARAKHAND

- Vacancies for accountants need to be urgently filled. There is limited supervision of the Block level and weak local procurement practices.
- Training for all finance personnel (State, District, Block, etc.) is needed in PFMS, best practices in financial management in India and the rules and procedures of GOI/ State Govt.
- Tally ERP 9 is being used at the District level. In the district of Nainital, no records are being maintained in Tally ERP 9 since financial year 2015-16. However manual records were available.
- HPDs are allocated around 25% - 30% more funding per capita as compared to other districts in the state as stated by the state officials.
- Payments to JSY are prioritized among other programs not being implemented fully. Informal payments from JSY beneficiaries are prevalent in the state.
- The State has requested for further training on the PFMS from the Centre.
- The State has launched the Mukhyamantri Swasthya Bima Yojana for financial protection of BPL population.

WEST BENGAL

- The State Exchequer transfers the funds to the account of SHS by E-transfer. Duration of total process is around one month.
- Registration of agencies under PFMS is 96%. Districts have not started filing expenditure on PFMS or FMR is generated through PFMS.
- Fund utilization was low in RBSK, District Health Action Plan, NUHM, RCH Training, IEC/BCC activities, Procurement under NRHM, several areas under National Vector Borne Disease Control Program, and National Leprosy Eradication Program and none under the iodine deficiency program.
- Additional funds are not allotted to High Priority Districts but State allocated funds for some specific activities for High Priority Districts for example, Construction of Mother & Child Hub, Mobile Medical Unit etc.
- Tally ERP 9 customized software in use at Block level, though no recent training has been conducted
- State has rolled out the RSBY scheme for BPL and certain occupations. Additional support for inpatients for transport has been provided under the scheme
- Payment to JSY beneficiary is made mainly through DBT and only 10% of the cases are through cheque. There are no cash transfers. Delays only 7-15 days from bank side.
- Under JSSK, all women and children get free services utilizing public facilities. While OOP were not found for consultation, ANC, PNC, medicines, diet and delivery. However, OOP expenditures were incurred on transportation to health care facilities. To reduce out of pocket expenditures fair price shops till SDH level (at 45-75% of MRP), very useful to patients not getting medicines from EDL.

TOR 8
QUALITY ASSURANCE

OBJECTIVES:

1. Review implementation of the Quality Assurance activities, constitution and functioning of various committees (at State, District & Facility Level; as per recommendations contained in 'Operational Guidelines for QA in Public Health Facilities'), status on recruitment for the QA units and its operationalisation, and State having a Road Map for Quality Certification of the Health Facilities.
2. Oversee the progress towards annual targets of certification, as approved in the RoP, training for QA, internal assessments of facilities, gap closure as per action plan and external assessment and system of Grievance redressal mechanism.
3. Review of roll-out of Kayakalp Initiative which largely involves formation of State level Award Committee and District Level Award Nomination Committee, Conduct of Kayakalp Awareness Training & External Assessors Trainings, Internal Assessment, Peer Assessment and External Assessment of Districts Hospitals (or equivalent) against the Kayakalp tools, declaration of Awards, follow-up action on gap-closure for improving the 'Swachhta'- at the Facilities.

NATIONAL OVERVIEW

Quality Improvement in Public Health Systems is means to achieve optimal efficiency with limited resources focusing on activities that are responsive to community needs and improving population health. A few milestones in the improving quality of care in public health facilities are listed below

RCH scheme in 1997, with improvement of quality as one of its main objectives, brought the focus on 'Quality in Healthcare'. While the National Health Policy (2002) noted that the reach and quality of the public health services was below the desired standards, one of the key focus areas of Tenth Five Year Plan (2002-2007) was improvement of "the efficiency of the existing health care system, quality of care, logistics of supplies of drugs and diagnostics and promotion of the rational use of drugs. "The concerns for quality of health care services are also duly reflected in the draft National Health Policy (2015)

The goal of National Rural Health Mission launched in 2005 was to "improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children". Another watershed moment in the quality improvement initiative came in March 2005, when the Honourable Supreme Court in Ramakant Rai and Health Watch UP and Bihar vs the Union of India (Writ Petition (C) No 209 of 2003), directed all states to set up a quality assurance committee (QAC) at the state and district level

Following the declaration of the Eleventh Five Year Plan (2007-2012) that "Development of uniform standards for infrastructure and service delivery" would be a priority area, IPHS were launched in 2007 and later revised in 2011 for all levels of public health facilities, focusing technical aspects in quality of care. A pilot project for Quality Management Systems through implementation of ISO 9001:2008 standards in district hospitals of Empowered Action Group (EAG) states was started by NHSRC in April 2008.Other quality improvement initiatives, like NABH, Family Friendly Hospital Initiative (FFHI) were also adopted.

Finally, based on specific requirements of Public Health System, National Quality Assurance Program was launched in November 2013 with the release of 'Operational Guidelines for Quality Assurance in Public Health Facilities" along with Assessors Guidebooks for District Hospitals. Subsequently, Standards and guidelines for Primary Health Centres and Community Health Centres were released in December 2014 followed by Standards for Urban PHC. All states and UTs have adopted National Quality Standards and Guidelines for improving quality of services and certification.

Implementation of Quality Assurance Standards and 'Kayakalp' Award scheme are key focus areas of MOHFW. The implementation requires reconstitution of State & District Quality Assurance Committees, Operationalisation of Quality Assurance Units, Capacity Building and Assessments followed by the supportive supervision. All states have reconstituted SQAC and operationalised State Quality Assurance Units except the State of Jammu & Kashmir. A pool of 1007 Qualified Internal Assessors and 119 External Assessors has been created as a part of Capacity Building efforts. The States & UTs are making an endeavour for State level Certification & National level QA Certification of Public Health Facilities. In December 2015, assessment of District Hospitals under Kayakalp Initiative has been completed in 24 States.

KEY FINDINGS

Organisational Structure for Quality Assurance: State Quality Assurance Committees have been constituted in all the states visited. District Quality Assurance Committees have also been constituted in all the states except Andhra Pradesh. Functionality of these committees in terms for periodic meeting is still an issue in some states, more so at district level. Meetings of State Quality Assurance Committees and District Quality Assurance Committees are not held at six monthly and quarterly intervals respectively, as mandated in "Operational Guidelines for Quality Assurance in Public Health Facilities.
The quality assurance program envisages establishment of Quality Assurance Units at State and District level with full time professionals to support their respective QA committees. The constitution of SQAU and DQAU is still a challenge in many of states as recruitment of full time professionals has not been done.

Training and Capacity Building: - Trainings plays a pivotal role in building capacity of QA team and the MOHFW supports Awareness Workshop, Internal Assessor Training,

Training for Service Providers, External Assessor Training, and Thematic Trainings focused on Patient Safety, Bio Medical Waste Management, Infection Control, Patient Satisfaction etc.

Delhi, Himachal Pradesh, Jharkhand, Madhya Pradesh, Meghalaya, Rajasthan, UP, Andhra Pradesh, Manipur, Haryana, West Bengal, Chhattisgarh, Punjab, Assam, Odisha and Maharashtra have conducted Internal Assessor Trainings with the support of NHSRC.

Service Provider Trainings are being conducted in MP, Punjab, Meghalaya, Rajasthan, UP, Haryana and West Bengal. While states like Assam, Delhi, Himachal Pradesh, Jharkhand are yet to start these trainings.

Baseline Assessment of Facilities (Facility Assessment and Gap Analysis): Quality Assurance is a continuous and cyclic process, which requires regular facility visits and its assessment against standards and scoring is required to identify gaps and formulation of action plans.

States have taken initiatives for baselines assessment of its public health facilities but overall progress is slow. Odisha has completed baseline assessment of all DHs and SDHs and the numbers vary in other states, except Karnataka where no assessment has been done. In Assam baseline assessment of 5 facilities has been done by RRC-NES.

Certification of Facilities: - Facilities have beenidentified for State/National Certification, which is the First Milestone of implementing the NQAS standards. So far only DH Panchkula in Haryana and DH Avanti Bai of UP have applied for National Certification during FY 2015-16

Common observation is that progress after Assessment/Gap Analysis is slow in terms of Prioritization of Gaps, developing Action Plan, implementing measures of ensuring Quality Care (detailed below), closing gaps and preparing facilities for certification.

Measures for ensuring Quality of Care at Public Facilities:

- **Standard Operating Procedures:** Standard Operating Procedures (SOPs) are an integral part of Quality Management System. Many states have developed SOPs under quality assurance program. E.g. SOPs have been developed at some of facilities in Himachal Pradesh, Jharkhand, Uttarakhand, Uttar Pradesh and Andhra Pradesh. Ten facilities in Odisha have formulated as well as implemented the SOPs. MP has developed templates of SOP at state level and disseminated to health facilities. In Himachal Pradesh, Jharkhand, Uttarakhand, UP and Andhra Pradesh one facility each has developed SOPs. Chhattisgarh has also developed SOP on some specific areas, but implementation of the same is not found in facilities. 6 facilities in West Bengal, 10 DH in Haryana, and in 2 facilities Manipur 2 have also developed SOP, but they were not found in any of the facilities visited in Punjab, Meghalaya, Assam and Maharashtra.
- **Measuring Patient Satisfaction Survey:-** Level of satisfaction of patients visiting a health facility is the litmus test of quality of services delivered. Public Health Facilities in Haryana, Delhi, Maharashtra and Odisha are conducting patient satisfaction survey. States like Andhra Pradesh, Himachal Pradesh, Meghalaya, Madhya Pradesh, Manipur, Assam, Punjab, Karnataka and Uttar Pradesh are yet to start Patient Satisfaction Surveys. However even in states like Rajasthan where Patient Satisfaction Surveys are

being conducted, there is much scope for feedbacks to be analyzed and efforts to improve satisfaction levels

- **Measuring Key Performance Indicators:** Reporting and analysis of the Key Performance Indicators has started Madhya Pradesh, Maharashtra, West Bengal, Haryana, Manipur, and Odisha. Uttarakhand, UP, Rajasthan, Meghalaya, Jharkhand, Punjab, Himachal Pradesh, Delhi and Karnataka are yet to start KPI reporting. On the positive side, many states have issued enabling order for monthly reporting of Key Performance Indicators.

- **Bio Medical Waste Management: -** Biomedical waste management has emerged as a major area of concern during the CRM visits with variable degrees of implementation. BMW Practises were fair in Punjab, Odisha, Meghalaya, and in some facilities of Maharashtra. Poor implementation was observed in Rajasthan, Andhra Pradesh (low knowledge about waste disposal and segregation of waste) and Delhi (mixing of BMW at the point of generation). Improper segregation of waste was noticed in Himachal Pradesh, Assam, Jharkhand, Haryana, Karnataka and West Bengal, while improper disposal was seen in Madhya Pradesh, Uttar Pradesh and Uttarakhand. Correct segregation of biomedical waste is responsibility of Hospital personnel, while responsibility of Common Waste Treatment Facility operator is collection, treatment and final disposal.

- **Hygiene and Sanitation:-** Overall cleanliness and sanitation was seen in Meghalaya, Punjab, Uttarakhand, Odisha and Maharashtra and Uttar Pradesh. Mixed levels of cleanliness and clogged toilets seen in facilities visited in Delhi, Himachal Pradesh, Jharkhand and Assam

- **Grievance redressal mechanism for addressing grievances of patients:-** In Punjab, grievance redressal mechanism system through toll free no 104 is functioning effectively in both the districts, while monthly redressal of complaints are done at the level of the facility-in-charge. Rajasthan has initiated a program for grievance redressal called "Rajasthan Sampark", however no information has been disseminated to the end user. No proper mechanisms were seen in the states of Delhi, Maharashtra, Uttrakhand, Assam, Madhya Pradesh, Meghalaya, Jharkhand, Himachal Pradesh, Andhra Pradesh and Uttar Pradesh. Unused and unopened complaints/suggestion boxes were a common sight in these states.

KAYAKALP: The Prime Minister launched the Swachh Bharat Abhiyaan on 2nd October 2014, focused on promoting cleanliness in public spaces. To recognise efforts of ensuring Quality Assurance at Public Health Facilities including cleanliness, hygiene and infection control practices, the Ministry of Health & Family Welfare, Government of India launched 'KAYAKALP' Awards (A Clean Hospital Initiative). This is a National Initiative to recognise public health facilities that demonstrate high levels of cleanliness, hygiene and infection control.

Kayakalp has shown high degree of commitment, enthusiasm, and progress. Program roll out and remarkable improvements were seen in public health facilities in many states. Andhra Pradesh, Jharkhand, Madhya Pradesh, Chhattisgarh, Meghalaya, Himachal Pradesh, Rajasthan, West Bengal, Haryana, Manipur, Punjab, Karnataka, Assam, Maharashtra and Odisha have completed the process of Kayakalp for the financial year 2015-16. Uttar Pradesh, Uttarakhand and Delhi are yet to initiate the process of peer assessment

RECOMMENDATIONS

1. **Organizational Structures:** States need to reconstitute and operationalise their state as well as district level quality assurance committees and units by recruiting HR, conducting periodic and regular meetings. This will ensure regular follow up of the program as well as other related issues being addressed at the desired level.

2. **Trainings:** Apart from conducting QA trainings, it is essential for states to make optimum utilization of the trained resources for strengthening the system where they can provide directions and support for improving the quality of services. Trained resources may be used for conducting internal assessments and providing inputs in closing gaps observed at the facility and help them move towards certification process.

3. **Going beyond Assessment and Gap Analysis:** After Assessment and Internal Assessment, Gaps identified should be prioritized to develop time-bound Action Plan. Efforts should be made to close the gaps and preparing facilities for state or national certification.

4. **Kayakalp and other QA Activities: -**
   - **Cleanliness and hygiene in Public Health Facilities** are critical to preventing infections, improving patients' satisfaction and building trust and confidence of community. States shall leverage "Kayakalp" scheme and its tools to improve conditions.
   - **Bio Medical Waste Management** is of prime importance and a proper management system is of essence. States can work on strengthening the process by following correct methods of handling, segregation, transportation and disposal of biomedical waste. Under the Biomedical Waste Rules, the facilities in charges are required to obtain authorization from the designated authority. It needs to be monitored centrally at the State level.
   - **Infection Control Activities:** Healthcare Associated Infections (HAI) occurs frequently, cause morbidity and mortality and represents a significant burden among patients, health-care workers and health systems. States need to adapt and implement core infection prevention and control interventions for health care facilities which include hand hygiene practices, use of personal protective equipment, isolation precautions, sterilization, cleaning and disinfection practices.
   - **Conducting Patient Satisfaction Surveys:** Patient satisfaction is an important indicator to measure the quality of care rendered to the patients while in hospital. Patient satisfaction surveys can help identify ways of improving health care services and states may undertake this important activity with defined time frame for both IPD as well as OPD. Formats in vernacular need to be developed with correct sample size for better analysis and conclusion. Analyses of results are necessary to understand issues and appropriate actions to improve the quality of services.
   - **Reporting of Key Performance Indicators:** States require putting a system in place where all healthcare facilities capture, measure and report the KPIs. Analysis of the KPIs is helpful at state, district and facility level for planning and improvement of health facilities.

- **Grievance Redressal Mechanism** goes a long way in providing patient-centric care and building trust of community. Measures for a robust grievance redressal may include installing Complaint/Suggestion Box, Dedicated Helpline, Open meetings etc. All complaints need to be resolved within a stipulated time-bound manner and feedback provided to the complainant.
- **Audits:** Periodic and regular Prescription, Medical and Death audits should be carried out at all levels of health facilities followed by analysis with corrective and preventive actions based on findings.
- **Internal and External Quality Assurance Program** including regular monitoring, implementation of housekeeping checklist, conducting internal assessment at periodic intervals, mock drills, validation of lab tests, calibration of equipment, monitoring of radiation exposure by TLD badges etc. need to be done on regular basis.

STATE FINDINGS

ANDHRA PRADESH

Quality Assurance:

- Quality Assurance Committee and Units have been constituted and functional at the state level but not in the districts
- Recruitment of HR for Quality Assurance has been completed but teams in facilities are yet to be constituted.
- QA-targets need to be disseminated further and service providers trained on priority.
- Baseline assessment of 5 DH is completed but efforts to close the gaps is lacking.
- Internal Assessors need to be designated with the responsibility of assessing various facilities against the NQAS Standards
- Lack of knowledge about waste disposal and segregation of waste has resulted in poor implementation of the guidelines and norms.

Kayakalp:

- State has completed the process of Internal Assessment, Peer Assessment and External Assessment
- Kayakalp and Awards for District Hospitals have been declared.

ASSAM

Quality Assurance:

- Assam has reconstituted State and District Quality Assurance Committees
- One Awareness Training and two Internal Assessor Trainings, while service provider trainings are yet to start.

- RRC-NES has conducted assessment of 5 DH but facilities have not prepared action plan and reporting on Key Performance Indicators (KPIs).
- Sanitation & hygiene, cleanliness of public health facilities, particularly toilets are not satisfactory.
- In higher facilities such as Assam Medical College, Dibrugarh and KK Civil Hospital, Golaghat, quality of care is compromised due to heavy patient load and overcrowding.
- There is no dedicated grievance redressal system in the health facilities. Patient feedback forms are not being filled from the OPD and IPD patients.
- The government has put a 24x7 centralized helpline call centre (SARATHI 104) at the state level
- None of the facilities visited has Bio-Medical Waste Management Authorization Certificate mandated by Law, to generate the bio-medical waste.

Kayakalp:

- 25 DHs participated for the Kayakalp Award and 8 hospitals scored above 70% in the peer assessment with 4 hospitals qualifying for external assessment.

CHHATTISGARH

Quality Assurance:

- SQAC & DQAC have been reconstituted in the state.
- HR approved in the ROP 2015-16 for Regional Units are yet to be recruited
- State has completed awareness training, Internal Assessor training. Service Provider Training is being planned
- State has planning for certification of 4 district hospitals (Korba, Kanker, Jashpur, Durg) & 2 CHCs (Palari & Bagicha) but yet to initiate baseline assessment at any of the facility.
- State has not recruited approved HR for DQAU and Regional QAU hence they are not functional.

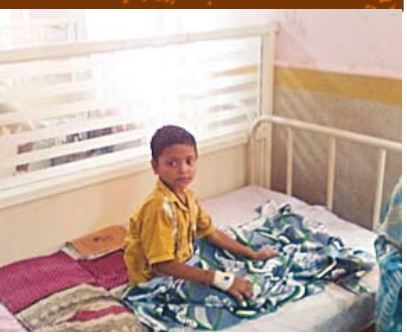
Kayakalp:

- State has completed the process of Kayakalp implementation and award ceremony conducted.

DELHI

Quality Assurance:

- State Quality Assurance Committee and District Quality Assurance committees are formed but no meetings have been conducted
- Two batches of Quality Circles trainings have been imparted in this financial year. Quality circles have been formed at dispensary level comprising of MO in-charge,



Pharmacist and ANM but no meetings have been conducted at the facilities visited.

- State consultants have conducted baseline assessments of 6 District Hospitals and 55 Delhi government dispensaries in September 2014-February 2015 but no action plan has been prepared to transverse identified gaps.
- Online tracking system for Patient Satisfaction Survey has been developed and started in 2014, but only 143 patients have been interviewed in 2015
- No facilities have been proposed for the certification in this financial year.
- Overall cleanliness at all the visited facilities was satisfactory
- Patient's rights and responsibilities were not displayed prominently in all facilities.
- Sub optimal infection control practices have been observed in almost all the visited facilities
- Poor implementation of BMW protocols

Kayakalp:

- Internal Assessment and Peer Assessment has been completed.
- State is yet to initiate External Assessment, finalization and distribution of Kayakalp Awards.

HARYANA

Quality Assurance:

- State and District level Quality Assurance Committees are in place. Regular meetings take place and minutes of the meeting are maintained.
- In spite of having all HR in place, overall progress is very slow. Only DH Panchkula has applied of national certification. Monitoring visits to support facilities are also minimal.
- State team has completed baseline assessment of 14 hospitals. However, Action Plan and efforts to close the gaps was lacking.
- 3 Awareness, 3 Service Provider and 1 Internal Assessor trainings have been completed.
- State has developed and distributed SOPs but awareness and adherence to these SOPs was missing at facility level.
- Maternal and Child Death review are being conducted at regular interval.
- Although inputs required for biomedical waste management (Colour coded bins, liners, hub cutters, sodium hypochlorite, Display of posters, wheel barrow etc.) are in place, adherence to protocols was lacking in the facilities visited.
- Suggestion/Complaint Boxes are installed at facilities but are not being opened

Kayakalp:

- Kayakalp Award Scheme is successfully implemented.
- Awards for District Hospitals have been declared.

HIMACHAL PRADESH

Quality Assurance:

- State Quality Assurance Committee and District Quality Assurance Committees has been notified and reconstituted in state and districts but are not functional.
- State is yet to recruit HR for quality assurance, approved in PIP.
- State level meeting held only once till November 2015, whereas none of the districts have had any review meetings
- 38 internal assessors were trained (2 to 3 members from each district and faculties from medical college) in the state/districts.
- The state has identified 12 district hospitals, 24 community health centres/civil hospitals (two from each district) and 36 PHC (3 from each district) for accreditation. Internal assessment of district hospitals was done and action plan for the gap closure is under process.
- None of the districts have initiated key performance indicators measurement and reporting from district hospitals.

Kayakalp:

- The state level committee has assessed all shortlisted facilities.
- Kayakalp awards were declared in October 2015.

JHARKHAND

Quality Assurance:

- The state team has completed baseline assessment of 23 hospitals including partial assessment in 7 hospitals. Time bound action plan (TBAP) yet to be prepared to address gaps.
- 3 Awareness Trainings and two Internal Assessors trainings have been conducted in the state with 28 Internal Assessors & 1 External Assessor.
- 36 monitoring visits has been done by state quality assurance units
- State has earmarked 6 District Hospitals (Deoghar, Chaibasa, Girdih, East Singhbhum, Gumla and Hazaribagh) for national certification but is yet to apply for certification for any of the facilities.
- Progress on recruitment of approved HR for Quality Assurance is slow. Only 3 Regional consultants and 12 district hospital managers have been recruited for 23 district hospitals.

- The 104 toll free number for grievance redressal is actively used. The grievance complaints are dispersed to the respective centres
- At the state level calibration of equipments has not been done but few districts have taken initiatives for calibration of measuring and monitoring equipments.

Kayakalp:

- Kayakalp Award Scheme successfully implemented.
- State has completed the process of award declaration.

KARNATAKA

Quality Assurance:

- Mangalore and Koppal DQACs have been constituted, but they have not met even once.
- Internal Assessors training and Service Providers training are yet to be conducted.
- DQAUs have been recently oriented on usage of checklist for facility orientation. No reports have been submitted to SQAC till now.
- The State Quality Assurance Unit is operational. The State has recruited one State consultant Public Health and one State level Program Assistant for the SQAU.
- 15 District Quaity Consultants and 18 Administrative cum Program Assistants have been recuited so far.
- Recruitment for the few DQAU positions is still pending – 5 District Consultants and 2 Program Assistants are yet to be hired.
- As the SQAU is recently engaged in Implementing Quality Assurance Program, no facilities have been assessed yet.
- KPI reporting has not started yet.
- Complaint box for grievance redressal observed in some facilities but no defined process for complaints. Very few complaints are being received through the 104 helpline.
- Varying degrees of BMW practices ranging from presence of demarcated bins and segregation practices to complete lack of awareness among staff.

Kayakalp

- Internal and Peer Assessment is completed in District Hospitals.
- 4 Three-Member External Assessment Teams have been constituted and External Assessment is in process.
- The Wenlock Hospital secured the runner up prize in the Kayakalp Awards in the State.

MADHYA PRADESH

Quality Assurance:

- The State Quality Assurance Committee (SQAC) has been re-constituted with a specified TOR, member ship and a commitment for bi-annual meetings, where MD, State Health Mission reviews the action points. Frequency of District Quality Assurance Committee (DQAC) meetings has gone up considerably
- Inordinate delays in recruitment process have affected monitoring visits at the state as well as the district level.
- State officials cited a paucity of funds to implement interventions such as a regular annual contract for pest control, AMC and calibration.
- The facilities targeted for state level as well as National Level Certification for FY 2015-16 are yet to be streamlined.

Kayakalp:

- Internal Assessment, Peer Assessment and External Assessment are completed.
- Awards for District Hospitals have been declared.

MAHARASHTRA

Quality Assurance:

- The State and District Quality Assurance Committee have been reconstituted.
- An internal assessor training as per NQAS has been conducted along with Training of internal assessors for PHC
- Infection Control Committee is constituted at both the district hospital visited. Regular monthly meetings of the committed were noted where checklist for infection control and adverse drug reaction is discussed.
- Patient satisfaction survey is carried out in a very adhoc manner with no fixed frequency
- Biomedical waste disposal is done through outsourcing – waste is segregated at the DH and stored in a separate room, from where it is collected every alternate day.
- Mechanism of calibration of equipment is not in place and staff reported that it is done as part of Annual Maintenance Contract
- External Assurance of Laboratory service is yet to be implemented.

Kayakalp

- Internal Assessment and External Assessment of District Hospitals is completed.
- Awards for District Hospitals have been finalized.

MANIPUR

Quality Assurance:

- State has constituted Quality Assurance committees (SQAC) at State level and in all the 9 districts (DQACs). However, the committees have conducted no meetings after their reconstitution.
- Recruitments (State and District level consultants) are awaiting cabinet approval resulting in undue delays.
- Implementation of Quality protocols requires improvement. All institutions visited had clinical protocols displayed but many staff members lacked awareness and knowledge
- Protocols on Biomedical Waste Management are good in terms of segregation but storage and disposal should adhere to guidelines.
- Weak mechanism for patient feedback and grievance redressal - only few institutions had suggestion boxes in place and there was no mechanism for addressing them

Kayakalp:

- Internal Assessment of District Hospital is completed and peer assessment is in process.

MEGHALAYA

Quality Assurance:

- Quality Assurance Committees have been formed at State and District level in, but committees have not reported any review meeting after the re-constitution.
- The State and Districts (7 out of 11 districts) have re-constituted Quality Assurance Committees, but State and District Quality Assurance Units not yet established
- State has taken up 32 health facilities for State and National Certification, however there is no 'Road-map' for Quality Assurance,
- Baseline assessment of DH in West Jaintia Hills has been completed.
- Training on Biomedical Waste Management and infection control practices has been done at the state as well as at district level.
- The state has not yet started reporting & analysis of Key Performance Indicators of selected health facilities for quality assurance as per new guidelines.
- SOPs at facilities level are yet to be developed.

Kayakalp:

- The state has completed the process of Internal and External Assessment under Kayakalp and Awards have been finalized.
- Awareness cum internal assessor training completed for Kayakalp in August 2015.

ODISHA

Quality Assurance:

- The State and the District Quality Assurance committees have been reconstituted
- The State has conducted Awareness, Internal as well as Service Provider Training with the support of NHSRC.
- During 2015-16 state plans to take its 10 DH (9 ISO Certified DHH and DHH Kalahandi) for NQAS certification.
- Baseline assessment of all DHs and SDHs have been completed, but action plan is yet to be framed
- The districts have stated reporting KPI.
- SOPs and protocols on MNCH and Disease Control Programmes are available and displayed categorically.
- Biomedical Waste Management is outsourced for the DHH (Bhadrak). Autoclave, shredder, waste pits, colour coded bags and containers, wheelbarrows etc. available. Treated waste is sold to local vendors.
- Containment areas with waste pits are available up to SC level, well covered and demarcated. HR is also trained on IMEP guidelines.
- External Quality Assurance at the Laboratories is in place at all ISO certified DHHs process is yet to be started for other DHHs.
- Complaint boxes found in the facilities visited but contact details of the nodal person not displayed.

Kayakalp:

- State has completed the Process of Kayakalp.
- Winner and runner-up facility have been declared but State is yet to organize an official award function

PUNJAB

Quality Assurance:

- Punjab has constituted State Quality Assurance Committee (SQAC) and State Quality Assurance Unit (SQAU).
- State has also re-constituted District Quality Assurance Committee (DQAC), District Quality Assurance Units (DQAU), and District Quality Team (at District Hospital).
- Awareness training, Internal and External Assessor training as well as Service Provider Trainings have been completed
- For state level certification, all 22 District Hospitals and Sub divisional Hospitals have been chosen by the state.
- For the National Level Certification 4 District Hospitals and 3 SDH have been selected.

- Baseline Assessment Survey is being conducted at all DH, SDH and CHC
- Reporting of Key Performance Indicators at the state level is yet to start.
- SOPs not yet framed.
- Overall facilities visited were clean and maintained properly
- Segregation of hospital waste is being properly done in differently coloured bins.
- License for Biomedical waste management is renewed every year by the Punjab State Pollution Control Board.
- State is yet to institutionalize the practice of conducting regular patient satisfaction surveys.
- Grievance redressal system/ complaint management system through toll free no 104 is functioning effectively in both the districts visited

Kayakalp:

- Kayakalp Award function has already been organized on 7th October 2015 where awards and prize money given to 1st DH Amritsar (Rs. 50 Lakhs), 2nd DH Pathankot (Rs. 3 lakhs) and 3rd DH Bathinda (Rs. 3 lakhs)

RAJASTHAN

Quality Assurance:

- State Quality Assurance Committee (SQAC) has been constituted and one meeting held so far
- State has also formulated State Quality Assurance Unit (SQAU) by deputing three officials of regular cadre and one consultant Quality Assurance. However, frequent change of members is hampering the progress of the program. No review meetings have been conducted by the SQAU.
- District Quality Assurance Committee (DQAC) has been constituted in the districts.
- Reconstitution of District Quality Assurance Committee (DQAC) has been done but their level of functionality is questionable
- Two batches of Internal Assessor's Training have been conducted. State has a pool of total 96 Internal Assessors, who have conducted Baseline assessments of 15 District Hospitals.
- 34 District Hospitals have been selected for rolling out National Quality Assurance Program in the state. However, no commitment for State and National certification of the facilities could be observed.

Kayakalp:

- Process of Internal Assessment, Peer Assessment and External Assessment has been completed
- Awards to District Hospitals have been finalized.

UTTAR PRADESH

Quality Assurance:

- State is yet to establish organizational framework for implementation of QA at State, Division, District and DH Level.
- Quality Assurance Units (SQAU and DQAU) are yet to be constituted as approved HR for quality has not been recruited.
- State is nowhere near its target of getting 197 health facilities certified against National Quality Assurance Standards.
- Some of the key activities like Baseline Assessment, Gap Analysis, developing Action Plan, Reporting and monitoring of KPIs, Patients Satisfaction Surveys, Calibration of equipment, External Quality Assurance Program for Laboratories are yet to be initiated.
- Quality assurance activities are limited to 'Virangana Avanti Bai Mahila Chikitsalya Lucknow', which has also applied for certification.
- Recruitment of approved HR for QA in the last two years, not initiated - likely to result in delays in operationalizing QA and Kayakalp.
- State team has completed baseline assessment of only 14 hospitals. No actions have been taken to traverse the gaps.
- BMW management emerged as major area of concern in the facilities of Uttar Pradesh.

Kayakalp:

- State is running a parallel program 'Clean-Green Hospitals' with similar objectives and methodology of Kayakalp creating duplication of efforts and confusion at health facilities.
- Overall progress on Kayakalp is very slow. State and District Award Notification Committees are notified but not fully functional.
- Out of 157 District Hospitals, initial assessment has been completed at only 20 facilities.
- State is yet to initiate Peer Assessment, External Assessment, finalization and distribution of Kayakalp Awards.

UTTARAKHAND

Quality Assurance:

- Reconstitution of State Quality Assurance Committee (SQAC) has been completed.
- State is yet to recruit required HR and make DQAC functional.
- Out of 6 approved Trainings (2 Awareness, 2 Internal Assessors and 2 Service Provider Trainings), only one awareness training has been conducted so far.

- Assessment of 5 District Hospitals have been undertaken against the National Quality Assurance Standards. However all checklist have not been run through.
- Categorization of the gaps, prioritization and Action planning for closure of the gaps has not yet been initiated.
- State has committed for State Level Quality Certification of 26 L-3 facilities, and National Certification of 2 L3 facilities. However, there is no preparedness and 'road-map' for achieving the stated target before March 2015.

Kayakalp:

- Progress on Kayakalp is very slow. State is still in first phase of the program i.e. Internal Assessment
- Peer Assessment and External Assessment are yet to be initiated.

WEST BENGAL

Quality Assurance:

- The state has established State and District Quality Assurance Committees and one sensitization/introductory meeting has been conducted.
- Consultant positions for quality assurance, public health and quality monitoring positions at state and district levels are yet to be filled.
- According to the national guidelines, district hospitals are required to establish 10 internal committees, which are still to be formed in many district hospitals.
- State has conducted baseline assessment of the Cooch Behar but there is no clear road map available as to how the gaps will be addressed. Even in the DH, which is being identified as the winner for KAYAKALP program, overall upkeep and cleanliness continue to be an issue?
- Patient satisfaction and feedback systems are non-functional. The hospital has placed complaint/suggestion boxes in prominent locations, however this system does not seem to be popular among patients and no complaint/suggestion were received in the last three months.
- The state plans to take a phased approach and has focused on quality assurance certification for 16 district hospitals.
- Biomedical Waste Management – non-timely disposal of waste
- Monitoring of Patient Satisfaction survey (PSS) on monthly basis, both for OPD & IPD is yet to be done.

Kayakalp

- Internal and Peer Assessment under Kayakalp is completed.
- External Assessment of the selected facilities completed between 22nd and 29th September 2015. Awards for District Hospitals have been finalised.

TOR 9
National Urban Health Mission

OBJECTIVES:

1. Review of NUHM implementation, vulnerability mapping, and integration of NUHM activities with pre-existing schemes like NRHM, RCH, DCPs and NCDs, convergence mechanisms at various levels.
2. Oversee the adequacy and service delivery of UPHCs and UCHCs, reporting of urban facilities in HMIS/MCTS, constitution of RKS and untied fund utilization.
3. Review the community outreach services, UHND functions, MAS formation, status on ASHA selection and training, and involvement of urban local bodies.

NATIONAL OVERVIEW

The National Urban Health Mission (NUHM), launched in May 2013 aims to provide equitable and quality primary health care services to the urban population with special focus on slum and vulnerable groups, through a revamped primary health care system, targeted outreach services and involvement of the community and the urban local bodies.

Major components in implementation of NUHM include slum and vulnerability mapping, city health planning, operationalization of Urban Primary Health Centers (through construction, renovation and up gradation), recruitment of Program Management staff at state, district and city level, recruitment of medical and para medical staff (full time and part time Medical Officers, Public Health Managers, Staff nurses, ANMs, Urban ASHAs), their trainings and capacity building; convergence with Urban Local Bodies (ULBs) and other allied departments. However, standardization of health facilities and services across the country is a challenge.

Unlike rural areas, urban health systems in India vary among states and cities. Reflecting this diversity, there is a wide variety in the way NUHM is implemented in different states, based on state-specific legacies and models. For example, Tamil Nadu does not employ ASHAs, and has Public Health Nurses as their frontline community health workers instead; Kerala does not constitute Mahila Arogya Samitis as it has an existing model of community women's groups (Kudumbshree Model). Uttarakhand has been managing their urban health centers through local NGOs. Himachal Pradesh proposed ASHAs for the first time in 2014. These diversities both enrich and make it challenging for NUHM to ensure delivery of identified services to the urban vulnerable.

Participation and involvement of ULBs is essential for NUHM implementation. However, the involvement of ULBs in NUHM has been varied across states, and even within states depending upon their capacity and prioritization of health. In metropolitan cities such as Chennai, Mumbai, Kolkata, the corporations are key health care providers, while in some smaller cities, the role of municipalities is minimal.

In the 12th Plan an allocation of Rs.15,143 crores have been made for NUHM. Rs 1000 crore was provided in the Revised Estimate of 2013-14 for NUHM out of which Rs.662.23 crore was released to 29 States/UTs on the basis of PIPs received from the States/UTs. In FY 2014-2015, Program Implementation Plans (PIPs) were received and approved for 34 States/UTs. In 2015-16, an outlay of 1,386 crore or 7.5% of total NHM allocation of 18328 crore was approved for NUHM. Utilization of funds has been low in the first two years, but have picked up in the third year.

KEY FINDINGS

- **Planning and Mapping:** Urban slum and vulnerability mapping is the first and essential step towards understanding the needs of the target population, and planning services for them. While most states have begun the mapping exercise, the progress has been slow and sporadic. Vulnerability Mapping is lagging behind schedule in Haryana, Punjab and MP. It has not been initiated in WB, Karnataka, HP, Meghalaya, Uttarakhand, Uttar Pradesh, Andhra Pradesh and Jharkhand. Delhi state has completed mapping, using polling station data and demarcations. Slum mapping too is at various stages in different states. Most of the states have obtained list of slums and slum maps from urban development departments and slum mapping has been initiated at major cities in the states. Progress in smaller cities is very slow, such as UP, Jharkhand. Rajasthan has contracted out the GIS based mapping to the Department of Information Technology (DOIT). Data based on 342 urban health facilities has been compiled and provided to DOIT.

- States such as Haryana, West Bengal, MP, Uttarakhand have out sourced GIS mapping to state remote sensing organizations, Departments of Science and Technologies and other consultancy services. Most states will be undertaking vulnerability mapping after the GIS mapping has been completed. GIS mapping has been done in cities of Bangalore, Delhi and few states such as Meghalaya. Health facility mapping has been undertaken in most states. It has been completed in Delhi, Meghalaya, and is under progress in others. It has not yet been initiated in HP and Andhra Pradesh.

- **Infrastructure:** NUHM infrastructure includes a network of UPHCs and UCHCs. Large metros have inherited a variety of health infrastructure of providing a diverse range of services. They are now being standardized either as UPHCs or UCHCs. Very few

states, such as Delhi, have been able to establish the sanctioned number of UPHCs. States close to achieving their sanctioned number of functional UPHCs include MP, Haryana, while states lagging way behind targets include Meghalaya and Karnataka. In Delhi existing maternity homes are being strengthened as UCHCs.

- Due to difficulty in procuring space in and around slum areas as mandated by NUHM, many states are operating UPHCs out of rental premises. In Meghalaya, all NUHM facilities are run on rental basis. In many cases Corporations provide space for the facilities. In Ranchi, quality infrastructure was observed by the CRM team.

- **Human Resources:** Recruitment of staff under NUHM, both program and clinical has been difficult in states. The reasons range from low salaries (in view of high cost of living in cities), reluctance to work during evening shifts, unavailability of trained personnel in smaller towns, and slow recruitment processes at the state level. Program staff is in place in most states at state level (MP, Haryana) but large numbers of vacancies exist at the district level (Uttar Pradesh). Haryana is trying to catch up with recruitment, while in Delhi, most positions are in place. In West Bengal and Himachal Pradesh most of the positions are yet to be filled. West Bengal 95% positions are vacant. Large numbers of clinical staff positions are also vacant in states of MP, Karnataka, and Himachal. In Uttarakhand, all positions have been outsourced to NGOs, and have been filled.

- Absence of staff at key positions is hampering implementation of the Program. Even after recruitment, staff requires trainings and orientations for a specialized program such as NUHM. Very few states have actively trained and oriented the program staff on program areas.

- **Governance and Convergence:** In Madhya Pradesh, convergence with departments such as women and child development, water and sanitation, urban development has been initiated, with their representation in the state and city health committees and societies. However this convergence is yet to be reflected in city health plans. Convergence with ULBs is limited to providing space for UPHCs (Madhya Pradesh), and in ASHA selection (Madhya Pradesh). Poor convergence observed in Himachal Pradesh (slum identification not done), Uttarakhand, Uttar Pradesh. Delhi is also in process of involving Corporations in NUHM implementation. However, Convergence with organization such as ESI, CGHS, and Railways has been difficult in Delhi. States such as Haryana, Jharkhand, Madhya Pradesh have begun to conduct orientation workshops for ULBs.

- **Community Processes and Outreach:** Urban ASHA recruitment is at varied stages in different states. In MP and Meghalaya, ASHA recruitment and MAS formation is on track, and accounts for MAS have also been opened. Delhi has also recruited and trained the required no. of ASHAs, although MAS formation is lagging behind. In Himachal and Uttar Pradesh, no ASHAs and no MAS are yet in place. Training of urban ASHAs is in process in most states. In Rajasthan, 3752 Mahila Arogya Samiti (MAS) against the sanctioned 4664 are present. Bank accounts of 3105 MAS have been opened and funds have been transferred to 2754 MAS.

- Regarding Outreach sessions, most states with ASHAs in place have begun conducting the routine Urban Health and Nutrition Days. Haryana, Madhya Pradesh, Delhi, Himachal regularly conduct the requisite number of UHNDs and urban health melas. In West Bengal, only about 2% of the sanctioned UHNDs were conducted in

the first 6 months of the year. Special Outreach camps have not been started by Himachal, Andhra.

GOOD PRACTICES:

- Madhya Pradesh has converted part time MOs into Full time to retain them; provision of fixed day specialized services in UPHCs for NCDs and RMNCHA; instituting awards for best performing urban ASHA; instructing MAS to purchase radio sets as a training tool
- Kolkata Municipal Corporation's strategies on rabies control is quite commendable
- Delhi is strengthening its two way referral linkages, by clearly defining referral protocols and area wise facility linkages.
- Delhi has used polling booth data and demarcations to allocate population among ANMs and ASHAs.
- **Meghalaya:** close follow up for immunization at Ladthadlaboh UPHC, Jowai town on a monthly basis, through beneficiary identification.
- **Mumbai:** Due to high burden of MDR/XDR TB patients in Mumbai, (about 3000 MDR patients and 400 XDR patients reported in 2014), the State with financial support from IDBI Bank (for one year) conceived "Arogya Vardhini" for nutritional support to MDR/ XDR TB patients of Mumbai, under NUHM.
- **Odisha:** Ward Kalyan Samitis have been formed based on the rural Goan Kalyan samiti model to ensure convergent action i.e health, nutrition, sanitation, water etc at ward level

RECOMMENDATIONS:

1. **Planning & Mapping:** Expedite completion of planning and mapping activities. Strategic city-level planning for health infrastructure and services should be given more focus in subsequent PIPs. Empower and increase planning capacity and flexibility to respond to local needs at city level.
2. **Human resources:** Expedite recruitment of remaining program management and clinical/paramedical staff. Efforts should be made to utilize the staff for which they are recruited for. The remaining staff programmes and paramedical should be recruited to improve service delivery.
3. **Convergence:** Role clarity is required for different stakeholders in NUHM especially for ULB. So far ULBs responsibilities are limited to provision of space for UPHC/UCHC. ULBs need to be actively engaged in health activities. There is need to formalize convergence mechanism with different departments and ULBs. Sensitization to newly elected members and officers (Commissioner, Health officer) should be done early to ensure their participation in NUHM activities. State should devise ways to ensure convergence between different stakeholders and service providers in order to improve service provisioning
4. **Infrastructure:** Space is constraint in urban area but there should be standard for minimum space requirement for different purposes like OPD room, pharmacy, laboratory, dressing room, waiting area etc, to keep certain level of quality in

service delivery. Renovation or new construction plan should be able to cater future need e.g. increase in patient load, expansion of health services and related human resource, upgradation of UPHC into UCHC etc. Health facilities' structure requires specialized construction plan aligned to its processes, process flow, services, equipment etc. Hence, health facilities drawings should be technically vetted by appropriate experts.

5. **Human resources:** Current salary for doctors (contractual) may not be sufficient. The Municipality is geared more towards contractual employment and they may not be able to have permanent doctors. This would lead to high attrition and will negatively impact services. Training and capacity building of program management staff as well as sensitization of clinical staff towards the urban vulnerable must be undertaken periodically.

6. **Monitoring and Supervising:** Since, the NUHM is at the nascent stage of implementation in the state. Efforts are required to establish a robust support and monitoring system/ mechanism to achieve the desired trajectories. The key performance indicators as enlisted in the contract of the PPP agency/NGO needs to be monitored continuously for effective management and implementation of the program.

STATE FINDINGS

ANDHRA PRADESH

- NUHM has not been formally launched in AP. However, state level nodal officers have been appointed. No systemic institutional arrangement or program management for monitoring urban health due to lack of exclusive Urban Health Program Management Unit.
- Planning and Mapping have not been initiated in the state.
- 193 health centers are run by NGOs, while 19 centers are run by municipalities.
- Community Processes: 2635 Urban ASHAs have been recruited against sanctioned strength of 2660 in the state. All ASHA positions in the district are filled and they are reporting through ANM to community organizer and medical officer. More than 2000 Urban ASHAs were given induction training several years back but oriented in various ASHA modules of GoI. Available Urban ASHAs have been given drug and HBNC kits, although not trained in HBNC. Out of 10,000 MAS in the state, 5425 MAS have been formed. Further formation of MAS has been delayed since state is planning to formally launch NUHM. In Anantpur, the district visited, 404 MAS have been formed, and who are conducting trainings and meetings, supported by an NGO.
- GOI has approved setting up 10 e-UPHC in the State. Two e-UPHCs were already piloted (one each in Vizag and Vijaywada).

ASSAM

- A state level urban health coordinator is yet to be recruited. The program is being managed by the State ASHA Manager with District Urban Coordinators in 14 districts.

- As per the gaps identified, the state has proposed the upgradation plan for UPHCs. Of the 38 UPHCs, 36 UPHCs are run in government building and 2 in Dhubri & Goal para are in rented buildings. A state level training for the district urban health coordinators has been conducted.
- There was some inconsistency in information from state and field realities. While the state shared that vulnerability mapping has been completed, the same could not be verified in the field. Again, though as per state information UHNDs are not conducted, but in the facility visited there was detailed microplan for the UHNDs which are regularly conducted and monitored. The monitoring report is uploaded on the Health Services Monitoring System.
- The state has initiated the engagement of the Urban ASHAs and also formed the Mahila Arogya Samit is (MAS). The district has formed 51 MAS in September 2015 with the support from the Anganwadi workers and the local ward members of Dibrugarh Municipality. The active MAS members have been identified from the past experience of the AWW and the ASHAs. A meeting for the formation of the MAS was held.
- In Dibrugarh, total urban population of 134734 (165990-31256) is covered by 22 wards under Dibrugarh Urban Health Centre. Besides urban slum, the vulnerable population has been identified in each ward using basic criteria such as the daily wagers, petty vendors, and families with poor health awareness & poor accessibility to the health services and poor sanitation facilities in their localities.
- Untied funds were not utilized in FY 2014-15 and are lying with the state which was revalidated for FY 2015-16 by MoHFW. As per the financial statements shared by the state, no untied funds are disbursed to the UHCs. As per the information of the Urban Health Coordinator, Dibrugarh, the district received the untied funds for the UHCs in October 2015.

CHATTISGARH

- Raipur city has 70 Wards and under the NUHM, 9 UPHCs have been made functional, each catering to about 7-10 Wards and under each UPHC, 7-10 *Swasthya Suraksha Kendras* (SSK) are operational.
- Analysis of HR status, utilization of vital services, such as, ANC, OPD and IP services showed that during 2014-15, there was large-scale vacancy of critical human resources to cater to the health needs of urban population. For example, out of 62 sanctioned positions for medical officers, 21 had been recruited (Graph-2) as well as 50 out of the 93 staff nurse posts.
- Available HMIS data indicated that in general, utilization of OPD services was encouraging across all the 11 city centers of the State. But the utilization of IP services was not up to the mark - Doctors were reluctant to admit patients to the UPHCs for lack of security guards. MAS members informed that since launching of NUHM, no child remains unimmunized in the urban areas.

DELHI

- Delhi has made significant progress under NUHM, despite challenges such as large urban vulnerable population, reluctance of Corporations to undertake implementation, issues of migration and high density of population.

- A State Program Management Unit has been established under the Mission. NUHM supports an HR of 28 including a Mission Director and a dedicated State Programme Manager. The state proposes to set up three City PMUs corresponding to the three Municipal Corporations. Corporations have been apprehensive about donning the mantle of NUHM and need to be convinced to take over. The state has eleven District PMUs corresponding to the eleven districts.
- The state has 778 ANMs, 86 MOs, 44 LTs, 86 pharmacists. Most of the requisite human resources are in place. The state has 5019 Urban ASHA, all of who have been trained. The process of MAS formation has been lagging behind with only 100 MAS in place. The state cites non-sanction of funds in ROP 2014-15 and 2015-16 as the reason behind the delay. The ANM is the ASHA supervisor in the state. UHNDs are regularly conducted in the state.
- Being predominantly urban, all healthcare facilities in Delhi are subsumed in NUHM, some under Delhi Government and some under Municipal Corporations. The state has inherited a variety of urban health facilities run under various projects, with varying services and mandates. The state has 200 UPHCs, 62 Seed UPHCs, 29 Hospitals and 4 UCHCs. Sixty-two new UPHCs have been opened in vulnerable areas underserved by existing facilities. Maternity homes in the state are also being strengthened as Urban CHCs.
- The **Seed UPHCs** are delivering services to the unreached in an effective manner, as these are located within the slum, usually on rented premises. Efforts are being made to operationalize two-way referral linkages from UPHC to community and upwards to secondary and tertiary care centers.
- **One Mohalla Clinic and 6 Dental MMUs** have been started in Delhi. The Mohalla Clinic is situated within the Peeragarhi slum which provides basic health services in two shifts (morning and evening). The utilization of the Clinic is high and uptake of services is good.
- Efforts have been made to map all facilities and define a minimum service package. Each ANMs catchment population of 10,000 has been mapped onto software so that no unnerved populations remain. Mapping of vulnerable populations has been undertaken using GIS maps and polling station data, then earmarking area of individual ANM on to it.
- Corporations have been slow in uptake of NUHM. There is little convergence with autonomous agencies running health facilities like CGHS, Railways, ESI, and Jal Board.
- All facilities reporting to HMIS. All GNCTD and MCD UPHCs and UCHCs are entering data into MCTS. Trainings on HMIS and MCTS have also been undertaken.
- Owing to absence of RKS at seed UPHCs, untied fund utilisation is a problem although the money is available.

HARYANA

- GIS Mapping has been undertaken by Haryana Remote Sensing Organization (HARSAC) for Panchkula and is being undertaken in rest of the cities. The base maps of Districts Sonepat and Yamunanagar have been prepared and finalization of the

map is in process. Vulnerability Mapping will be undertaken after the completion of GIS mapping.

- A total of 146 UPHCs and 2 UCHCs have been sanctioned under the NUHM, out of which 110 UPHCs and 2 UCHCs are functional. 18 UPHCs are housed in government buildings and 92 in rental buildings.
- Out of 146 MOs position sanctioned, 79 have been filled; SNs - 307 sanctioned and 103 filled; Pharmacists 146 sanctioned and 105 filled; Lab technicians 146 sanctioned and 103 filled; ANMs – 862 sanctioned and 663 filled; Information cum account assistant – 146 sanctioned and 92 filled; class IV employees 146 sanctioned and 87 filled; and ASHAs – 2493 sanctioned and 1885 filled. In the cities visited, it was found that 24 ANMs and 64 ASHAs have been recruited in Sonipat and 33 ANMs and 53 ASHAs are serving in Yamunanagar. The recruitment in these two cities is also more than 70%.
- Orientation workshops of ULBs were conducted in district Faridabad and Jhajjar, and are in process in rest of the cities. A state level Orientation workshop on NUHM was conducted for all MOs, SNs, ANMs, UH Consultants and account assistants working in U-PHCs.
- Since the inception of NUHM, out of the total fund of Rs.38.63 released Rs.22.7 Crores have been spent. The unspent balance of FY 2013-14 was 25.85 Crores, and the accumulated unspent funds in FY 2014-15 were 41.78 Crores. In the FY 2015-16 Rs.10.25 Crores have been spent till August 2015 and a committed liability of Rs.13.27 Crores is due for payment.
- All facilities under NUHM have been tagged as urban on DHIS-2/HMIS and MCTS portals.
- A total of 3731 UHNDs have been conducted and 308 of these have been organized by ANMs in both the cities in 2015-16. 24 Specialized Urban Health Melas have also been celebrated in Urban Slums. Seven Urban Health Melashave been organized in U-PHCs in Sonipat and 2 in Yamunanagar. Specialist Services, General Check-ups, Adolescent Health Counselling, Screening of anaemia, Healthy Mother and Healthy Infant Competition were included as a part of these meals.

HIMACHAL PRADESH

- Vulnerability, health facility and stakeholder mapping has not yet been in the state, and there is clear information regarding status of slums has not been provided by the ULBs.
- 11 urban PHCs and 9 urban sub-centres are functioning in the state across three selected districts. Renovations for 4 UPHCs have been completed since 2013-14, with 8 UPHCs sanctioned for renovation. All 20 urban health centers, which include 11 UPHCs and 9 urban health centers were tagged and reporting under HMIS in the state.
- There is no convergence mechanisms established at state and district level and no visibility of involvement of urban local bodies in implementing NUHM in the state. 17/53 ANMs have been recruited through various NGOs in the state.
- HR recruitment is lagging. Out of the 28 sanctioned HR, recruitment of 8 is in process.

- No ASHAs have been recruited yet. MAS have also not been formed. NGO engagement for ASHA recruitment and MAS formation was not visible. UHNDs are being conducted, but special outreach camps have not been started.

JHARKHAND

- The Mission Director of NHM is the combined Director for both rural and urban health programs in the state. The notification of Nodal Officers for NUHM at State & Districts has been done. The expansion of State and District Health Society has been incorporated in governing body. The District Reproductive and Child health officer (RCHO) is nominated as the nodal person for urban health at the district level. Urban Health Cells at state and district levels are not yet in place.
- There has been no progress in planning and mapping in the whole state. The hiring of agency is under process for the activity. The ToRs have been developed and finalized.
- The process for recruitment of human resources (Programme Management, Clinical & Para-clinical) is under process. Only 37% full time MOs and 77% part time MOs are in position. No recruitment has been done for positions such as SN, ANM, Lab Technicians &Pharmacists. In some districts existing staff has been relocated in NUHM facilities.
- 70% ASHA are in position and 47% MAS formation have been done in urban areas. Few ASHAs, MAS and ULBs have been oriented. The NGO CINI is providing support for community processes in the state. The state has developed its own guidelines on Outreach session, UPHC and implementation framework. Total number of UHNDs held is 3856 against 18516 sanctioned and special outreach sessions held are 134 against 2014 sanctioned.
- 40 UPHCs (30 in rented and 10 in government buildings) out of 53 sanctioned has been made functional. Similarly 4 UCHCs out of 6 sanctioned are functional. Untied grants have been sanctioned to the facilities. The Rogi Kalyan Samitis are not yet in place.
- The procurement of medicines & consumables is under process. The Essential Drug List is available. The citizen charter has not been displayed in most of the facilities. No Grievances Redressal Mechanism is in place. IEC/BCC activities in urban health have been done especially for RCH and Disease Control Activities. Total expenditure is about Rs 12.81 lakhs.
- Total fund Sanctioned in FY (2013-14): 897.68 Lacs, FY(2014-15):16.50 Lakhs, FY(2015-16): 1852.94 Lacs. The Utilization in- FY (2014-15)- 52.22 Lakhs and in FY(2015-16)- 2.77crore up to Sep'2015.
- Following a state level orientation workshop for departments such as Urban development, W & CD, water & sanitation, Education, Housing and development partners, one nodal officer from each department will be nominated for taking convergent action. The officer will also provide key documents required for city health planning such as city development plan for inclusion of health, list of slums, list of neighborhood committees for co-option into MAS, list of unused land and buildings for UPHCs etc.

- 'Guidelines for Urban Primary health Centre' is developed in the local language by the state, the MAS module developed by NHSRC was contextualized to state specific scenario and 'Guidelines for ward committee and the City Coordination committee' are drafted with active support from development partners in the state.

KARNATAKA

- Vulnerability mapping has not been conducted. In Bangalore, GIS mapping with location of facilities and slums have been completed. Language based city profiling is done to plan customized IEC activities.
- Mangalore City Corporation (MCC) has been providing building and has assured to relocate few UPHCs. Renovation process is very slow
- In Mangalore district, ASHA selection is still under progress. MAS has not been formed; to be formed after completion of ASHA selection. Outreach services have not been initiated. At the state and district level also, UHNDs will start. ASHAs not provided with drug kit.
- None of the UPHCs visited had minimum staff strength as prescribed NUHM Framework. The position of Public Health Manager (PHM)/Community Mobiliser position does not exist in Karnataka. Only one position of clerk was sanctioned, but not in all UPHCs, although two such positions have been prescribed. Low professional fee for Medical officer, Pharmacist and Laboratory technician were counted as major reason for not getting required human resource in a city with high cost of living.
- UPHC services are limited to OPD, UPHC based immunization, ANC check-up, passive detection of suspected TB and Malaria cases
- Quality assurance committees are yet to be constituted. Vaccines storage was found to be improper and unhygienic. Knowledge regarding handling of sterile instruments, and biomedical waste management was found to be lacking.
- Fund utilization was very low 3% to 5%. Areas where untied funds could be utilized were not clear.

MADHYA PRADESH

- The State has contracted out the task of Mapping to Map IT and Vimarsh. The mapping of slum population and facilities is being undertaken in 31 cities and therest35areyettobe completed. The vulnerability mappings hall be undertaken by the ASHAs with training by the MIScum data assistants.
- The state has functionalized 126 UPHCs, out of 136 sanctioned, with 16 renovations and 14 up gradations. No new constructions have been undertaken. Most of the UPHCs are run in rented buildings (110). All the UPHCs have been provided untied grants as per norms. No UPHCs are run by ULBs or through PPPs. The Quality Assessment systems are in the place.
- The appointment of Additional Mission Director (NUHM) has not been done by the State. The urban health cells have been formed in the State, District and city levels. Program staff recruited in districts is around one third of the sanctioned numbers (32/94)). In cities, recruited personnel are more than the sanctioned numbers (14/3). Out of the 540 sanctioned clinics staff, only 162 are in place.

- Training modules and orientation materials sent by MoHFW have been translated . State has developed Modules for orientation for ULBs, TOR for mapping and other documents.
- The State has close linkages with the Women and Child Development (WCD) department, urban development, Public Health Engineering division and Public Works Department. State has initiated orientations for ULBs in different cities.
- The health facilities mapped under HMIS are 123, and 92 are reporting.
- 3800 ASHAs have been recruited out of 4200; 1900 MAS have been formed, with a target number of 3000. 1340 MAS accounts have been opened so far.
- Out of the sanctioned 50,700 UHNDs, a total of 49,179 have been conducted till date. Special outreach camps areal so being conducted. Availability of medical personnel is a major difficulty faced in organizing such camps.
- Theoverallexpenditurein2014-15was18%andin the year 2015-16 it is 41%. In 2015-16, expenditure for drugs and consumables has been only 20% of the sanctioned amount.
- Madhya Pradesh has converted part time MOs into Full time tore ta in them; has initiated fixed day specialized services in UPHCs for NCDs and RMNCHA; instituted awards for best performing urban ASHA and instructed MAS to purchase radio sets as a training tool.

MAHARASHTRA

- NUHM is implemented through City PMUs (in 21 of the 26 Corporations) and health cells in 64 Municipal Councils under the Urban Development department. A separate PIP for Mumbai is prepared by Greater Mumbai Municipal Corporation (MCGM) as the City Integrated Health and Family Welfare Society has been responsible for the delivery of health care for a number of years.
- Planning and mapping has been completed in Maharashtra, with support of MCGM.
- In Mumbai, out of 22 staff sanctioned, only 4 posts are filled. In UPHCs under MCGM, 154 out of 334 sanctioned staff is recruited. 421/1028 staff nurses and 121/486 lab technicians have been recruited. Part time MOs are not there at any facility. Recruitment process is under progress for each facility in the State.
- All 45 UCHCs and 611 UPHCs sanctioned under NUHM have been mapped, of which 67% of the UPHCs are currently functional.
- At district level, Outreached services are provided at UPHC level, but staff has not been trained under NUHM, as staff lacked information about UHNDs, special camps. In the last 6 months, 50 special outreach camps in Mumbai and 170 in rest of Maharashtra have been held. UHNDs are not conducted in the state as funds for the same were not proposed in PIP.
- In Mumbai, there are demands for fixed remuneration for ASHAs, on the lines of Community Health Volunteers (CHVs) working from pre-NUHM days, who are getting fixed remunerations. Link workers (LW) working as urban ASHAs have not received their incentives since January because of lack of clarity of their selection as

ASHAs. 61% ASHAs planned have been recruited (ASHA training expected to take place in December). Out of 9333 MAS sanctioned, only 908 MAS are formed in the state and their training have not yet been conducted.

- Apart from RCH aspects like standardization of labour room, establishment of essential committees as per MNH toolkit, there is little integration of NUHM and NRHM service delivery. Multisectoral convergence is occurring in high resource corporations such as MCGM.
- Till FY 2015-16, total Rs. 362.86 Cr has been released, out of which Rs. 19.52 Cr (5%) has been utilized so far. At State level, during the FY 2014-15 NUHM fund was diverted to NRHM (RCH, MFP & Immunization) flexipool as temporary advance. Expenditure for NUHM is very low; it was reported to be because of the challenge in recruiting staff under NUHM and delays in procurement and new construction/renovation.
- Innovations
  - In Mumbai, two **Dilaasa** Crisis Centers, functioning at 2 hospitals provides counseling and social support to women facing domestic violence to enable them to effectively cope with and manage crisis. Corporation proposes to start Dilaasa in 11 newly proposed UPHCs, while it is approved in FY 2015-16, was only for 6 months. However since then the issue has been sorted out and continuation assured.
  - **Arogyavardhani -** Due to high burden of MDR/XDR TB patients in Mumbai, (about 3000 MDR patients and 400 XDR patients reported in 2014), The State with financial support from IDBI Bank (for one year) conceived a project "AROGYAVARDHINI" for nutritional support to MDR/ XDR TB patients of Mumbai, under NUHM.

MANIPUR

- The District Urban Health Action Plan was developed in a participatory manner with facilitators. A District Planning Team was constituted who carried out the planning process of urban Health Action Plan. The Team focused on each of the thematic areas with the present situation, the bottlenecks, and strategies and how to achieve the goals.
- The District Plans are an output of wide-ranging discussions with key stakeholders. At the first stage, a vision for the future development of the urban areas was developed which was a shared development in the medium perspective.
- 409 Mahila Aarogya Samitis have been formed, as proposed in 2013-4. The recruitment of 81 urban ASHAs has also been completed. All 15 ANMs have been recruited. 2 UPHCs are in the process of being operationalized.

MEGHALAYA

- GIS mapping of the slums & health facilities had been done while preparing city plans. Vulnerability mapping to identify the most vulnerable groups under NUHM is yet to be initiated by the State.
- All the facilities under NUHM are functioning on rental basis. New constructions of building of 1 UPHC sanctioned in FY 2014 – 15 which has not been started, although

land has been identified and transferred to the health department. Re-designation of UHCs as UPHCs not done.

- 65% of Urban ASHAs have been recruited and 94% MAS have been formed. Training of urban ASHAs is under process. UHNDs and Special Outreach Camps are also being conducted. So far 46% UHNDs and 35% Special Outreach Camps have been conducted out of the sanctioned number. The special outreach camps are being held as a screening camps rather being as a comprehensive care services to the vulnerable section of the urban poor with diagnostics, curative and referral care services.
- Four out of 5 positions have been filled for the porgam management staff. Deployment of the staff has been done at State and District level. Program management staff is unavailable at only Nongstion District. Clinical and Paramedical staff recruitment is also almost complete. 100% MOs and ANMs are in place, while there are a few vacancies among ANMs (16%), LTs (11%), and pharmacists (16%).
- In FY 2013 – 14 and 2014 – 15, an amount of Rs. 2.48 Crore and Rs. 13.17 Crore has been released to the State. Against the total amount of Rs. 15.93 Crore released to the State, the expenditure of Rs. 0.14 Crore (1%) has been reported so far. RKS are not operational for UPHCs, and UPHC bank accounts have not been opened.
- Reporting being done in Sub Center format for UPHCs instead of UPHC format.
- Re-designation of Urban Health Centers as UPHC has not been done.

ODISHA

- Mapping has been completed in 46 cities. Vulnerability mapping (identification of slum & other vulnerable populations) has been done for 2362 slums. Stakeholder mapping has also been conducted in the NUHM cities.
- Additional Mission Director, NHM has been made responsible for NUHM as State Nodal Officer. At the city level, City Health Mission/City Health Society has been established in five cities i.e. Bhubaneswar, Cuttack, Berhampur, Sambalpur and Rourkela city and a dedicated City Program Management Unit has been established at the ULB premises to support for implementation of the NUHM program.
- The ULBs are directly involved and implementing the program. In the CHM/CHS, the representative of various departments like WCD, H &UD, S &ME are included to ensure convergent action at different level.
- All 46 sanctioned UPHCs have been established**.** 41 UPHC (New) have been sanctioned in 17 districts and are in the process of being established. Facility assessment of infrastructure, HR, equipments in all UPHCs has been completed**.** However, infrastructure in some of the facilities visited was found to be unsatisfactory. Toilet services were below satisfactory in UPHC Bhadrak, and lab services at Puranabazar UPHC were not available
- NGOs have been engaged to for formation of MAS, capacity building of MAS, hand holding support to MAS, selection of the ASHA, capacity building of ASHA, formation of Ward Kalyan Samitis (WKS), capacity building of WKS, slum survey,

identification of UHND sites, stakeholder analysis etc. Two NGOs Reads and Gramya Vikas Samiti (GVS) have been mentoring the MAS in Nabarangpur. The MAS have ward Councilor and the ANM as the signatory for the untied fund. Number of UHND held are 6908 against a sanctioned number of 18054 in the last 6 months. UHNDs are being organized with involvement of ANM, Urban ASHA, AWW, ICDS supervisor and MAS members. Against a sanctioned number of 108 special Outreach camp, no camps have been held yet.

- Funds of Rs.24.59 crore (FY 2015-16) were sanctioned. Rs.50.39 crore was available as unspent balance of previous year including interest (No funds was received from GoI in current financial year) Untied grants been sanctioned to 46 UPHC and 3 UCHC, and released to to 41 UPHC and 1 UCHC. However, untied grant has been utilised by 27 and 1 UCHC. Rogi Kalyan Samiti formed at 42 UPHC and 3 UCHC.
- Grievance redressal box was available in the premise of UPHC in Puranabazar but patients were not aware of any such mechanism. The team observed poor monitoring mechanisms at all levels. There was little data usage for planning and implementation.

PUNJAB

- City health plan for 40 cities (39 having population more than 50,000 and One District HQ SBS Nagar) were prepared in the year 2013-14. Based on the existing infrastructure and gap analysis, city plans were prepared and NUHM PIP was prepared accordingly. Preliminary Mapping of all the cities was done while preparing city plans. All Government Urban Health Institutions were listed and the status of available human resource and infrastructure was assessed. Preliminary mapping and facility survey of all Health Institutions was conducted. The detailed ToR for vulnerability mapping and plotting of health centres on digital map have been prepared and State is in process of undertaking vulnerability mapping.
- 13 Urban CHCs are to be established (6 at Ludhiana, 4 at Amritsar and 3 at Jalandhar) including 2 already functional CHCs at Verka (Amritsar) and PAP (Jalandhar). One CHC at Vardhaman Ludiana has been constructed and functional. Prince of Wales Janana Hospital, Amritsar is being strengthened as Urban CHC. At Narayangarh a Municipal Corporation Dispensary where Urban CHC is being constructed. 2 Urban CHC at Basti Guzan and Khurla Kingra (Jalandhar) is being constructed. Land for 5 another CHCs in Ludhiana city has been identified and work in progress.
- 142 existing health institutions out of which 85 are in Government building (59 Health Department and 26 Municipal Corporation buildings). For the 1st year 93 Urban PHCs have been operationalized – 60 already existing health institutions and 33 UPHCs in rental building. 33 new building of already existing health institutions is being constructed to function as Urban PHCs.
- 2052 ASHAs out of 2394 ASHAs have been selected. 1528 ASHAs have been trained. 6885 Mahila Arogya Samitis have been constituted out of 8974 MAS
- 23 urban health kiosks have been established at: Amritsar (2), Bathinda (4), Jalandhar (6), Khanna (1), Ludhiana (6), Patiala (1), Malerkotla (1) and SAS Nagar (2).

RAJASTHAN

- The State NUHM Mission has contracted out the GIS based mapping to the Department of Information Technology (DOIT), and the results will be available within a quarter. The State has completed the Stakeholders mapping exercise. The vulnerability mapping exercise is going on.
- Additional Mission Director leads the process of NUHM program implementation under the State Program Management Unit. Various program functionaries under the NUHM program have been recruited (State – 10, Cities – 20, and Districts – 60) in recent past through a transparent recruitment processes. Doctors and paramedical staff (approx. total - 103) recruitment processes are in the final stage. The State aims to complete the entire recruitment processes by November end.
- The State suffers from service delivery infrastructure deficiency in the urban areas. The state has 206 UPHCs, of which 102 need to be constructed. 82 need to be renovated and 22 require up-gradation. The Department's engineering wing is very helpful in this regard. 133 are functional—104 are being run by government buildings and short term measures have been adopted by the State to run 29 UPHCs in the rented private buildings, which are close to the slum population. In Jaipur, It is expected that these service delivery points will be functional by next quarter. The State is also planning to have 36 Health Kiosks (Jaipur-16, Jodhpur-10, and Kota-10) to extend the services to most needy areas.
- The drug distribution system and basic diagnostic facilities in these functional UPHCs are providing services to the users. Drug procurement and distribution in urban health facilities part of large state drug procurement and distribution system under NHM in the State.
- Sahyogin is working under ICDS were co-opted as ASHAs in the Urban Health. 2,703 ASHAs are in place under the NUHM program although 1,555 have been sanctioned in FY 2015-16 to receive incentives. They have been given the induction training. This is a good example of convergence between ICDS and Health Department. The State has formed 3,752 Mahila Arogya Samiti (MAS) against 4,664 sanctioned MAS. Bank accounts of 3,105 MAS have been opened and funds have been transferred to 2,754 MAS. Monthly UHNDs have been planned in each UPHC. ANC and Immunisation are the regular services offered during the UHND. The due-list is prepared by AWW and ASHAs. 174 health camps have been organized so far.
- The overall fund utilisation is low in the state (13.14% against allocation),

UTTARAKHAND

- Uttarakhand has had a delayed start in the implementation of the urban mission. The legacy of implementing the erstwhile Urban-Reproductive & Child Health programme through Public Private Partnership (PPP) has also been carried forward for NUHM by the state.
- The state had out sourced GIS mapping to Remote Sensing Authority. The vulnerability mapping and assessment has also not been planned by the state.
- The complete implementation of the program has been outsourced to NGOs under PPP. The establishment of the UPHCs, recruitment and posting of the clinical

and support HR, development of orientation and training material is undertaken by the NGO partner. All the requisite HR is in place at the health facility.

- The infrastructure of the UPHCs was found satisfactory and was well maintained; although uninterrupted power supply facility was not available. Service delivery at all the UPHCs visited was found par below than the enlisted services in the PPP contract. Convergence of NUHM with various disease control and non-communicable disease programs is lacking at the UPHC.
- The convergence and coordination system between ULBs and state/district health department is very weak. USAID's Health for Urban Poor program had a presence in the state but no convergence was established to render any technical support in urban health. ULBs have limited role in the primary health care of their population and are weak in terms of HR, technical knowledge and monetary support.
- Although the urban ASHAs are in place adequately, their irrational deployment leaves gaps at the community level services. As ASHAs are attached to a rural PHC for their administrative work, their reporting structure also needs to be streamlined. Further, a delay of 6 months has been found in urban ASHA's incentives payment. No training for the urban ASHAs has been conducted in the urban induction module. Formation of *Mahila Arogya Samitis (MAS)* has not been initiated, with a sanctioned number of 1100 MAS. The "*Rogi Kalyan Samitis"* (RKS) have not been constituted at any of the UPHCs across the state.
- Unavailability of IT support systems hampers the facility based reporting through HMIS, MCTS etc. Further, the newly recruited staff being untrained in HMIS/MCTS enlarges the gaps in timely and effective data reporting.

UTTAR PRADESH

- Vulnerability mapping has not yet initiated in the state. However, with support of Urban Health Initiative (UHI) state has completed stakeholder mapping in 83 cities approved in 2013-14. But the funding for UHI supported project is discontinued in the current financial year.
- In SPMU 10 Program Management staffs are in-position (1 GM, 1 DGM, 2 Program Coordinators, 1 Accountant, 1 Computer Operator, 4 support staff). Positions of 1 Additional Mission Director and 2 consultants are vacant. Urban Health Cells at Divisional/District/City level are not functional due to non-appointment of sanctioned positions. Urban Health Cells were not present in the districts visited.
- 558 UPHCs and 9 UCHCs have been approved under NUHM. 93 UPHCs are functional in Govt. Building and 462 are in rented building. Approval has been given for renovation of 59 facilities. Gap analysis has been conducted to identify the status of HR and Infrastructure. 540 UPHCs are functional in the State. Health Kiosk have not set-up. Infrastructure observed in the facilities visited was good, including signage, bio medical waste disposal water supply seating etc
- Selection of Urban ASHA and formation of MAS has not been done yet, which is affecting implementation of outreach sessions. State has reported that 11696 UHNDs/month will be organized after selection of Urban ASHA & release of fund.

Outreach activities (eg. during VHND) limited primarily to immunization, ANC and contraceptive distribution.

- Although funds have been approved, no fund has been released in the current financial year. In FY 2014-15, utilization was 41% only, till September. There is a provision of bank accounting system for 1st tier for NUHM so there is a single account at DHS for NUHM. There is a separate account for RKS for each UCHC/BMC. There is no separate account for UPHC and thus, RKS is not constituted for UPHCs. It is stated that at UPHC approval has given by GoI for contractual staffs only. Therefore, signatory for RKS account is still not identified.

WEST BENGAL

- Mapping of health facilities and slums have been completed only for Kolkata while it is under progress in 31 cities. Another 60 cities are yet to start the process of mapping. Slums have been identified in all the 92 ULBs. The Department of Science & Technology, Govt of West Bengal is to complete GIS Map for all 92 ULBs in phased manner. UPHC sites have been identified after proper surveys. Vulnerability mapping has not been initiated.
- Over 95% sanctioned positions for program management staff under NUHM is yet to be filled. About 5% full time MOs, 0% public health managers, 5% nurses, 10% pharmacists and 0% lab techs were currently in place. The delay in recruitment is largely due to difficulty in finding suitable candidates. In Haldia, it was observed that doctors are available for only 3 days per week at each UPHC for 2-3 hours. The Municipality is geared more towards contractual employment.
- While the state and districts PMUs have adequate technical resources for implementing NUHM, capacity of municipalities was found to be limited. The implementation in Kolkata (mega city) is being done efficiently by the Kolkata Municipal Corporation, with many best practices such as rabies control; modern abattoirs, modern burning ghats, compactor machines (conservancy), complaint mechanism through WhatsApp.
- At State level, convergence has been established with Departments of Municipal Affairs, Women & Child Development, Science & Technology, Municipal Engineering Directorate and State Urban Development Agency (SUDA). At district level, convergence has been established through DHFWS. The district levels officers of different line department are part of this Samiti. Urban health societies been established in all 6 cities including Kolkata, with representation from various urban development departments.
- A little less than 50% of the sanctioned UPHCs are functioning in the state. In Kolkata, there has been very good infrastructure creation by wards. Proposal to convert all Ward Health Units into UPHCs seems to be effective. BMW practices being followed even at new UPHCs.
- ASHAs and MAS haven't been formed in the state. However, existing experienced Honarary health workers (HWW) have been retained and are expected to be positioned as ASHAs. About 2% of the sanctioned UHNDs were conducted in the first 6 months of the year. Special outreach camps have started.

- Only Rs. 1.20 crores were utilized within the first 6 months of this year. Reason cited for low pace expenditure was the Municipal elections in the first quarter of 2015-16. 20% untied funds being given to ULB.
- Functions of ULB under NUHM have been defined well by the state and capacity is being built by giving responsibilities, funds and seeking participation and accountability. Though this is a slow process, the state has shown the patience for longer term benefit and capacity development of ULBs.

TOR 10
GOVERNANCE AND MANAGEMENT

OBJECTIVES

1. Review the functioning of State Health Mission, State Health Society- governing body and executive body, operations of district health societies, the district planning process and use of evidence (survey data/HMIS/ MCTS/SS visit reports) for planning purposes at various levels.
2. Assess functioning and organization of State PMU, integration/coordination with State health directorate, performance of Staff, field visits and system of review of the program and supportive supervision mechanism.
3. Review CEA and PCPNDT implementation.

NATIONAL OVERVIEW

Effective governance mechanisms are instrumental in creating enabling environment in which health workers and programme managers are more likely to secure medicines, staff, equipment, supplies and facilities they need to save lives and improve health. Under the National Health Mission, support provided to establish programme management structures have yielded results, in almost all the States. However, the programme management structures need strengthening in the Urban Health Mission. Decentralized planning is struggling below block level in all the States. Supportive Supervision systems are now streamlined but analysis and feedback mechanisms are still a challenge. NHM support to the States implementing CEA, PCPNDT, etc. is beginning to yield results. Convergence is still a challenge, but the linkages with ICDS appear to be the most successful among them. Coordination of state departments with urban local bodies is now a priority concern for implementation of urban health mission.

KEY FINDINGS

- **Institutional Mechanism of NHM:** The State/District Health Mission and Health Societies in Karnataka and West Bengal are still in process of including urban directorate, local bodies & related officials and experts. They are yet to be included in Assam, Delhi, Himachal Pradesh, Jharkhand and Manipur.

- Conduction of timely meeting is a concern in many states except for Madhya Pradesh, Punjab, Rajasthan and Karnataka. DHM meetings are held regularly in Chhattisgarh and Uttar Pradesh only. The prior agenda and minutes of meeting are shared in all the states in SHS and DHS meetings. There is a system in place for the document approval in the meeting in states where meetings are also regularly conducted. Only in emergency case post facto approvals are taken in such instances. Below district level maintenance of minutes of meeting is an issue. There is clear cut devolution of financial powers in place in nine states Chhattisgarh, Delhi, Himachal Pradesh, Jharkhand, Karnataka, Odisha, Rajasthan, Uttar Pradesh and West Bengal. Capacity of PRIs is inadequate in Andhra Pradesh, Odisha and Punjab.

- **Planning Process:** The decentralized planning is poor in States like Andhra Pradesh, Delhi and Manipur and probably this is not just defeat of decentralized process but also an inability to view the entire picture at desired levels. States such as Chhattisgarh, Jharkhand, Karnataka, Odisha, Punjab, Uttarakhand and UP have initiated planning from village level and they are also aware of tentative allocation limit. Delhi, Chhattisgarh, Jharkhand, Karnataka, UP and Uttarakhand made cuts in budgetary allocation in district plan with prior consultation with the district while in West Bengal and Haryana budget allocation is not as per the District Health Action Plan. In West Bengal there was limited decentralized planning in the district with no involvement of VHNCs in the planning process. In Punjab, devolution exists but risk aversion limits fiscal authority. In Maharashtra 3-year perspective plan is found to be good but post ROP, district officials are not aware of financial allocations.

- **Review and Supportive Supervision:** The overall review and supportive supervision are weak across many states. Regularity in monthly review at all levels is observed in West Bengal and Jharkhand. Only in Delhi corrective actions based on field visits were observed. Linkages with stakeholders (esp. development partners in TSUs) for ensuring a structured and systematic supportive supervision system for HPDs were limited, except West Bengal where a fixed day review system exists where all concerned officials participate.

- District Level Vigilance & Monitoring Committee (DLVMC) as per GoI guidelines has been successfully reconstituted in Assam, Karnataka, Rajasthan, Chhattisgarh, Punjab, Haryana, Meghalaya and Odisha but this is lacking in Manipur and Madhya Pradesh and UP and is in process of reconstitution in Jharkhand and Maharashtra.

- **Convergence Measures:** Chhattisgarh, Delhi, Himachal Pradesh, Jharkhand, Maharashtra, Punjab Uttarakhand, Uttar Pradesh, and West Bengal have a framework and action for convergence in place and has extended to ICDS, Education department, PHED and PRIs etc. In Delhi, Uttarakhand and UP convergence at district and block level is lacking and no such framework in Andhra Pradesh, Assam, Haryana, Jharkhand, Manipur, Odisha and Rajasthan were observed. In Maharashtra Governing Board of DHS is chaired by District

Collector and co-chaired by Chief Executive Officer, Zila Parishad of Panchayati Raj department. Other state like Uttarakhand has undertaken interventions for convergence with other departments, which is expected to yield positive results.

- **Regulation:** Chhattisgarh, Himachal Pradesh, Jharkhand, Odisha and Rajasthan implemented CEA 2010. The number of clinics registered under CEA 2010 in Himachal Pradesh is 5741 and Chhattisgarh is 172. The process is yet to be initiated (notification of rules, designating authorities, initiating registrations etc.) in Andhra Pradesh, Madhya Pradesh and Maharashtra. States such as Assam, Delhi, Karnataka, Manipur and West Bengal have state specific Acts in place.
- Implementation of PCPNDT Act is there in almost all states (West Bengal, Uttarakhand, Himachal Pradesh, Andhra Pradesh, Chhattisgarh, Uttar Pradesh, Manipur, Jharkhand, Assam, Punjab, Maharashtra, Karnataka and Rajasthan) except Meghalaya, Delhi and Haryana. However poor monitoring is observed in Uttarakhand, Jharkhand and Odisha.
- In last one year very few (1-3) complaints are registered under PCPNDT act in states like Himachal Pradesh, Maharashtra, Manipur and Uttarakhand and registered cases are being disposed off at slower pace in Jharkhand, Maharashtra and Punjab. It is important to note that implementation of Act would gain from analysis in the trends of sex ratio (gender disaggregated data for all ages) which is by and large not attempted. Implementation of PCPNDT Act continues to be a challenge in Maharastra.
- **Programme Management Unit and Integration with Directorate:** Mission Directors of Delhi, Jharkhand, Rajasthan and West Bengal are also the Secretary or Commissioner of Health Services and also handle some additional charges. In Chhattisgarh MD also holds the charge of Additional Director, Health & Family Welfare and CEO of CGMSC. In Uttarakhand, MD also holds charge of Additional Secretary, Medical Education and General Administration department. In Jharkhand, the Director–in–chief shares financial signatory with MD. The directorate officials handle thematic areas under NHM however their pro-active approach and involvement is not adequate except in Jharkhand, MP, Odisha, Rajasthan and West Bengal.
- The problem of high attrition rates, turnover and vacancies in the contractual staff is undermining functionality of program. The problem is highest in three states (Uttarakhand, Chhattisgarh and Jharkhand) where more than 35% positions are vacant which is attributable to lower salaries and unavailability of skilled workforce. DPMU capacity in states is mixed. Frequent changes in leadership level are adversely affecting the programme management (e.g. UP).
- Well structured performance assessment system is in place in Delhi, Chhattisgarh, Karnataka, Odisha and Uttarakhand but ineffective in Rajasthan and West Bengal and yet to be initiated in others states. Linkages of performance appraisal with capacity building mechanisms is absent in all states. Chhattisgarh, Jharkhand and Odisha conduct well established capacity building sessions whereas Delhi, Uttarakhand and Andhra Pradesh have limited and inadequate structured systems. In almost all the states SPMUs and DPMUs are in for multitasking and as a result, in most of the instances core NHM focus area becomes diluted.

RECOMMENDATIONS:

1. State-wise mapping of urban local bodies and directorate needs to be undertaken with a clear directive at state and district level for including them in State/ District Health Mission.
2. All ULBs and Directorate should also be oriented on the programme and policies of NHM with special focus to urban health. Induction training on NHM of all officials including Secretary, Mission Directors, DHS and SPMUs needs to be undertaken.
3. The SHM and DHM members' participation helps in improving and accelerating the various initiatives under NHM. So adequate orientation and advocacy to the chairmen and the members needs to be undertaken. A letter from GoI (preferably from Honorable HFM) needs to be written to all states for prioritizing these initiatives.
4. All the states need to issue a GO for systemic organization of SHM, DHM and SHS, DHS meetings where the agenda should be based on the issues and the problems and should be circulated at least 2-3 weeks in advance and minutes of the meeting must be circulated within a week of conduction of the meeting.
5. Periodic orientation on Public Financial Management System for district and state level functionary should be regularly organized. Keeping transparency at every step in financial dealings must be communicated to all concerned.
6. A necessary GO on devolution of powers with clear roles and responsibilities upto block level needs to be issued. This will help in fast tracking of the activities undertaken under NHM.
7. Involving PRIs, VHNCs and Urban Local bodies needs to be emphasized by the states and capacity building of these bodies needs to be undertaken on priority in almost all states.
8. States needs to indicate in advance the tentative budget allocation for the districts and blocks before the planning process is initiated. This will help in preparing meaningful action plans.
9. Allotment of funds to the districts and blocks should be a flexi-pool under the broad head. However once the activity is accomplished the expenditure should be booked against the relevant FMR.
10. HMIS, survey data at local situations must be taken into consideration before planning a particular activity.
11. States must ensure involvement of other departments in preparing district action plans/ district PIP since many activities under health are cross cutting and can be implemented by the better expertise of the concerned departments.
12. Effort for better convergence between NHM/ SPM and health directorate will improve if the various levels of officials in the directorate are given financial powers or at least made joint signatories. This will help in developing ownership of the programme.
13. States need to create models in district where good governance and transparent financial management can be showcased for replication in other districts/ states.

14. State should also develop HR policy for all levels of contractual staff and it should be based on HR retention approach.
15. Capacity building should be linked with performance appraisal and state should link HRIS and HMIS for performance monitoring of service providers.
16. TORs with clearly deliverable targets and measurement of performance against TORs of SPMU and DPMU staff should be monitored by their supervisors and reviewers before giving increment/ renewal of contract.
17. Team incentives (monetary/non-monetary) could be developed for good performance particularly for those who are working in hard to reach areas.
18. GoI has developed supportive supervision mechanism for RMNCH+A. However it is not implemented as envisaged. Therefore the recommendations of supervision should be incorporated in the district review meeting for the follow up action and eventually District Health action plan.
19. All states needs to improve supervisory visits with a defined checklist, brief gap analysis, time bound actions and mechanism for review.
20. DLVMC needs to be reconstituted as per GoI guidelines in left out states.
21. District Collector's orientation in NHM activities and various governance mechanisms must be undertaken by all states.
22. Maharashtra model of convergence at district level is a good model for replication in other states.
23. Advocacy for implementation of CEA 2010 in all the left out states needs to be undertaken by GoI.
24. Orientation of PRIs, religious leaders, community leaders needs to be undertaken involving legislators and parliamentarians on the issues like sex selection and importance of girl child.
25. NGOs and SHGs can be involved in monitoring the implementation of PCPNDT act.

STATE FINDINGS

ANDHRA PRADESH

- State is yet to improve institutional mechanism for systemic planning and operationlization of health. Devolution of power for administrative and financial approvals is grossly inadequate.
- Lack of standardized approach to support supervisory & monitoring mechanism at all levels of community
- Inadequate mobility support is hampering supportive supervision visits.
- State has poor convergence between different departments. Social Audit for community health care is not established in the state.
- State has implemented PCPNDT act.
- Clinical establishment act is yet to be implemented.

- Requirement for Training, Re-orientation programme was felt for all programme management units.
- PMU lacks basic operational facilities like computers, printers, cabinets and cupboards etc.
- AP fares poorly across all parameters, but this can be due to the recent division of the State. The state needs to strengthen governance & accountability mechanisms and recover the lost ground.

ASSAM

- State health mission reconstituted with representative of Zila Parishad, PHE Department, Schools etc. are included in the DHS, with Deputy Commissioner as Chairperson.
- DHAP is formed out of block plans and so is State PIP
- State has revised terms of reference and performance appraisal process
- DLVMC has been reconstituted by state as per GOI guidelines.
- State has institutionalized supportive supervision mechanism at various level
- State has Assam Health Establishment Act 1993 in public domain
- State has implemented PCPNDT Act, dedicated website for PCPNDT Act is in public domain
- Lack of Convergence and Coordination among Directorate and SHS was observed which is integral to planning and optimal utilization of resources
- PMU is not fully integrated with directorate in terms of posting, salary and other benefits.

CHHATTISGARH

- The State has included Urban Development Directorates, Urban Local Bodies in SHM/DHM & SHS/DHS.
- Prior approval of the competent authority is obtained before incurring expenditure.
- Clear 'Devolution of Financial Power' exists and Order copy is available at all levels.
- Gap identification, compilation, consultation & incorporation in the planning process seen at all levels. The good planning model followed is limited by high HR gaps.
- Districts are unaware of tentative allocations by the state and are not informed about cut in their plan /budget.
- State is facing governance issues with Jeevan Deep Samitis, which on priority needs to be sorted out.
- Supportive supervision mechanism is followed in the state, visits were happening as per the schedule and reports have been uploaded on the website
- State has DLVMC existing, proper follow up action are reviewed in review meetings

- State has implemented Clinic Regulation Act, 172 clinics registered under the Act. However there are no clinic registered in the district under the Act
- State has implemented PCPNDT Act, but no complaints are registered under the Act.
- Mission director NHM holds ex- officio charge of additional director, health & family welfare and CEO of CGMSC
- Skilled based competency testing and interview followed for recruitment
- State has system in place for regular training for capacity building of all staff and annual performance assessment

DELHI

- SHM/SHS has not yet included the Urban Development Department and DHM does not have any PRI involved.
- Planning and budgeting process leaves little scope for incorporating local requirements/priorities
- State is yet to reconstitute DLVMC as per GOI guidelines
- State practices isolated field visits for supportive supervision which is not structured or comprehensive, except QA teams and ASHA coordinators.
- NHM has convergence with ICDS Department at field level
- State has Delhi Nursing Home Act and more than 1000 nursing homes are registered under the Act.
- Mission director NHM is also chief of the directorate of health services, Delhi
- State has no capacity assessment plan for management of staff
- Well structured performance assessment system developed as criteria for contract renewal &performance

HARYANA

- DHM has been expanded to include urban local bodies
- District planning process is in place but implementation is getting affected due to non-release/shortfall of funds.
- District is not aware about the resource envelop
- State has supportive supervision portal, reports on supervision by the civil surgeon, DCS, SMO & MOs are being uploaded on the portal.
- State has reconstituted DLVMC as per GOI guidelines.
- State yet to develop action plan and framework with respect to convergence between different departments.
- Programme management structure at state level is benefitting from SHSRC
- Accountability and stakeholder coordination mechanisms are not strengthened in the state, although many partners are engaged with the processes.

- Information generated by different information sources is not adequately utilized for decision making process
- Best practices and lessons learned from different initiatives in districts are not replicated for common good

HIMACHAL PRADESH

- SHM/ DHM & SHS/DHS have not yet included the Urban Development Directorate.
- Meetings of governing body/ executive body of SHS & DHS not held as per the norm.
- HP is using existing staff to manage state, district and block PMUs. While the reluctance to recruit contractual staff is understandable, the lack of a managerial / public health cadre affects several functions such as planning, supportive supervision etc. which have been identified as weak areas by the team
- Devolution of financial power up to SHC level have been issued in the state
- Districts ROPS prepared at state level do not take into consideration DHAP.
- State has developed a comprehensive supportive plan which includes RMNCH+A, NCDs, DCPs and all other programme of NHM.
- Faculty of medical college, state program officers and development partners are nominated for strengthening supportive supervision. Monthly reviews are being done at state, district and block level
- In the state convergence is observed for departments like women and child development for RMNCH+A, Panchayati Raj for community process, Education for Adolescent Health, Ayurveda for RMNCH+A, DCP and NCD etc.
- PCPNDT is implemented in the state. 261 ultrasound centres (86 govt. & 175 private) are registered in state.
- Clinical establishment act has been notified in the state, the copy and rules are available in public domain.

JHARKHAND

- SHM & SHS have not been expanded to include urban local bodies
- Meetings at DHM level are not being held.
- Gap analyses starts from block level and local needs are incorporated in DHAP.
- Gap analyses of HR and infrastructure is done once a year
- In case of cuts in district plan, consultation workshop is held prior to finalization of state plan.
- DLVMC yet to be reconstituted and non-functional in the state.
- State is regularly conducting monthly review for supportive supervision and reports are provided as per the structured format.
- State is conducting regular reviews

- State has constituted a committee for convergence on different health issues and programs. Departments such as School Education & Literacy Development: Drinking Water and Sanitation Department: Women, Child Development & Social security Department etc. are on board
- State Health Mission has made successful headway in the convergence of Directorate of health Services and State Health Society.
- The Clinical Establishment Registration and Regulation Act,2010 has been implemented by Jharkhand
- The state of Jharkhand reconstituted the state level committees for CEA, 2011& sensitization of the officials at state& district level held.
- State is under process to implement PCPNDT Act.
- Training conducted for capacity building for DPMU & BPMU
- Performance of staff assessed through self assessment template reviewed at three levels.

KARNATAKA

- SHM/SHS and DHM/DHS expanded to include the representatives of Urban Development officials.
- SHM & SHS and DHS & DHM meetings held regularly
- The financial powers delegated to DH, Taluk, PHC and MO Health Officers.
- Gap analyses report prepared at village level, included in DHAP & State PIP.
- HMIS data utilized in planning
- At state level, a workshop is held before finalizing the state PIP where all district representatives are called for the deliberations
- State yet to have to improvise supportive supervision to bring in proper structured mechanism.
- DLVMCs have been reconstituted in the state.
- State has implemented CEA i.e. Karnataka Private Establishment Act 2007and 1733 clinics have been registered under the Act
- State has implemented PCPNDT Act.
- Effective & Well planned performance assessment system in state

MADHYA PRADESH

- Urban health component included in SHM, SHS and DHS
- Limited coordination with local bodies seen i.e. Nagar Palika for ruling out UHM
- RKS records and handling funds also found very weak.
- Gap analyses conducted from block level

- State yet to have a proper mechanism for supportive supervision, monitoring & reporting
- State has not CEA, 2010 but the Madhya Pradesh Nursing Homes Registration Act (The Madhya Pradesh Upcharyagriha Tatha Rajopchar Sambandhi Sthapanaye (Ragistrikaran Tatha Anugyapan Adhiniyam, 1973) is in force.
- Requirement to have a better coordination among different programmes felt.
- Human resource demand is program specific showing many vacancies as the demand is based upon particular program and not based upon work load

MAHARASHTRA

- State has set up PMUs at state, divisional, district and block level.
- SHM/SHS and DHM/DHS have been expanded to include Urban Development directorate and urban local bodies
- Meetings of GB and EC held at regular bases
- District officials found unaware about the resource envelope.
- DHAPs not contributing significantly to state PIP
- DLVMC is under process of reconstitution.
- Supervision visits are conducted as per schedule.
- Review meetings are being conducted monthly & weekly
- State needs to emphasize on the reporting mechanism & then visualize solution to the problem in reports.
- Convergent departments have been coordinated through Panchayati Raj institutions.
- State of Maharashtra has implemented PCPNDT Act but continues to face challenges.
- State is tracking each delivery online.
- CEA has not be implemented in the state yet.
- State has revised terms of reference and performance appraisal process (e.g.- Osmanabad district)
- State has sufficient program management staff
- There are eight divisions in the state in addition to this state has created Circle Programme Management units at divisional level

MANIPUR

- SHM has been formed but meetings not held timely. DHMs are being formed
- DHAP are made but not block/village action plans.
- Poor governance is reflected across all parameters, supportive supervision, financial allocation, recruitments etc.

- Centralized recruiting system, requiring cabinet approval is time consuming, making district PMUs eventually weak
- Need to strengthen systematic supportive supervision in a proper manner felt.
- State yet to develop convergence between different departments for NHM goals
- Two districts of state been selected for PC-PNDT Act under the GOI 'BETI BACHAO – BETI PADHAO' SCHEME
- Under Manipur nursing home and Clinical Registration Act, 199226 private clinics has been registered.

MEGHALYA

- State & District health societies formed and only one meeting held one year back
- Below state level planning (DHAP & BHAP) not evident.
- DLVMCs are constituted in the state.
- State needs a comprehensive supportive supervision mechanism.
- Meghalya Clinical Establishment Act is under process of implementation
- PCPNDT Act implemented but field staff lack awareness about Act
- State Health Mission and District Health Mission is being formed.

ODISHA

- There is good integration of NHM with directorates for planning and service delivery
- Decentralized planning not in place
- State has established integrated monitoring teams.
- State has reconstituted vigilance and monitoring committees
- State is implementing Clinical Establishment Act & PC-PNDT Act.
- State has implemented the strategy of performance based incentive to NHM staff.
- State has not started the process of recruitment of staff

PUNJAB

- Expansion of the programme in the urban areas as per NHUM norms, has been undertaken.
- Payments are being done by prior approval and ex-post facto cases are rare
- Village level planning is not there. Village Sarpanchs have shown willingness to participate in planning process and shared that currently scope for their involvement is limited.
- Review and supportive supervision as per format of NHM is being followed.
- Supportive supervision system is not structured

- DLVMCs reconstitution process is still in process
- In the state, Ayush and Allopathy services are being observed under one roof and convergence with different departments like Education department WCD, Water Sanitation Department or even local bodies services being converged to maximize the results.
- State hasn't yet established CEA, 2010
- PC-PNDT Act has been implemented in the state.
- Recruitment of staff done under SPMU/DPMU
- ACRs and Performance Appraisal formats are being used to access performance of administrative staff and service providers

RAJASTHAN

- SHS & DHS expanded to include representative of Urban Development Directorate and urban local bodies.
- State, District and Block PMU are functional with adequate staff
- RKS (Rajasthan Medical Relief Society- RMRS) is functional at all facilities but meetingsare not conducted on a regular basis.
- There is clear cut devolution of financial powers in place in State.
- Planning process starting from block to district and then to state level.
- Prior to planning exercise, one day orientation for block and district officials is done at State.
- DLVMCs have been reconstituted.
- Supportive supervision mechanism field reports/ inspection reports are uploaded on website on second week of every month.
- State has adopted Clinical Establishment Act. State council and district registering authority has been constituted.
- PC-PNDT Act successfully implemented in the state. State has online portal on PCPNDT under Department of Medical Health & Family Welfare
- Mission Director NHM is also Commissioner of health services
- Performance appraisal system exists in the state however in Bikaner performance appraisal of DPMU staff has not been carried out in last three years.

UTTAR PRADESH

- SHM & DHM have been expanded to incorporate National Urban Health Mission.
- SHM/DHM and SHS/DHS meetings are not regularly held
- Pragmatic bottom up data information and top down plan allocation
- DHAP prepared based on HMIS data review.
- Once the ROP is received, district is informed and DHAP is revised to suit the ROP.

- State mechanism for supportive supervision involve frequent visits by state & divisional staff.
- Visits are not conducted as per the pre-decided schedule.
- State has convergence among various departments, but at the field level convergence with the ICDS departments appears to be remarkable and significant(AAA platform is one such example in Sitapur)
- State is implementing PCPNDT Act
- The CEA act in state of Uttar Pradesh is under process of implementation
- State has established divisional units and programmes management units at district and block level.
- DPMU staff is overburdened by the number of programmatic intervention of various programmes. Lack of public health skills among district staff limits potential for health system strengthening in districts
- Performance appraisal process is not comprehensive
- Synergy between SPMU, SIFPSA and Directorate is effective, facilitating implementation by leveraging NHM funds
- Devolution of powers to the district and block is not yielding results in the absence of oversight and monitoring (esp. by district to blocks), resulting in poor governance

UTTARAKHAND

- SHM is being chaired by Chief Minister and DHM by Chairman of Zila Parishad
- SHM/ DHM and SHS/DHS meetings are not being held as per the norms.
- Ministry of urban health has been included in SHM
- District level plans discussed prior to finalization of State PIP.
- Lack of use of HMIS/MCTS data in planning
- Districts are aware of tentative allocations prior to budget allocation made by the state
- State has a weak supportive supervision mechanism at all levels
- DLVMCs have been reconstituted by the state.
- State practices good convergence with ICDS at the grass root level.
- State Level workshop held to enhance the convergence with other departments.
- The implementation of CEA is under process (Act notified, rules pending).
- PCPNDT Act has been implemented in the state. State is trying innovative methods like, 'Dharma Guru', 'Hamari Betiyan Hamara Gaurav campaign', 'Brand ambassadors', installation of 'Silent Observer Device' in USG etc.
- Mission director NHM holds additional charge of 'Additional Secretary, Medical Education and General Administration Department'

- Performance assessment is done prior to renewal of staff contract but no defined objective criteria are available.
- Convergence with ICDS at grass root level is good

WEST BENGAL

- Representative of Urban Development Directorate, urban local bodies are in process to be included in SHM/DHM & SHS/DHS.
- SHS & DHS meeting held, prior agenda being circulated, post facto approval in emergency situations only
- The district budget has been made by state and does not clearly align with the demand by the district
- State has institutionalized supportive supervision mechanism.
- Meetings under chairmanship of MD are held regularly at scheduled time & customized documented reports are being reported.
- DLVMCs reconstitution still in the process
- In the state convergence with different departments for various programs under NHM such as Education department for RKSK, RVSK, ICDS Department, PWD Department Cultural Department, WCD etc.
- State has implemented PCPNDT Act.
- West Bengal clinical establishment act, 1950 successfully implemented in the state.
- Mission director NHM holds additional charge of secretary or commissioner of health service
- Staff performance assessed annually, renewal is being done on the basis of government order and feedback from the institution.

Annexures

ANNEXURE - 1

States	Rural (selected/ target)	Urban (Selected/target)	Training status	Support Structures
High Focus States	484613/ 537998 (90.08%)	12791/ 22151 (57.74%)	Round 1 - >95% in all states except Bihar with 91% and UP with 59% Round 2- >95% in Jharkhand, Odisha and UK; >79% in Bihar and MP; 66% in Rajasthan and 33% in UP Round 3 - > 95% in Odisha and UK, 91% in Jharkhand; 46% in MP and 4% in Rajasthan Round 4 – 52% in UK and 11% in Odisha and 1% in Bihar. Chhattisgarh, has its own training structure and has completed 19 rounds of training for ASHAs	All states have a support cadre at all four levels except, Odisha, which has no dedicated community processes coordinator at the block level.
North Eastern States	54960/ 55476 (99.07%)	1976/ 2184 (90.48%)	Round 1 - >95% in all states except Nagaland with 74% Round 2- >95% in Assam, Manipur, Mizoram, Sikkim and Tripura; >85% in Arunachal Pradesh and Meghalaya and 74% in Nagaland Round 3 - >95% in Manipur, Mizoram, Sikkim and Tripura; >85% in Arunachal Pradesh, Meghalaya and Nagaland; 56% in Assam Round 4 – > 95% in Manipur, Sikkim and Tripura; 84% in Mizoram and 31%in Arunachal Pradesh.	All states have 3-4 levels of support structures except Sikkim. All states have AFs in place, except Nagaland. Assam, Tripura and Nagaland have dedicated support cadre at block level District ASHA Coordinators are in place in all states except, Sikkim
Non High Focus States	316028/ 358234 (88.22%)	22758/ 38673 (58.85%)	Round 1 - >95% in all Karnataka, Maharashtra, Punjab, Delhi and WB; >90% in AP, Gujarat, Haryana and Telangana, 69% in J &K and 27% in Tamil Nadu. Round 2- >95% in Karnataka, Punjab, Delhi and WB; >90% in Gujarat and Haryana; 80% in AP, Maharashtra, Telangana, 69% in J &K and 27% in Tamil Nadu. Round 3 - >93% in Karnataka and Punjab; >80% in AP, Gujarat and WB; >27% in Delhi, Tamil Nadu and Maharashtra and yet to begin is remaining states.	States of Haryana, Karnataka and Maharashtra have dedicated support structure at all four levels. Punjab has a dedicated support cadre at state, district and sub block levels while Gujarat has selected only ASHA Facilitators at the sub block level.

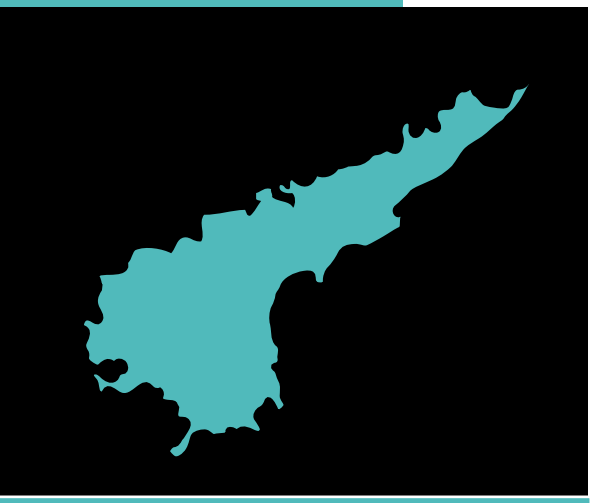
States	Rural (selected/ target)	Urban (Selected/target)	Training status	Support Structures
			Round 4 – initiated only in four states - >94% in Karnataka and Punjab; 78% in Gujarat and 22% in Tamil Nadu. Himachal Pradesh has completed 99% training of ASHAs in Induction Module while Training in Module 6 &7 is yet to begin. Kerala has a different training system based on state specific needs.	In all other states existing cadre supports the programme. J & K, WB and Delhi use existing cadre (ANMs) as AFs, for supporting ASHAs in the field. In addition, Delhi has also recruited District ASHA Coordinators in all districts
UTs	804/870 (92.41%)	92/451 (20.40%)	Round 1 and 2 under way in Andaman & Nicobar Islands; Dadar & Nagar Haveli and Daman & Diu.	Existing staff cadre supports the programme

ANNEXURE - 2

State	Proposed ASHAs	ASHA selected/ working	%	Round-3 Module 6&7 Training	Round-4 Module 6&7 Training	Urban ASHA – Target	Urban ASHA- Selected	Routine & Recurring Incentive	CRM finding - Delay in incentive (Yes/No)	Career Opportunities
Assam	30619	30619	100	22006	10098	1336	1068	Yes	No	
AP	39009	37727	96	26895	0	2660	2635	NA	No	
*Chhattisgarh	66220	66220	100	66109	66109	3295	3781	NA	Yes	Yes
Delhi				1896	Nil	5019	4706	No	No	No
*Haryana	18000	17373		Nil	Nil	2676	1872	NA	NA	No
HP	7752	7539	97%	Nil	Nil	No	No	Yes	Yes	No
*Jharkhand	40964	40964	100	35982	0	216	135	Yes	Yes	Yes
Karnataka	39135	28508	73	27325	27325	2942	1877	Yes	Yes	Yes
*Maharashtra	59203	59118	99.8	19728	Nil	5844	2847	Yes	No	Yes
Meghalaya	6519	6357	97.5	5710	2825	250	156	No	Yes	No
*MP	60105	57765	99	32522	4024	Nil	Nil	NA	No	Yes
Manipur	3925	3878	98.8	3804	3756	81	81	NA	Yes	No
*Odisha	45812	43862	95	42597	9155	1267	1267	Yes	No	No
Punjab	17360	17108	98.5	16416	16576	2394	2032	Yes	No	Yes
Rajasthan	54915	51500	94	4238	0	-	2703	Yes	No	No
UP	160175	138203	86	Nil	Nil	-	-	Yes	No	No
Uttarakhand	11086	10764	97	10209	6794	666	666	NA	Yes	Yes
West Bengal	61,000	46,585	76	41042	0	46621	44909	NA	Yes	NA

NA- Not documented in the report

STATE POSITIVES AND CHALLENGES



ANDHRA PRADESH

REVIEW TEAM

Visakhapatnam District	
1.	Dr. Damodar Bachani, DC(NCD)
2.	Dr. Amol Patil, AD(IDSP)
3.	Dr. ChandanaDeka, NE-RRC
4.	Dr. Aruna Bhattacharya, PHFI
5.	Dr. Anuradha, Asst. Director, RoHFW, Hyderabad
6.	Ms RichaSaxena, Stats
7.	Sh. S. Mahapatra, Under Secretary, M/o WCD
8.	Sh. Sanjeev Gupta, FMG

Anantapur District	
1.	Dr. HimanshuBhushan, NHSRC
2.	Dr. Anil Sain, CMO, DGHS
3.	Dr. Indranil Ghosh Mondal, Assistant Adviser(H)-AYUSH
4.	Ms. Renuka Patnaik, FP
5.	Sh. Daya Shankar Singh, IHBP-USAID
6.	Dr. Pratap Kumar Sahoo, NIPI
7.	Sh. Deepak Kumar, AH

POSITIVES

- Utilization of public health facilities has increased over years. OPD load increased by 30% in last 2 years and IPD by 57%. Number of major surgeries and institutional deliveries have increased remarkably
- No out of pocket expenses reported during client interactions. All drugs as per RMNCH+A matrix available
- Blood bank and Blood Storage Units (BSUs) are licensed and functional
- 108-ambulance services are functional and transporting patients
- The total no. of maternal deaths reported matches with the estimated no. of maternal deaths for the districts. Anantapur district is following the 2 tier MDR process (review by DMHO followed by review by DM) as per the GoI guidelines. All the 85 maternal deaths were reviewed by the District Collector (DC)
- Operational guidelines for use of Gentamicin by ANMs and InjVit-K prophylaxis at birth was found in most of the facilities visited. However, use of corticosteroid was not in place.
- Work chart and ToRare well defined for all cadre from DMHO to ANM
- ASHAs and ANMs are performing extremely well in the state. They are role models for other States.
- Convergence and community processes in the district and state are satisfactory.

DISTRICTS/INSTITUTIONS VISITED

Facility	Visakhapatnam	Anantapur	Urban Facilities
Dist. hospital	Anakapalli	Hindupur	Govt. General Hospital, Anantapur
Area Hospital	Narsipatnam	Guntakal	Medical College, Vizag KG Hospital, Vizag Victoria Hospital, Vizag Regional Eye Hospital, Vizag DEIC, Vizag E Vaidya UHC Urban Sub-centre Urban SC (Lion's) Urban PHC (Red Cross) SIHFW (proposed), Vizag Regional Vaccine store, Vizag Regional TB Laboratory, Vizag Rural Development Trust, Anantapur
CHC	Chodavaram Aganampudi Paderu*	KalyanDurg	
PHC	Kasimkota Thallapalem Rolugunta Makavarapalem G'madugula* Ananthagiri*	Somandepalli Krishtipadu Vidapanekal Atmakur Puttapurthy Cheturu	
Sub centre	Bayyavaram Koturu Chettupalli K.Agraharam Kulupadu* Tokuru* Kasipatnam*	S. Kothapalli Somandepalli Tippanapalli Puttapurthy Talupuru Vadiyam BukkkaRaya Samudram	
Villages	7	3 (AWW)	

CHALLENGES

- Only 50% SCs have their own building
- Inadequate distribution of health facilities as per the geographical needs
- Lab Technicians (LTs) are still working for their vertical programs and comprehensive utilization is lacking resulting in LTs from general side doing more than 100 tests in comparison to others who are doing only 10-20 tests
- AYUSH doctors still working in vertical silos and governed by vertical system with no local controls.
- Under child health, new born care has not got due attention. Newborn action plan has not been initiated. NBCC available but lacks technical competence of service providers in majority of labor rooms
- NCD program as per the GoI guidelines is yet to be rolled out in the state and district Anantapur. Services given only in case there is a complaint
- Abnormal delay in transfer of funds from treasury to health

ASSAM

REVIEW TEAM

Golaghat District		Dibrugarh District	
1.	Dr. A. K. Puri	1.	Dr. P.J. Gogoi
2.	Sh. R. S. Sinha	2.	Sh. Atul Basumatary
3.	Sh. N. K. Santoshi	3.	Smt. Seema Upadhay
4.	Dr. Bandana Bhuyan	4.	Sh. Sumit Priyadarshi
5.	Dr. Amit Arun Shah	5.	Dr. P.R. Sodani
6.	Mr. Prabash Jha	6.	Dr. Narayan Gaonkar
7.	Mr. Vikas Sheemar	7.	Dr. Ashish Banerjee
8.	Ms. Samina Parveen	8.	Mr. Arindam Saha
9.	Dr. Sonia Luna	9.	Dr. R.K. Lakhani

POSITIVES

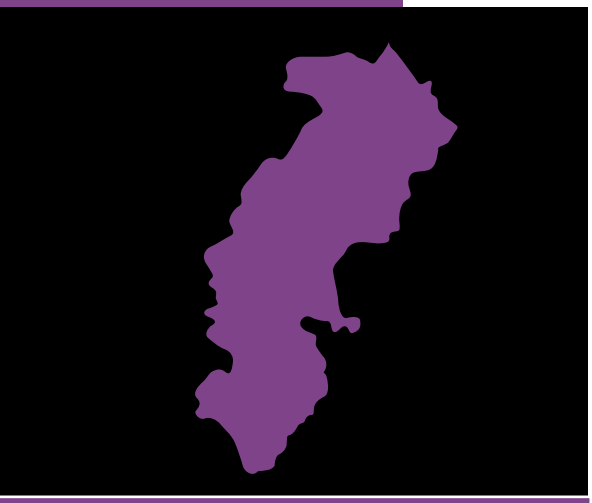
- To reduce the MMR, Assam has under taken serious measures like immediate online reporting of maternal deaths, identification and tracking of high risk pregnancies, assured referral transport and drop back, Mission Tejaswee- to reduce the MMR in the state.
- Strategies adopted to improve health services in the Tea Garden areas- improved services under PPP mode, dedicated ambulances, drug supply, improved infrastructure, financial assistance etc.
- Increased accessibility due to 108, 102, Adarani and ambulance for PPP mode hospitals in TEs.
- Boat clinics in Dibrugarh providing the services to the unreached population. Only source of health care services for the river island population.
- Regular review on RMNCH+A progress undertaken by District Magistrate. All the important parameters including 16 dashboard indicators are discussed in the review meeting and minutes circulated.
- Line listing of high risk pregnancies was being generated and registered were maintained in the visited Sub-centres
- Essential child health commodities well-stocked across all facilities. Radiant warmers were found to be functional at all delivery points. Staff nurses are aware and could explain all steps of new-born resuscitation.
- Model of Convergence with the ULBs and ICDS as these are active in MAS formation in Dibrugarh. The MAS groups formed were validated by the Ward Commissioners of the Dibrugarh Municipal Board. The Anganwadi Workers (AWW) and the Urban ASHAs were members in the Mahila Arogya Samities (MAS).
- All the payments towards ASHA incentive and JSY beneficiary are being paid through a/c payee cheque or e-transfer.
- 99% registration of Agencies on PFMS portal has been done.

DISTRICTS/INSTITUTIONS VISITED

Level of facility	Dibrugarh	Golaghat
Medical College	Assam Medical College Hospital	K. K. Civil Hospital
State Dispensary/ Sub District hospital	Moran, Dibrumukh and Sissia Bakuloni	Bokakhat
CHC	Moron Tiloi	Dergaon and Sarupathar
Block PHCs	Lohawal and Barbaruah	Charingia and Kamarbanda Ali
Mini PHCs	Tengakhet	Barpathar and Sumounigaon
UHC	Dibrugarh	Tenpur
Sub Centres	Titadimour, Nutun Gown Sub Centre, Tilikiamguri, Wilton Grant, Tingrai Chariali	Mohima, Sitalpathar, Kacharihat, Silonijan, Gonthokoroi, Amguri and Barichowa
Tea Garden Hospitals	PPP mode: Green-wood and Basmotia Non PPP mode: TATA Tea Garden Referral Hospital (Pvt.), Desam	PPP mode: Ghillidary and Halmira Non PPP mode: Borjan TE, Rungagora and Huatal
MMU/Boat clinics	Boat Clinic	MMU operated by govt.
Schools	Schools: Moron HS, Jayanbont ME, Dadhiy ME, Natun Bolai LP School	Schools: Guyanpeeth Girls HS, Jamugiri Girls ME, Ganthagoroi Medium and Potiapathar ME
Outreach/AWC	Charchuti Village (Char area)	Rupkalia AWC, Vill. Athkhelia
	RHTC and Model Hospital, Chabua	Village Cinatuli, Milonpur, Puranimilia, Borjan Tea Estate

CHALLENGES

- Crowded and overburdened secondary and tertiary level health care facility
- Optimal utilization of primary health care facilities
- Maternity wards: Privacy, security and cleanliness major issues: security bare minimal or non-existent at facilities. Overcrowded maternity wings at AMC, Dibrugarh and KKCH, Golaghat pose risks.
- PP-IUCD supply is a major issue across facilities. Follow up of PPIUCD beneficiaries was found to be inadequate.
- Critical life-saving drugs stock outs have not being monitored. For instance: one of the visited CHC does not have supplies of Inj. MgSO4 since September 2013.
- No feedback mechanism in place for outcome of referred obstetric cases. This is a missed opportunity for learning purposes. (at present facilities that refer cases come to know of outcome only through ASHAs)
- Blue tablets under WIFS program were being given to pregnant women due to unavailability of IFA large – Red (same recommendation as 8th CRM to Assam – no action taken)
- ASHA drug kits and RMNCH+A counselor kits not available across all facilities due to which roll-out of HDC is affected
- No HR policy in Health. Cadre of Health Specialist not created
  - Separate cadre for specialists and MBBS doctors not in place
  - Time scale promotion not practiced
- Vacant position of state level Urban health coordinator to manage the NUHM programme
- In Assam, none of the facility has the Bio-Medical Waste Management Authorization Certificate mandated by Law, to generate the bio-medical waste.
- Un-utilised Untied funds for UHC in FY 2014-15 lying with the state which was revalidated for FY 2015-16 by MoHFW.
- Malpractice of reporting monthly meetings of the VHSNCs and falsely writing minutes for the claim of the incentive money.



CHHATTISGARH

REVIEW TEAM

Balrampur District	
1.	Ms. Bindu Sharma, Dir (RCH), Team Leader
2.	Sh. S.K. Srivastava, NIPCCD
3.	Dr. Manorama Bakshi, ConsNRU
4.	Dr. Ruchika Arora, Cons CH
5.	Dr. Krushna Sirmanwar, Cons NHM
6.	Dr. Mayank Shersiya, YP, NITI Aayog
7.	Mr. Nishant Sharma, Cons NHSRC
8.	Mr. Perwaiz, Cons HIMS
9.	Sh. Satyajeet Sahoo, FMG

Rajnandgaon District	
1.	Dr. Dilip Singh, Advisor, NHSRC
2.	Dr. Prabir Chatterjee, ED, SHRC Raipur
3.	Dr. Poonam Khattar, NIHFW
4.	Dr. S.V. Gitte, ROHFW
5.	Dr. Bhupatra Panda, PHFI
6.	Ms. AP Meera, AD, Stats
7.	Ms. Risha Kushawa, Adolescent Health
8.	Sh. Satyajeet Sahoo, FMG

POSITIVES

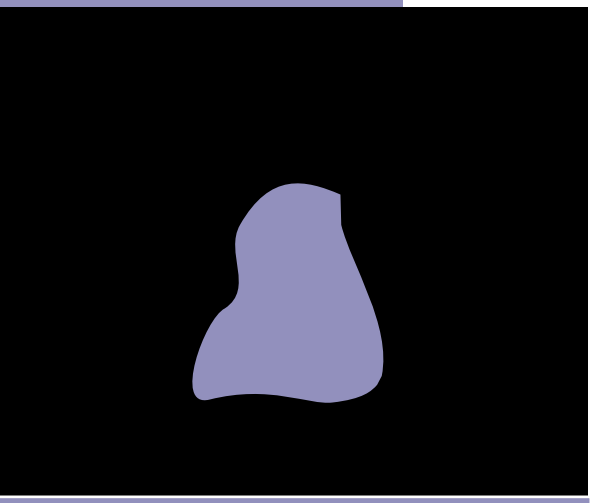
- Awareness about the availability of '102' Mehtari express services for transporting cases with maternity related conditions, was found satisfactory among the mothers.
- Provision of OPD services in evening hours has been helpful in increasing access to health services at various facilities.
- Drug Procurement is being done through web-enabled Inventory management system, which has helped in streamlining the supply chain management of the drugs in state.
- Block Medical Officers and Rural Medical Assistants are designated as Birth & Death Registrar and at the Sub-center level, ANMs are designated as Sub-registrar for smooth functioning of Civil Registration.
- In view of the lack of Allopathic MOs, state has deployed AYUSH MOs and RMAs at the PHCs to provide primary care. RMAs are also provided with various skill-based trainings (including BEmOC, NSSK, Basic Life Support, etc).
- HMIS data is being used for planning, monitoring and review purposes at the state and district level.
- Provision of performance linked CRMC incentive package was found to be helpful in retention of skilled care providers in difficult and inaccessible areas in the state.
- State uses Human Resource Management Information System (HRMIS) to capture HR related information in the state whereunder all CHCs have been designated as data points for data entry.

DISTRICTS/INSTITUTIONS VISITED

Type of Facility	Balrampur	Rajnandgaon
District Hospital	District Hospital	Medical College Hospital (Earlier District Hospital)
SDH (1)	Civil Hospital Wardfnagar	
Civil Hospital (1)		Khairagarh
CHC (5)	Shankargarh, Kusmi	Mohla, Dongargaon
PHC (10)	Bariyo, Deepadih Kala, Barti Kalan, Badkagar, Markol	Gotatola, Pandadah, Gendatola, Arjuni, L.B Nagar
SHC (13)	Sewari, Lodai, Belkona, Rehda, Nawapar	Damri, Tolagaon, Pandadah, Amlidih, Dumardih Khurd, Tilai, Kasari, Rengakhatera (found closed due to ANM Strike)
Villages/Primary School/ Training Centre/NUHM	Govt Middle School Lodhi, Primary school Lodhi, Madhmik Shala Sewari, Primary School Nawapara, Secondary School Nawapara, AWC-Lodhi, AWC Nawapara, Baghicha Para AWC, Kot Rahi, Murkol, Kunda1, Kunda2, Kathnam, Bariya Charpa, Baghima, Kargi, Anmol Phulwari, Binsari Village, Shankargarh Village, belkona Village	Rengakathera, ICDS Center Rengakhatera, Middle School Rengakhatera, Vijayur, Sangli, Chikhali, Prakashpur, Lulikasa, Khursitikul, Amlidih, Dumardih Khurd, Tilai, Kasari, Kohkhadhaba

CHALLENGES

- Notable proportion of health facilities, especially PHCs and Subcenters are functioning in rented buildings, which calls for expediting pace of infrastructure development for health department in the state.
- Unavailability of blood storage services was seen as the limiting factor for operationalizing EmOC services at various facilities, which calls for expanding network of the blood storage units through operationalizing the existing 27 non-functional Blood Storage units at FRUs.
- Knowledge on mechanisms about segregation of different types of waste materials and bio-medical waste management was found lacking among staff in the facilities.
- Processes such as line-listing and tracking of severely anemic mothers were not properly done by many staff.
- AYUSH MOs are conducting deliveries in PHCs but in the facilities visited none was found trained in SBA or BEmOC training.
- Maternal Death Reporting was found to be lower in the state – only 335 of 1571 estimated maternal deaths reported in state.



DELHI

REVIEW TEAM

West District Team	North District Team
Member, Organisation	Member, Organisation
Ms. Navanita Gogoi, MOHFW	Ms. Vandana Jain, MOHFW
Dr. Pragya Sharma, MAMC	Dr. N. Sarojini, MSG, NHM; SAMA
Dr. Manju Rahi, ICMR	Dr. Manjula Singh, ICMR
Dr. Renu Shahrawat, NIHFW	Dr. S. S. Das, MOHFW
Dr. Anuradha Jain, USAID	Ms. Smrity Kumar, MOHFW
Mr. Rajiv Gupta, DFID	Ms. Vinny Arora, NHSRC
Dr. Bijit Roy, PFI	Dr. V. K. Shahi, AYUSH
Dr. Richa Kandpal, NHSRC	Dr. S. Premi Devi, MWCD
Dr. Neha Gulati, MOHFW	

POSITIVES

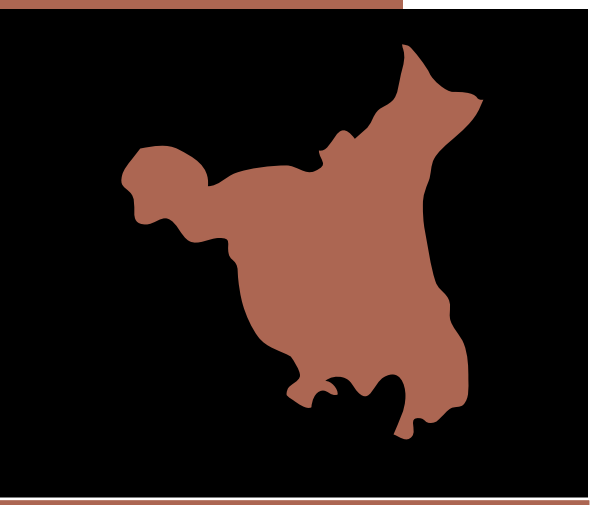
- State Quality Assurance Committees, District Quality Assurance committees & Quality Circles at facility level have been constituted.
- Assessment of the 6 District hospitals has been conducted by state consultants.
- Online tracking system for Patient Satisfaction Survey has been developed.
- Availability of Essential Drug list at all the facilities.
- All the facilities are covered by common treatment facility operators for Bio-Medical waste Management.
- Internal assessment in all the 37 hospitals has been completed under the Kayakalp Program. Awareness and 3 batches of Internal Assessor Trainings have been imparted under the program.

DISTRICTS/INSTITUTIONS VISITED

District Hospital	Guru Govind Singh Hospital, Babu Jagjivam Ram Hospital, Maharishi Valmiki Hospital, Satyavadi Raja Harishchandra Hospital
Sub District Hospital	Sardar Vallabh Bhai Patel Hospital,
CHC	Jwalapuri, Madipur, Subhash Nagar, Sant Paramanand Maternity Homes
PHC	DGD Nawada, M&CW Centre Hiran Kudna, DGD Khyala, DGD Nangloi, DGD Jahangir Puri (H Block), DGD Jahangir Puri (B Block), MnCW Centre Bawana, DGD Katawara, DGD Daryapur Kalan, DGD Bhorgarh, DGD Narala, DGD Holambi Kalan, DGD Sannoth, Chandrawati Unnani Dispensary, Narela, MV Hospital Pooth Khurd, DGD ShahzadaBagh, Bakhtawarpur DGD
UPHC	Mansa Ram Park, Nilothi, Swarup Nagar
AWC	Nilothi, Nangloi 79 and 80, Jahangir Puri Project A no. 96, Holambi Project A Kendra, Narela no. 28, 29, 79 and 80
School	GSVM Nilothi
Village	Bharola, Sarai Peepalthala, Katewara, Daryapur, Bhorgarh, Nihal Vihar
Mohalla Clinic	Peeragarhi

CHALLENGES

- State Quality Assurance Committee, District Quality Assurance Committee & Quality Circles meetings to be conducted at defined intervals.
- Time bound action plan & gap closure activities to be initiated in the hospitals to transverse the gaps identified during the assessments conducted.
- External Quality Assurance Programme like Calibration of Equipments, External Quality Assurance Program for lab's to be initiated.
- Monitoring & Analysis of Key Performance Indicators has to be initiated.
- Sensitization of the hospital staff about the implementation of the Kayakalp Program to be done by conducting Awareness training at the facility level.
- Standard Operating Procedures may be prepared and implemented at facility level.



HARYANA

REVIEW TEAM

1.	Dr. Ajay Khera, Deputy Commissioner, MOHFW
2.	Dr. Joydeep Das, Senior Consultant, Public Health, RRC for North Eastern States, MOHFW
3.	Ms. Anita Makhijani, Deputy Technical Adviser, Ministry of WCD
4.	Dr. Md. Zakiruddin, Deputy Director, Ministry of AYUSH
5.	Dr. Amarjeet Kaur, CMO(NFSG), ROHFW Chandigarh
6.	Dr. M Prakasamma, MSG Member, Civil Society
7.	Ms. Indu Capoor, Founder Director CHETNA, Civil Society
8.	Dr. Irina Papieva, Technical Specialist, WHO
9.	Dr. Varun Goyal, Technical Specialist, SAATHII
10.	Dr. Manika Sharma, Senior Consultant, MOHFW
11.	Mr. Tushar Mokashi, Consultant, NHSRC
12.	Dr. Pawan Pathak, Team Leader, National RMNCH+A Unit

POSITIVES

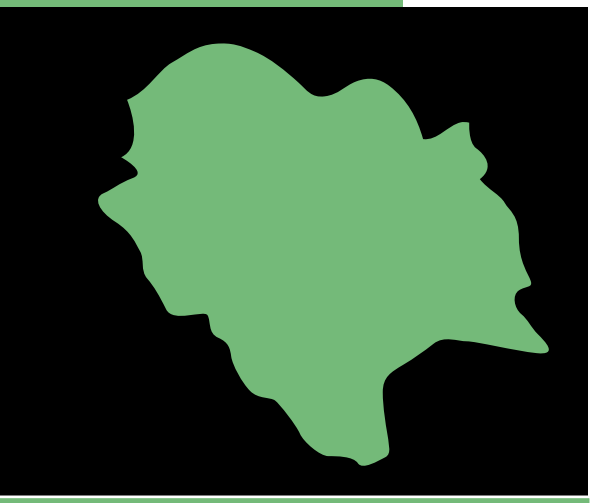
- The State has achieved a significant reduction in MMR and U5MR since the inception of National Health Mission. The MMR has since declined by 32% whereas U5MR has registered a decline of 41%.
- Significant increase in the coverage of essential interventions like use of ORS, breastfeeding and full immunization.
- The state has successfully engaged private diagnostic services and specialist care or patients seeking care from public health facilities.
- The 102-ambulance service is providing good emergency transport services, the referral mechanism has to be rationalized to avoid un-necessary referral of high-risk pregnant mothers across the facilities.
- Adequate number of fully trained ASHAs (including ASHA Kits) is available in the community.
- The state has a good vaccine logistics and cold chain management system.
- The current status of PFMS registration is 94 per cent. All the districts have started real time payment using PFMS.

DISTRICTS/INSTITUTIONS VISITED

Health Facilities	Sonepat	Yamunanagar
District Hospitals	1	1
Sub divisional Hospitals	-	1 (Jagdhadri)
CHC	Kharkhoda, Badkhalsa	3 (Sadhaura, Bilaspur, Naharpur)
PHC	4 (Farmana,Bhatgaon, Murthal, Kundli)	3 (Sadhaura, Rasoolpur,Haibatpur)
SC & Villages	6 (Silana , Nandaur, Ridhau, Jathedi, Nangal Kalan, Jathi Kala)	7 (Sadhaura, Capt. Majri,Rattuwala, Mehmedpur,Kheri, Musambil,Chaharwala)
Nursing School		ANM Nursing School, Bilaspur

CHALLENGES

- The rate of institutional deliveries in the State is 89% with the private sector contributing 50% of the total number of institutional deliveries. 11% deliveries are still occurring at home i.e. 56,610 home deliveries every year, it was noted that their follow up is not carried out by ANMs, thus leading to unfavorable maternal and child health outcomes.
- The norm of 48 hours stay in health facility was not being followed in most of the facilities visited. Beneficiaries were found to be leaving the facilities within 4-5 hours of deliveries,
- More than 90% of all abortions in the state are being conducted in the private health facilities.
- Non availability/ stalk outs of essential items like iron and folic acid
- Shortage of nursing and support staff. Most of the existing nurses and technicians have additional responsibility of managing the pharmacies, stores and other administrative duties.
- The withdrawal of ASHA facilitators in the state have resulted in limited community level motivation and action. Moreover, monitoring and mentoring of ASHAs is substantially inadequate.
- Active participation of various community representatives is lacking in VHSNC meetings. With regard to SKS too, the renewal of registration is overdue and the delay in release of funds is affecting SKS meetings.
- Signs and directions were found to be inadequate at the facilities visited and the patient help desks were not functional. The complaint boxes when available were not being used.



HIMACHAL PRADESH

REVIEW TEAM

Hamirpur District	
1.	Sh. Franklin L. Khobung, Director AYUSH
2.	Sh. Rajpal Bhatia, SO FMG, MOHFW
3.	Mr. KunalDhawan, Consultant, HMIS, MoHFW
4.	Dr. Shailaja Sharma, Consultant, Burns & Injury
5.	Mr. Mohit Sharma, DyRC, NRU
6.	Dr. Ameet Barbre, DFID
7.	Mr. Venkatesh Roddawar, Consultant, NHSRC
8.	State Representative: Dr. Anadi Gupta, SPO, Himachal Pradesh

Sirmaur District	
1.	Dr. D.K. Raut Director , FWTRC, Mumbai
2.	Ms. Asmita Jyoti Singh, Sr. Consultant, MoHFW
3.	Mr. Vipin Garg, Consultant, JSY, MoHFW
4.	Mr. Rakesh Shokeen, Consultant, MoHFW
5.	Dr. Anubhav Srivastava, Consultant, MoHFW
6.	Mr. Mohammad Ameel, Consultant, NHSRC
7.	Dr. Abhishek, RD Shimla
8.	State Representative: Dr. Anuj Gupta, Dy. MD, NHM, Himachal Pradesh

POSITIVES

- WIFS convergence with education department: State has trained a total of 4599 nodal teachers under the programme covering 4599 schools. Around 16.5 lakh WIFS IFA tablets have been distributed so far in the current FY 2015-16.
- State has initiated online blood bank management information system, to provides live availability of blood stock across all the district blood banks, blood group stock and also provides the list of blood donors registered with the district blood banks.
- Tele-medicine through PPP in hard-to-reach areas to provide specialty and emergency consultation services at Kaza & Keylong in Lahul –Spiti district (at 14000 ft above sea level) on a proof of concept basis. As on October, 2015, 1505 Tele consultations organized under this program covering over 14 specialties. During the same period 129 emergency cases were supported through the Tele-emergency services. This project has made specialty services accessible at such difficult areas and reduced referrals.
- In RSBY scheme in addition to basic package of Rs. 30,000, the State is providing an additional benefit for Critical illness expenses up to the limit of Rs 1,75,000 on family floater basis since 2010. The Claim Ratio under RSBY is more than 100% and government of India has awarded the state on national level as "Best Utilization Rate State" on 8th April, 2013.
- Himachal Pradesh Tele-stroke project delivers stroke treatment in all the government hospital, which have CT-scan facility and they are called stroke centers. Available neurologists in the state (public) were made available on phone 24x7 and social networking site like "Whatsapp" for transmitting CT-scan images for consultation. Till date 98 Thromobolysis have been done in various hospitals in the state.

DISTRICTS/INSTITUTIONS VISITED

Category	Hamirpur District	Sirmaur District
RH	RH Hamirpur	RH Naahan
CH/CHC	CHC Barsar, CH Galore, CHC Sujanpur, CH Bhorang	CH Paonta, CHC Shillai, CH Sarahan, CH Dadahu
PHC	PHC Bhota, PHC Nalti, PHC Jangal Beri, PHC Mahel, PHC Bhareri	PHC Majra, PHC Kamrau, PHC Kafota
SC	SC Samoh, SC Ree, SC Banal, SC Chandradruhi	SC Manpur Devda, SC Peb Manal, SC Dugana, SC Millaah, SC Dharkyari,
AWW	Chandroli AWW	Shillai Vrat AWW, AWW Manpur Devda
Schools	Samoh, Ree, Banal, Chandradruhi, Bahyal	
VHND	Chandrauli	Shillai Vrat
FGD conducted	Village Bhyar,	PHC Majra, SC Manpur Devda

CHALLENGES

- HP government entered into partnership with SRL labs to provide diagnostic services in 24 health facilities in the state. This resulted in almost defunct of existing in-house lab services that need to be reviewed critically.
- Currently there is no provision of MMU in the state. However, state got approval from Golto run MMU in 10 districts (except Kinnaur and Lahaul Spiti) in public private partnership mode but unable to rollout due to various reasons including lack of manpower.
- Of the sanctioned 29 blood storage units, only 5 are functional in the state and rest of them are non-functional due to lack of space, staff and renewal of license.
- No system in place for updating knowledge and skills of service providers on technical guidelines and protocols. Multiple protocols being followed and some of them are not recommended for example use of Oxytocin for inducing labour, lack of clarity for usage of radiant warmers in new-born.
- VHSNCs are almost non-functional and working on merely for the name sake. Delays in funds transfer to VHSNC from the Rural Development & Panchayati Raj Department was observed
- The post of State Accounts Manager is vacant for the last 3-4 years. Advances amounting to crores issued to various implementing agencies, vendors, govt. institutions etc. are pending for settlement for a period ranging from 6 months to 2 years.
- Under NUHM, state has not conducted vulnerability assessment and health facility & stakeholder mapping in the state. State do not have details regarding slum areas and clear cut distinction between notified and un-notified slums in the state. There is no convergence mechanisms established at state and district level and no visibility of involvement of urban local bodies in implementing NUHM in the state.
- Of the 12 districts, only 8 District Level Monitoring and Vigilance Committee (DLVMC) have been constituted. The State needs to institutionalize the mechanism of holding regular meetings, record keeping, sharing minutes, recommendations and regular follow up.

JHARKHAND

REVIEW TEAM

Lohardaga District	
1.	Ms. Sudha Kesari, Director, NITI Ayog
2.	Dr. Shashi Kala K. Sr. Consultant NHSRC
3.	Ms. Manjari Sharma, Consultant, Imm, MOHFW
4.	Dr. Rajeev Agarwal, Sr. Consultant, MH, MOHFW
5.	Dr. Ajit Prasad (DD CH), Govt of Jharkhand
6.	Dr. Pradeep Baske, JD, NVBDCP, Govt of Jharkhand
7.	Ms. Shweta Roy-TSA, Deloitte
8.	Ms. Pragnya Das, DFID

Dhanbad District	
1.	Dr. Veena Dhawan (AC-MH), MOHFW
2.	Dr. Anju Puri, WHO
3.	Prof. R.B Bhagat, IIPS, Mumbai
4.	Ms. Sudipta Basa, Consultant, NUHM, MOHFW
5.	Mr. Vivek Mudgal, UNICEF
6.	Mr. Prankul Goel, NHSRC
7.	Dr. Barkakaty, DPMR, Leprosy
8.	Dr. Shiv Shankar(NVBDCP),
	Ms. Akay Minz, State Program Coordinator,
	Mr. Rajeev Prasad, Consultant FMG, MOHFW

POSITIVES

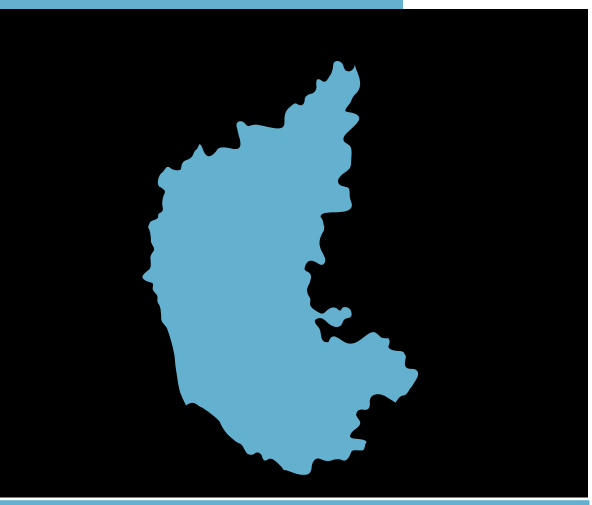
- The state with the existing recruitment processes have covered the shortages of staff nurses.
- Jharkhand Medical and Health Infrastructure Development and Procurement Corporation have been set up as Central procurement agency to ensure proper procurement of Drugs.
- Free drugs and free diagnostics policy under JSSK is operational.
- Development of 76 Sahiya Help Desk at several facilities, Participatory Learning Action (PLA) & Sas Bahu Pati Sammelan implemented in all 24 district.
- Focused, strategic approach observed in routine immunization.
- Proactive ANMs, Shaiya with good knowledge and skills are the strength of the state. Convergence at community level was satisfactory.

DISTRICTS/INSTITUTIONS VISITED

District Lohardaga		District Dhanbad	
Blocks	Facilities	Sadar	PMCH
Kuru	FRU Kuru (CHC)		UCHC - Kenduadih
	PHC – Kairo (24X7)		VHND – Wasseypur & Loharkulhi
	SC - Jingi	Jharia cum Jorahpokhar	FRU CHC
	SC-kolsimari		SC - Borari
	SC- Jeema		UCHC Sindri
Kisko	CHC Kisko		UPHC Rajbari
	SC- Patratu	Baliapur	CHC
	SC- Salaiya	Govindpura	CHC
	SC- Nwadih	Nirsha	CHC
	SC Merle		PHC Bangariya
Bhandra	CHC Bhandra	Bagmara	CHC
	PHC- Nagjua		PHC- Katras
	SC- Bhramandia		SC- Nichitpur
			SC - Ghoradih
			MMU - Paharpur
		Topchanchi	CHC
			SC - Chalkari

CHALLENGES

- Although the state has identified the vacancies for all programmes but with the existing skilled health professionals, to make all FRUs functional will be a major challenge.
- Need for Infrastructure planning in the districts with comprehensive need based approach as a few PHCs were functioning in two room building with 2-4 bed strength.
- Strengthening of drug procurement & indent process at District level and below as it is not consumption based.
- Information Communication Technology a way towards e-governance.
- Strengthening the recruitments processes to rejuvenate the dying cadres like LHVs.
- Strong implementation of both PCPNDT & Clinical Establishment Act for better monitoring of the private sector
- There is a need to strengthen the Concurrent Audit mechanism for better internal control.
- Requirement of time bound action plan and prioritization of addressing gaps.
- Recruitment of Human Resources (HR) at UPHC/UCHC level especially the specialists & paramedical staff.



KARNATAKA

REVIEW TEAM

Koppal District		Dakshina Kannada District	
1.	Dr. Teja Ram, DC (FP), MOHFW	1.	Shri. G. Narayan, Director(BOP), MOHFW
2.	Dr. K. Ravi, JA, MOAYUSH	2.	Dr. L. Devanand, Sr. RD
3.	Dr. M Bharat Kumar, RD, Bengaluru	3.	Shri. Sanjay Wadhawan, US (Coord), MOHFW
4.	Shri. R. S. Negi, US (TC), MOHFW	4.	Dr. S.C. Agarwal, AD(BOP), MOHFW
5.	Shri. K. K. Makwana, EO, NITI Aayog	5.	Dr. Ankur Yadav, NIHFW
6.	Shri. Jayant Kumar Mandal (FMG), MOHFW	6.	Dr. Puneet Khanduja, MOHFW
7.	Dr. Adil Shafie, NUHM, MoHFW	7.	Lt. Aseema Mahunta, MoHFW
8.	Shri. Prabhat, NHSR	8.	Dr. Rahul Reddy, NHSRC
9.	Dr. Naina Rani, WHO	9.	Ms. Sahitha Sagir, BMGF
10.	Dr. H. Sudardarshan, Karuna Trust	10.	Shri. Bhupendra Prabhakar, PWC
		11.	Ms. Shalini Nair, TSA

POSITIVES

- The Karnataka State Civil Services (Regulation of Transfer of Medical Officers and other staff) Act, 2011 passed in 2011 provides the regulation of transfer of medical officers and other staffs of the Department of Health & Family Welfare so as to ensure their availability in government health facilities in rural areas.
- The Human Resource Management System is implemented for all information with respect to contact details, employment & types, deployment, service details, transfer & promotion, vacancy positions, trainings/deputations, payrolls, retirement and performance review etc.
- Thayi Bhagya & Thayi Plus: To overcome the shortage of specialists in rural areas, totally cashless delivery services is being provided through Public Private Partnership in accredited private hospitals in seven backward districts.
- State insurance schemes for financial protection for tertiary care operated through the Suvarna Aarogya Suraksha Trust (SAST) have been able to cover both below poverty line and above poverty line population.
- e-Hospital Programme implemented in 32 hospitals under Government health institutions in financial year 2015-16 to Improve the transparency, accountability & quality of health services.
- Mano Chaithanya Progarmme called as Super Tuesday Clinics is implemented to treat persons suffering from Mental Illness and Epilepsy. Conducted at Taluka Head Quarters by Psychiatrists from District Hospitals and Private Sector.

DISTRICTS/INSTITUTIONS VISITED

Koppal District	Dakshina Kannada District	NUHM facilities
District Hospital: Koppal	District Hospital Wenlock and Maternity Hospital Lady Goschen	UPHC Kasba Bengre, Mangalore
Taluk Hospital: Kushtagi and Yalburga	Taluka Hospital: Belthangady and Sulliya	UPHC Surathkal, Mangalore
CHC: Sriramnagar, Kukanoor, Karatgi, Munirabad,	CHC: Moodabidri	UPHC Jeppu, Mangalore
PHC: Mustur, Hanumnal, Chalgera, Bevoor, Irakalagade	PHC: Bellare, Mani, Shirthady, Naravi	UPHC Lady Hill, Mangalore
SC: Hulige, Talavagera, Nidashisi	SCs: Barimaru, Kodiyala, Yalaneru, Aaliyuru	UPHC Bunder, Mangalore
VHSNC: Nidashi	District Training Centre: Mangalore	UPHC Attavara (Padil), Mangalore
Govt. High School Jahagir, Guddur	Regional Drug Warehouse	UPHC Gangawati, Koppal
AWC: Nidashi	VHSNCs: Barimaru, Kodiyala	UPHC, Koppal
	Schools: Government Urdu Bandar, Aivarnad Higher Primary	UPHC, Shantinagar, Bangalore
	AWC: Attavvara, Urdu Bandar	Maternity Home, Shantinagar, Bangalore
		UPHC Ullal (upgradation approved for CHC)

CHALLENGES

- There is shortage of doctors both, specialists as well as medical officers especially in Koppal district.
- Most of FRUs do not have blood storage facilities especially in Koppal District. Only 2 out of7 sanctioned BSUs are functional.
- Both districts have short supply of AYUSH drugs and consumables. Although State has an extensive and exhaustive list of 750 drugs in its EDL, still a lot of drugs are being procured through local purchase from RKS funds.
- Low utilisation of funds under NHM. Utilisation under Mission Flexible Pool only 19% till second quarter and only5% under NUHM. Since the launch of NUHM, utilization under NUHM is only 14 % of total funds allotted.
- Delay in collection of expenditure and booking, no analysis of advances, advances to various agencies / institutions remained pending for longer period of time, non-collection of expenditure from agencies on % of utilisation basis.
- Sneha Clinics are not performing satisfactorily. There are no counsellors appointed and no separate counselling sessions are being taken. Also during interaction with the ANMs and ASHAs it has been highlighted that during VHND sessions, there is no interaction with adolescent girls.
- Delay in ASHA payments was observed. Some of the components under ASHA payment are pending since from Dec-2013.

MADHYA PRADESH

REVIEW TEAM

Dewas District	
1.	Dr. P K Prabhakar
2.	Dr. LeelaVisaria
3.	Dr. Nikhilesh Chandra
4.	Sh. Anshumann Sharma
5.	Ms. Hayman Win
6.	Dr. Vinay Bothra
7.	Shri Ritesh Aeron
8.	Dr. Rachita Gupta
9.	Dr. Nikhil Pradeep Utture

Shahdol District	
1.	Mr. Arun Srivastava
2.	Dr. Sachin Gupta
3.	Dr. P. Krishna Moorthy
4.	Dr. Kaushal Kumar
5.	Ms. Isha Rastogi
6.	Mr. Abhishek Singh
7.	Dr. Chandrakant Lahariya
8.	Dr. Chinmaye Panda
9.	Ms. Seema Pati
10.	Dr. Vishal Kataria

POSITIVES

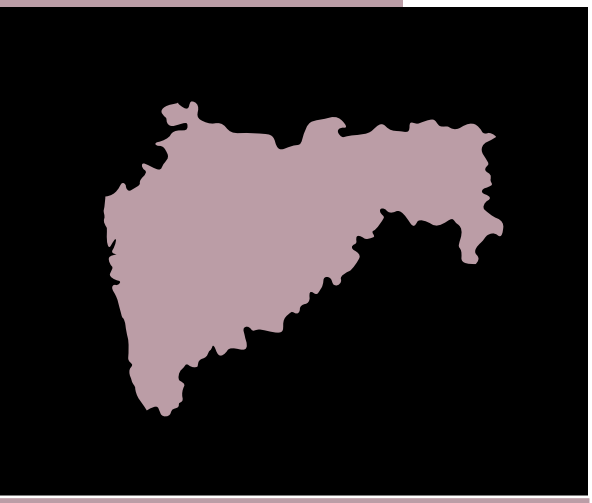
- Substantial progress has been made in the 'free drugs' and 'free diagnostics' initiatives across public health facilities in the state.
- Service provision for newborn and malnourished children in the form of SNCUs, NBSUs and NRCs has been good, though monitoring and follow-up to prevent relapses at NRCs needs strengthening.
- Access to RMNCH+A services at public health facilities has been satisfactory; there has been an improvement in ANC service provision at all levels.
- The establishment of Gram Arogya Kendras (GAK) in every village has provided access to 16 essential drugs and 5 basic diagnostic tests. This ASHA led initiative provides basic primary care, referral and counseling services; ASHAs have been trained to monitor blood pressure and Heamoglobin levels.
- Competency based tests have been introduced for the recruitment of staff nurses and ANMs; campus selections as a method for recruitment has been initiated for certain categories of NHM staff.
- The state has used examples from else where to developa(1)lowcostmodelforaffluent treatment at facilities and (2) a system for the disinfection of sharps prior to disposal.
- There is public awareness of the JSY scheme; benefits have been provided in a timely manner on most occasions.

DISTRICTS/INSTITUTIONS VISITED

Type of Facility	Shahdol	District Hospital
District Hospital	District Hospital, Dewas	District Hospital Shahdol
SDH	–	Civil Hospital Beohari
CHC (6)	CHC Khategaon, CHC Bagli, CHC Sonkachchh, CHC Kannod	CHC - Burhar, CHC -Jaisinghnagar.
PHC/ UPHC (14)	PHC-Satwas, PHC-Udayanagar, PHC-Nemawar, PHC-Punjapura, PHC-HaatPipalya, UPHCItawa (Dewas), UPHC Bawadiya (Dewas)	PHC-Biruhali, PHC-Keshwahi, PHC-Amjhor, PHC-Tihiki, UPHC- Gandhi Chowk (Shahdol), UPHC Sai Baba Nagar (Bhopal), UPHC Ashoka Garden (Bhopal)
SHC (18)	Katkut, Bangankheda, Khattli, Barwai, Kishangarh, Ajnaas, Magarahadeya, Bijukheda	Bahgad, Kharla, Bichiya, Bartar, Amjhor, Kauasarai, Sidhi, Mohini, Barkach, Mau
Villages/GAK/ Primary School/ Training Centre	Tanklikhera, School near Barwai, Jamlod Sanitary Napkin Manufacturing Centre- Dewas, ANM/GNM Training Centre, Dewas	Bahgad, Kharla, Bakaho, Bichiya,Harri, Kauasarai, Dholar, Mohini, Khamdnad, UHND – Railway Colony, UHND – Suhagpur, ANM/GNM Training Centre, Shahdol

CHALLENGES

- MMUs need to be made functional, especially for difficult inaccessible terrain.
- Better integration and rationalization of ambulance services and improvement in response time is urgently needed.
- Implementation of newer interventions for newborns such as Injection Gentamicin for newborn sepsis and community distribution of Misoprostol tablets needs to be implemented in a timely manner.
- NCD Clinics should be started across the state, with a focus on the early screening of diabetes and hypertension and common cancers
- Filling of HR vacancies across all levels, especially for sanctioned posts is recommended
- Strengthening support systems and supportive super vision for ASHAs is required
- RKS committees should be restructured and oriented, to ensure wider participation of local civil society actors and the general public.
- Meticulous monitoring and training for HMIS and MCTS needs to be ensured at the district and state level.
- The implementation and scaling up of PFMS needs to be expedited.
- Contracts and MOUs without sourced agencies need review and the building of systems for performance monitoring, accountability and corrective actions.
- Completion of HR recruitment, planning and mapping activities and strategic city-level planning for NUHM is required.



MAHARASTRA

REVIEW TEAM

Dewas District		Shahdol District	
1.	Dr. Sangeeta Saxena, DC(UH)	1.	Ms. Kavita Singh, Dir(NHM-Finance)
2.	Sh. Amit Biswas, US(MEP-II)	2.	Dr. S.N. Sharma, Jt Director (NVBDCP)
3.	Dr. C.K. Jagadeesan, AD(PH) & State Nodal Officer (ASHA), Kerala	3.	Dr. M.A. Qasmi, Deputy Adviser (U)-AYUSH
4.	Dr. Garima Gupta, NHSRC	4.	Sh. A H Ramteke, Asst. Director
5.	Dr. Rahul Kapse, UNICEF	5.	Mr. Ajit Kumar Singh, NHSRC
6.	Dr. Tanjul Saxena, Associate Professor-IIHMR-Jaipur	6.	Ms. Inez Mikkelsen-Lopez, ADB
7.	Ms. Shilpy Malra, Consultant, NUHM	7.	Dr. Kiran Sharma, WHO
8.	Dr. Ravish Sharma, Consultant, CH	8.	Sh. Sumanta Kar, FMG-MoHFw
9.	Mr. Tarun Gupta, Consultant, PWC		

POSITIVES

- Construction work of health facilities in the state is decentralized. The administrative approval power is given to Executive committee so that health officials can prioritize resources as per need of the districts.
- In last six months, OPD load increased by 60% and and IPD by 97% in all PHCs. Major surgeries and institutional deliveries have increased remarkably across PHCs.
- Both districts have mapped level-1, Level-2 and Level-3 facilities. Diagnostics tests like HB, urine (sugar albumin), BSL, BS for malaria, Sputum for AFB, BTCT, UPT, HIV test are being done free of cost. however CBC, biochemistry, serological testing, stool routine, X-ray, Ultra Sound .JSSK beneficiaries are exempted as per GOI guideline.
- SPARSH rural hospital in Osmanabad is providing excellent quality of services as per government norms, however this public health facility is run by trust.
- Total 711 AYUSH dispensiries and 114 Hospitals are functioning in the state. Out of 825 AYUSH hospitals, 748 are for Ayurved, 31 are for Unani and 46 are for Homoeopathy. health facilities are working. In the Ayurved Hospital, total number of beds are 7620, in Homeopathy 1707 and in Unani hospital total numbers of beds are 690. Total 23 district hospitals and 238 CHCs are having AYUSH wings as collocated AYUSH facilities in the state.
- Community monitoring of health services is being done by NGOs through PRA exercise. It seems it is a good tool for ensuring accountability in the health delivery system.
- Maternal death review is a top priority in the state. This methodology has given evidence (SRS) for those states where MMR is still high.
- The Medical mobile unit is functioning well in the visited district and utilization of service by the community is also very high.

DISTRICTS/INSTITUTIONS VISITED

Bhandara District		Osmanabad District	
1.	District Hospital, a	1.	District Hospital,
2.	Sub Divisional Hospital- Tumsar	2.	Women Hospital
3.	Rural Hospital- Pauni,	3.	Sub Divisional Hospital- Turjapur
4.	Rural Hospital- Adhyal	4.	Rural Hospital- Sastur
5.	PHC-Lendezari,	5.	Rural Hospital- Parand
6.	PHC Gobarwahi,	6.	PHC-Yengur
7.	PHC Pehala,	7.	PHC Ashu,
8.	HSC Wakeshwar,	8.	PHC Andur
9.	HSC Bagheda,	9.	PHC Sawargaw
10.	HSC Rongha,	10.	HSC Vatephal,
11.	HSC Garada	11.	HSC Dilamb ,
12.	UPHC- Narkeshari	12.	HSC Omerga,
13.	MMU- Sonegaon	13.	HSC Tamilbadi,
14.	K B Bhaba Hospital , Mumbai	14.	HSC Jakekur,
15.	Public Health Institute, Nagpur	15.	HSC Ingonda
16.	Regional Health Family Welfare Training Centre, Nagpur	16.	UPHC- Babha Hospital
17.	District Training Centre	17.	MMU Gosaviwadi
		18.	District Training Center,
		19.	Paramedical Training Center.
		20..	District T.B. Centre
Villages – Garra,		Villages - Pimpalwadi, Omerga, Gosaviwadi, Chichpur, Hingangaw, Dilmp, Vatephal, Tamilbadi, Jakekur, Ingonda	

CHALLENGES

- In Primary Health centres, it was observed that inpatient services are under utilized. The reasons for this may be studied and analyzed later.
- 'E-Aushadhi' is operational as part of the free drug policy. However, AYUSH drugs and HSC level indenting are not included in this system.
- Lab Tech: LTs from all the programs should be pooled for providing comprehensive services at health facilities
- The sanctioned number of Health Institutions is primarily based on the Census of 2001. The gap between the health facilities across the state against the sanctioned facilities for HSC, PHC and CHC is 21%, 17% and 33%, respectively, however the relative shortfall is largely due to inter decadal population growth. The state should ensure the smooth functioning of the existing health facilities rather than pursuing for creating new health facilities.
- 108 Ambulances need to be certified quarterly for its operational status by designated medical collage /health facilities in the district.
- Mapping of requirements of the ambulances should be done in the district and it should be brought under one umbrella of a centralized call center.
- All non-functional and non–repairable equipment need to be tagged and repaired/ condemned.
- The service delivery components for non-communicable diseases may be further expanded at primary and secondary care levels.

MANIPUR

REVIEW TEAM

1.	Dr. Swasti Charan, MoHFW – Team Leader
2.	Mr. Jugal K Sharma, NITI Ayog
3.	Dr. Paul Francis, WHO
4.	Dr. Meerambika Mahapatra, NIHFW
5.	Dr. Anil Kashyap, MoHFW
6.	Dr. Manoj Kumar, NHSRC
7.	Dr. Satyajit Chowdhury, DFID
8.	Ms. Mona Gupta, TSA

1.	Dr. L A Singh, MoHFW
2.	Shri C Chinnappa, PRI
3.	Sh. Rajesh Kumar Khatri, AYUSH
4.	Shri Srikant Prasad, MoHFW
5.	Dr. PrashantSoni, MoHFW
6.	Mr. Prasanth Subramanian, NHSRC
7.	Dr. Srihari Dutta, UNICEF
8.	Mr. Lipekho M Saprii, PHFI

POSITIVES

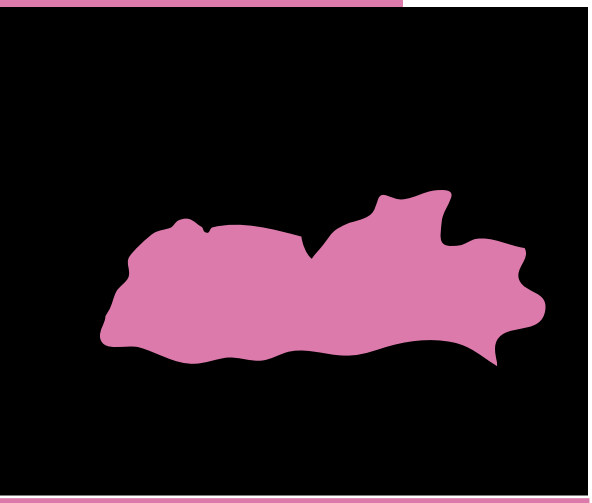
- Infrastructure is largely adequate, estimation on civil works are undertaken and renovated (esp. LR and OT).
- Portable USGs are available in MMUs for ANC examinations of expectant mothers
- Adolescent Friendly Health Clinics are established upto PHC level
- AYUSH doctors are main streamed to provide RMNCHA services in most of the facilities
- RBSK teams are deployed and screenings have been initiated
- Adequate human resources including specialists (Gynaecologists, Anaesthetists, Padiatricians, Pathologists etc.) available in most of the health facilities
- Good co-ordination and rapport is observed among ASHA, ANM and ASHA facilitator.
- District Level Vigilance and Monitoring Committees (DLVMC) are constituted.
- PC-PNDT act is being implemented and records are available.
- Food Safety and Standards Authority functional and samples taken for Quality control regularly.

DISTRICTS/INSTITUTIONS VISITED

Level	Senapati	Thoubal
District	DH, Senapati	DH, Khangabok
CHCs	Mao Kangokpi	Yairipok Kakching Sugnu Lilong Heirok
PHCs	Paomata Tadubi Motbung Saiku	NangpokSekmai Khonjom Wangjing Khairom Leisangthem Lilong Khunou Hiyanglam Pallel
Sub Centre	Pudunamei Tobumai Punanamei Maram-Khullen	Waithou Wangmataba Mantak Langmeidong Wabagai Waikhong Elangkhangp Okpi Salungpham UkhongShang Kekru
Panchayat/AWW/ Village/Community/ VHSNCs		Ukhongshang village and Gram Panchayat Yamalai village Khangabok Gram Panchayat/VHSNC and village Salungpham VHSNC

CHALLENGES

- Establish Central Drug and Equipment Procurement Agency/Corporation and IT based Supply Chain Management with Quality Control System.
- State to consider phasing out of user fees for drugs and diagnostics, and implement on priority free diagnostic and medicine scheme.
- State to act on development of integrated plan for all available ambulances under 102 for effective utilization, and institutionalization of performance management system.
- Evaluate performance of MMUs and ensure rational deployment, use of micro planning, and improved utilization.
- Initiate facility wise inventory mapping of biomedical equipments and finalization of agency for AMC. to address huge down time for equipments.
- Revisit current system of recruitment process, which is lengthy and complicated due to the requirement of cabinet approval even for filling vacant positions arising out of resignation of contractual staff.
- Lay out designs of OT are not as per protocols which needs to be corrected for patient safety.
- Salary disbursement to be regularized and made at the same time for all NHM staff irrespective of the program.
- State to initiate steps to put in place a robust Grievance Redressal System (complaints registration online, phone, at a help desk located in hospitals or a complaint box)
- State to explore formation of Knowledge Based partnerships involving RIMS and JNIMS for developing a support team at State level



MEGHALAYA

REVIEW TEAM

1.	Dr. Sushma Dureja, Dy. Commissioner (Adolescent Health), GoI – Team Leader
2.	Sh. B. S. Murthy, Dir (Nursing), MoHFW, GoI
3.	Dr. S. N. Rai, RNTCP
4.	Sh. S. R. Meena DS, M/o WCD GoI
5.	Dr. Sanjeev Upadhyaya, UNICEF
6.	Mr. Rahul Govila, FMG
7.	Dr. Haresh Patel, WHO
8.	Dr. Jatin Dhingra, NUHM, NHM
9.	Mr. Syed Mohd Abbas, NHSRC
10.	Ms. Annie Sechiang, State CP Coordinator

1.	Dr. (Mrs.) B.R. Sawhney, Addl. DDG, Health Services
2.	Sh. Raj kumar Director-AYUSH
3.	Sh. Sunil Kumar, US-Med Ser / CGHS-P
4.	Dr. Padam Khanna, NHSRC
5.	Dr. Jai Kishan, NIHFW
6.	Dr. Yashika Negi, Immunization, NHM
7.	Dr. Sahil Chopra, Child Health , NHM
8.	Dr. (Prof.) Sandra Albert, PHFI

POSITIVES

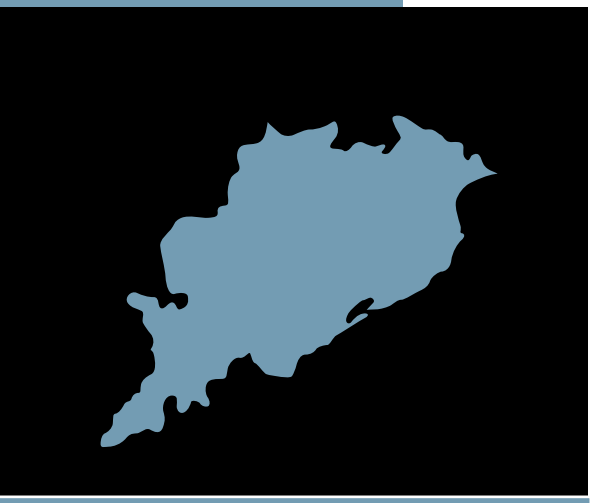
- State has adequate number of health facilities as per population norms.
- Good infrastructure, clean and well equipped facilities at most of visited places
- Good infrastructure for implementation of Malaria control programme.
- Service providers effectively providing the services in remote and inaccessible areas.
- In majority of the facilities, staff staying in the staff quarters and providing 24x7 services
- 3-tier support structure for the Community Processes Programme available at the state.
- Performance monitoring mechanism in community processes in place & comparative analysis with HMIS related indicators done at state level and shared with respective districts.
- 'State ASHA Benefit Scheme' – Matching/top up incentive introduced from the state funds.
- Quality Assurance committees at State and Districts level formed and 27 Quality Assurance Internal Assessors certified by MoHFW, GoI.
- Citizen charters available at all the facilities and displayed in the local language at the entrance of the health facilities in both the districts.
- Innovation on biomedical bins – appropriate marking on available bins for segregation.
- Ganesh Das Hospital awarded Best DH award and runner up commendation for Tura MCH.
- Well-established urban PHCs with motivated staffed.
- Regular outreach through UHNDs and Special outreach camps.
- Lack of supportive supervision mechanism for monitoring the functioning of DH/CHC/PHC/SC etc.

DISTRICTS/INSTITUTIONS VISITED

Level	West Jaintia Hills District	South West Garo Hills District
District hospital	1. DH Jowai West Jaintia Hills	There is no district hospital yet since it is a new district
CHC	1. Thadlaskein block-Ummulong CHC 2. Laskein block-Laskein CHC	1. Ampati CHC 2. MahindraGanj CHC
PHC	1. Thadlaskein block -Nartiang PHC 2. Thadlaskein block -Namdong PHC 3. Laskein block -Shangpung PHC 4. Laskein block -Barato PHC	1. Garobhada, 2. Zik Zak, 3. Salmanpara 4. Nogorpara PHCs
Village/ Health Sub-centre	1. Thadlaskein block -Village & Thadbamon HSC 2. Thadlaskein block -Village & Wahiajer HSC 3. Thadlaskein block -Village & Khaduli HSC 4. Thadlaskein block -Village & Moobakhon HSC 5. Laskein block- Village & Thangrain HSC 6. Laskein block –Village & Raliang HSC 7. Laskein block –Village & Mookaiaw HSC 8. Laskein block -Two AWCs 9. Laskein block -Two Schools	1. Gopinath Killa, 2. Kuligaon, 3. Kumligaon, 4. Godalgre 5. Anangpara SCs 1 AWC (Bongsang) & 1 School
Urban areas/ slums	Two Urban Health Center	

CHALLENGES

- Rational transfer & posting policy both at State is not streamlined and non-availability of HRMIS.
- Performance review mechanism of the staff was not in place at any level.
- State QA consultant position sanctioned but not filled from last one year.
- Understanding of QA guidelines and ToRs not found and no district road map available for improvement of QA services.
- About 50% of the total deliveries are home based and conducted by non-SBA service providers.
- Non-availability of caesarean section service in public health facilities in entire South West Garo Hills district.
- High out of pocket expenditures were reported on drugs, diagnostics as state has not followed the free drugs policy.
- The drug procurement and distribution system is erratic, as state has not initiated the process of constituting Central Procurement Agency (CPA).
- Variable user/ registration fees and lab charges at the facilities.
- Large un-met need of contraception in several pockets due to poor/erratic supplies – leads to people's reliance on private sector.
- State has no proper fund flow mechanism to ensure timely payment of incentives to ASHAs & overall implementation of single window payment mechanism was not implemented.
- Replenishment mechanism of ASHA's drug kits was not streamlined and AHSAs are facing regular stock outs.
- Grievance redressal or any help line system for ASHAs & ANMs was not in place at any level.
- Significant dropouts from ANC1 to ANC3.
- Partograph not used in spite of DH WJH being the training centre for SBA.
- Despite 70% of ASHAs having bank a/c, payment of incentives still made in cash in JH whereas in GH via e-transfer.
- Untied fund account at sub centre being maintained by ANM and PHC accountant instead of ANM and PRI member in both the districts.
- Internet connectivity is a big issues though computers present in most of the facilities.
- JSY payments significantly delayed (more than 1 year in some cases) and erratic in both the districts.
- Under NUHM a huge unspent balance of 78.14% at State level.



ODISHA

REVIEW TEAM

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2.	Dr. D.C Katoch, Advisor, Ministry of AYUSH
3.	Dr. Hitesh Deka, Senior Consultant, RRC, Guwahati
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5.	Ms. Jyoti Jagtap, Consultant, NHSRC
6.	Ms. Jenita Khwairakpam, Consultant, MoHFW,
7.	Ms. Vaidehi Agnihotri, Consultant, UNFPA
8.	Dr. Kamlesh Lalchandani, NPM, Jhpiego
9.	Mr. Kshitiz Sisodia, Prayas

1.	Capt. Kapil Chaudhary, DS, NHM, MoHFW
2.	Mr. G L Gupta, SRO, NITYAyog
3.	Dr. N M Somalkar, RD-PH Specialist, RoHFW Bhubaneshwar
4.	Dr. Sameer Pawar, Health Specialist, UNICEF, Guwahati
5.	Dr. Subrat Kumar Palo, Associate Professor, IIPH
6.	Ms. Tripti Chandra, Programme Manager, AGCA-PFI
7.	Ms. Kheya Furtado, Young Professional, NITI Ayog
8.	Ms. Sumitha Chalil, Consultant, NHM, MoHFW

POSITIVES

- Odisha has successfully established the online financial management through PFMS including remuneration of all the programme staff and ASHAs on fixed day i.e. 10th of the month. State is planning to introduce Web-based system for distributing salary of contractual employees as part of revised PMS.
- ASHAs are well supported and facilitated. 1672 better performing ASHAs have been selected as ASHA SATHI (ASHA Facilitator). ASHA performance is being monitored on 10 indicators and Low performing ASHAs are being provided with need based hand holding support at field level.
- AYUSH has been mainstreamed by creating various opportunies within the programme and multiskilled in SBA, IUCD insertion, IMNCI, NSSK etc. to conduct other functions of the programme.
- The concept of MWH was established in the state in the year 2010-11 in hard to reach areas and 45 Maternity waiting home are functional out of 67 targeted by 2015-16. During the last 3 years 21311 PW were admitted in 'Maa Gruha" and out of these 16545 deliveries were conducted at health facilities.
- E- Blood Banking system provides blood availability information of various blood banks using a bar code system for efficient handling and use within optimal storage dates. 52 blood banks are on the system. Any person can access the information on availability of blood in any specific blood bank through toll free IVRS (18003457777), SMS (BSNL: 54323 others: 56767) and through NRHM website.
- State has streamlined procurement and supply chain management (Odisha State Medical Corporation). Adequate fund provision of Rs. 200 crs has been made out of State budget for free drugs.

DISTRICTS/INSTITUTIONS VISITED

Type of Facility	Bhadrak District	Nabrangpur District
DHH (2)	Bhadrak	Nabrangpur
Other Hospitals(1)	R.N. Eye Hospital, Bhadrak	
CHC (9)	Basudevpur, Agarpada, Dhamnagar, Bhandaripokhri	Nandahandi, Tentulikundi, Kosagumuda, Ummerkote, Poojariguda
PHC (13)	Asurali, Bonth, Barikpur, Kenduapada, Manjuri, Baincha, Dhamara	Panaspadar, Dodhra, Singisari, Asanga, Kondigaon, Dhumurimunda
Sub Centre (8)	Sugo, Sendhatira, Asurali, Radhaballavpur	Deopali, Modigaon, Hatibadi, Majidhanua
Anganwadi Centres (7)	Naguan, Sarsoda, Lenjora, Kurikana	Modigaon, Dhansara, Kankumajiguda,
School (5)	Naguan, Sarsoda, Kothara	Tribal School, Kosagumuda
Villages (8)	Sarsoda, Lenjora, Asurali, Tikira	Nuagaon, Kankumanjhiguda, Dhensara, Panaspadar
Other Hospitals(1)	R.N. Eye Hospital, Bhadrak	
CHC (9)	Basudevpur, Agarpada, Dhamnagar, Bhandaripokhri	Nandahandi, Tentulikundi, Kosagumuda, Ummerkote, Poojariguda
PHC (13)	Asurali, Bonth, Barikpur, Kenduapada, Manjuri, Baincha, Dhamara	Panaspadar, Dodhra, Singisari, Asanga, Kondigaon, Dhumurimunda
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Anganwadi Centres (7)	Naguan, Sarsoda, Lenjora, Kurikana	Modigaon, Dhansara, Kankumajiguda,
School (5)	Naguan, Sarsoda, Kothara	Tribal School, Kosagumuda
Villages (8)	Sarsoda, Lenjora, Asurali, Tikira	Nuagaon, Kankumanjhiguda, Dhensara, Panaspadar

CHALLENGES

- There was poor 'suspect referral' for communicable disease was found in the state. TB suspects examined per lakh per quarter for State in 3Q15 is 131 per lakh per quarter. There is decline in rate of suspect examinations from over the years. Increase in number of Malaria cases in the last two years is a cause of concern. About 42,000 ASHAs were trained for suspect referral and follow up treatment by the state.
- State has irrational deployment of available HR including MBBS doctors, but many PHCs functioning without MBBS doctors. However, available skilled staff members in both districts visited by CRM were placed mostly at CHC and higher level facilities. Out of 187 doctors trained in LSAS and EmOC, only 108 (58%) were posted at FRUs.
- Low utilization of RKS funds (7.7%). More so, because the 'User Fee' is being charged from the patient which goes into the RKS funds in addition, donations are also included in the RKS.
- A total of 4.91 crores urban population, including 14.21 slum populations is covered under NUHM. Out of 36 cities and district headquarters, GIS mapping has been completed in Bhubaneshwar only and vulnerability mapping has been completed in 2362 slums in these cities.
- Though Urban Local bodies have taken ownership in the urban areas, the coordination with them was found to be poor. In many cities, the chairperson of the ULB has been added as a member in the District Health Mission and Executive officer of the ULB has been added as member in the District Health Society. A total of 16 Guidelines and 10 modules on NUHM have been developed by the State.

PUNJAB

REVIEW TEAM

1.	Sh. Amarjeet Singh, Director-DGHS (CRM Team Leader), Ministry of Health & Family Welfare,
2.	Dr. Satish Kumar, NHSRC, Advisor Public Health Planning , National Health System Resource Center (NHSRC)
3.	Sh. P.K. Anand, Deputy Director (P&E)-AYUSH, Ministry of Health & Family Welfare,
4.	Ms Vandana Thapar, JD, M/o WCD, Ministry of women & Child Development
5.	G. Balasubramanian, Deputy Adv-M/o DWS
6.	Ms. (Prof.) Surinder Jaswal, Prof. & Dean, MSG Member, Tata Institute of Social Science (TISS)
7.	Mr. Anil Kumar Gupta, Consultant Public Health Planning, National Health System Resource Center (NHSRC)
8.	Dr. Rajesh Kumar, Associate Professor, National Institute of Health and Family Welfare

1.	Ms. Shraddha Masih, Consultant, Ministry of Health and Family welfare
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4.	Ms. Gursimran Alagh, Consultant, Ministry of Health and Family welfare
5.	Mr. Jay Prakash rch, Consultant-FP, Ministry of Health and Family welfare
6.	Dr. Sharad Iyengar, AGCA Member
7.	Mr. Balasubramanian, SAATHII
8.	Mr. Shushil, Account officer

POSITIVES

- Good MCTS and Tele-medicine;
- Vibrant ASHAs – face of NHM in the field;
- Improved Health seeking behaviour;
- Physical Health Care infrastructure adequacy;
- Drugs and supply logistics working well;
- Well functioning MMU (HIV testing without pre & post counseling;
- Ambulance services are operational;
- Telemedicine is working well;
- ASHAs have bank account, where their due incentive is credited. ASHAs are actively involved in Mamata Divas;
- PRI members are involved in the functioning of VHSNC, RKS and DHS;
- Quality Assurance Committee formed and functional at district. Committees formed under Kayakalp;
- Facilities at district and block levels clean and well maintained;
- Bio-medical waste disposals contracted out and functioning well;
- Grievance redressal cell functioning in Hoshiarpur district;

DISTRICTS/INSTITUTIONS VISITED

Mansa	Hoshiarpur
DH – Mansa	SDH – Dasuya
SDH – Sartulghar	SDH – Mukeria
CHC – Khaira Kala	SDH – Garshankar
CHC – Jhunir	CHC – Budhabar
PHC- Joga	CHC – Hartabadla
PHC - Ubha	CHC – Tanda
	PHC – BHANGALA
Urban PHC – Vernagar	PHC – POSSI
Urban PHC- Under bridge road	PHC – PHUGLANA
SC – Joga	PHC – PALDI
SC – Aklia	BIGOWAL
SC – Alipur Khurd	SC – GURDASPUR
SC – Bhopal	SC – FEROZPUR
SC – Burj Rathi	MMU – TANDA JALALPUR
SC – Khaira Kala	MAMTA DIVAS TANDA

CHALLENGES

- State faces with triple burden of disease - a. Communicable Disease, b. NCD and substance abuse, c. Accidents.
- Peripheral units are weakened due to staff deployment at DH (100 Hospital Initiative of the State Government).
- Ambiguity with regard to Free diagnostic and equipment maintenance.
- No state or district specific IEC strategy is seen.
- Improvements needed in quality of ANC (Anaemia), referrals of high risk pregnancies and deliveries.
- Maternal Deaths Review need improvement and institutionalisation.
- SNCU not functional at Mansa DH.
- Adolescent Health-RKSK, RBSK, DEIC not fully functional in both district.
- Referral system needs improvement, screening kit not available.
- Nutrition component under child health needs to be strengthened.
- Paediatric IFA supplementation coverage is low.
- Poor fund utilization. Less than 20%. Exp plans at Mansa.
- Training Calendar prepared but could not be adhered to at both districts. Training database needs to updated.
- Non-residential training for ASHA to be discourage.
- Training resources at district level lacking at Mansa;
- HMIS - Quality and use of data.
- Contractual Staff—disparities in salaries, regular increments still hardly working—not sustainable.
- ASHA Facilitators support for the ASHAs need strengthening.
- Use of HBNC skills is an issue including filling up of HBNC forms.
- ASHAs 10 points performance monitoring needs strengthening.
- ASHA, ANMs (Supportive supervision needs improvement, Block Community Mobilizer proposed).
- Though VHSNC members were trained on their roles and responsibilities but re-orientation is needed for effective functioning.
- VHSNC members not found well aware about 108 referral transport and not well aware about 104 help line.
- Grievance redressal cell is not functioning at Mansa district.
- Needs to initiate Service providers' training and certification of facilities urgently.

RAJASTHAN

REVIEW TEAM

Dholpur District		Bikaner District	
1.	Dr. Sher Singh Kashotiya, Asstt. Director, (NVBDCP)	1.	Dr. Dinesh Baswal, DC(MH), MOHFW
2.	Mr. S. Mishra NIPPCD	2.	Sh. J.P.Meena, DD – BOP
3.	Sh. Ram Lakhan, Deputy Secretary AYUSH	3.	Dr. Raghunath Prasad Saini, Consultant-RCH-PIP
4.	Dr. Uddipan Dutta, NHSRC	4.	Ms. Sucheta Rawat, Consultant – CP, NHSRC
5.	Sh. R.S. Negi, SSO--BOP	5.	Dr. Diksha Chaudhary, NRU
6.	Dr. Sanjay Pandey, Programme Director, PFI	6.	Sh. Durga Prasad Sahu, FMG
7.	Mr. Brian Chin, ADB	7.	Mr. Ajay Mishra, Programme Manager--PFI
8.	Dr. Deepti Agrawal, UNDP--Newborn Project	8.	Dr. Girish Dwivedi, Project Director, Family Planning, Rajasthan
9.	Ms. Vinita Srivastava, National Consultant, Blood Cell, MoHFW	9.	Mr. Manish, Finance, Rajasthan
10.	Dr. Manisha Chawala, UNICEF		
11.	Dr. S.K. Garg; Project Director, Immunisation, Rajasthan		

POSITIVES

- Rajasthan Sampark - As an initiation to ensure proper service to the citizens. The project paves the way for a common man to reach the departments of the State Government for their queries and concerns. Rajasthan Sampark aims towards providing citizens with a centralized platform where any citizen of the state can lodge his/ her grievances to the respective departments.
- Process and systems of contracting infrastructure projects seems to be much streamlined, as almost all infrastructure projects are e-tendered lead by NHM Engineering wing.
- E-Aushidhi by Rajasthan Medical Services Corporation Limited is providing medicines to people at affordable rates.
- Mukhyamantri Nishulk Dava Yojna (MNDY) for poor is working well.
- Mukhyamantri Nishulk Janch Yojna (MNJY).
- Online JSY and Subhlakshmi (OJAS). DBT for JSY beneficiaries is done through OJAS since August 2015.
- Dedicated Bio medical engineer at divisional level
- Mukhbir Yojana- PC- PNDT
- DBT for ASHA is done through ASHA Soft since Sept. 2014
- EDL for various levels of facilities in place
- Social Audit as part of community based maternal death review
- Good financial record keeping by MAS members.

DISTRICTS/INSTITUTIONS VISITED

Level	Dholpur District	Bikaner District
District hospital	DH Dholpur	DH Bikaner
SDH	SDH Bari	
CHC	CHC Sarmathra CHC Basedi CHC Maniya	CHC, Nokha CHC, Panchu CHC, Khajuwala CHC, Gajner CHC, Sri Dunagrgarh
PHC	PHC Anagai PHC Bareoli PHC Tasimo	PHC Gadhiyala PHC Kaku PHC Pogal PHC Lakhasar
Village/ Health Subcentre	HSC Singhavali HSC Sathaniya HSC Malickpur HSC Paschim Chavni HSC Karkakheli, & neighbouring Villages	HSC Shobna HSC Dharsharpurhoit HSC hariapatawatan HSC Surajanasar HSC Grandhi HSC Dantor & neighbouring Villages
Other facilities		PVM Medical College
Urban areas/ slums	UPHCs, UHND & MAS groups	Urban PHC Viveknagar , MAS & urban slum area
Jaipur	UPHCs, UHND & MAS groups	

CHALLENGES

- Overall state has a shortfall of 50, L-3 facilities across all the districts. Districts like Bikaner and Dholpur with population >15 lacs and >13 lacs respectively have only one L-3 facility. There are many underserved areas, which are left uncovered in district Bikaner.
- It was found that 90% of beneficiaries were mostly utilizing private vehicles to reach the facilities for which they were sometimes being reimbursed on a fixed amount.
- Anemia issue - Very high rate of anaemia has been reported in both the districts.
- Irrational deployment of trained staff (Surgeon/s & Anaesthetist/LSAS trained doctor)
- Only one third of estimated maternal deaths are reported in Bikaner & Dholpur. Medical College, Bikaner has reported 47 deaths till now under MDR, which is much less than what has been reported in HMIS.
- Essential drugs as per 5*5 matrix were in shortage like Misoprostol, Nifedipine, Mifepristone, Labetalol, RTI/STI drugs etc. in both the districts. In Bikaner Methlyergometrine is being used instead of misoprostol; magnesium sulphate not available at PHC Pugal. Inj. Oxytocin was kept at room temperature at many sites.
- There is no or minimal involvement of ASHAs, ANMs and PRIs in Disease Control Programmes.
- Gap in ASHA selection was observed in both the districts i.e. 74 % (Bikaner) , 91 % (Dholpur). Vacancies exist at all levels; DAC post vacant in Dholpur district, BAF post vacant – 75 % in Dholpur, 66 % in Bikaner, PHS post vacant -62.9 % in Dholpur , 74 % in Bikaner. There is lack of clarity with regards to number of field visits and tasks that PHC supervisor should undertake as an ASHA facilitator.
- District Quality Teams are yet to be constituted in the District hospitals Dholpur and Bikaner. There was no district road map available for improvement of QA services in both Dholpur and Bikaner district.

UTTAR PRADESH

REVIEW TEAM

1.	Dr. Basab Gupta, DC(UH)	9.	Dr. Parminder Gautam, NHSRC
2.	Amrit Lal, Dir.(ME-I,II & III)	10.	Mr. Ajitkumar Sudke, BMGF
3.	Dr. Rajani Ved, NHSRC	11.	Dr. Pascal Zurn, WHO
4.	Sh. Jeetendra Singh, Dir-NITI Aayog	12.	Dr. Akshaya Kumar Mishra, UNICEF
5.	Mr. Varun Singh, NUHM, MoHFW	13.	Dr. Suresh Kumar, Research Officer-AYUSH
6.	Dr. V K Chaudhary, Addl RD, Lucknow	14.	Dr. Priti Choudhary, Immunization
7.	Dr. D D Pandey, RD, M/o WCD	15.	Mr. Ashutosh Jha, Stats
8.	Dr. Shalini Singh, Scientist-E, RCH, ICMR	16.	Mr. Puneet Jain, NHM-FMG

POSITIVES

- Substantial increases in OPD/IPD are observed as a result of effective Free Drugs and Diagnostics schemes. Numbers of women delivering at facilities have increased facilitated by JSY, JSSK, 108, ASHA, and SBA training.
- 108 and 102 Ambulance services working well with high patient satisfaction including the drop back system.
- Online procurement and inventory management system resulting in availability of "Free Drugs for all" is apromising start.
- Outsourcing in both districts for Bio-medical waste management, cleaning, providing hospital diet and laundry are working well.
- Adolescent Friendly Health Centers are in place in DH, Sitapur and in the two CHCs visited. - Male and female counsellors are in place and the trainings are underway.
- Introduction of special salary package for specialist in remote, difficult and underserved areas is promising. The performance incentives for nurses/ANMs in Sitapur are also a very good initiative.
- ASHA are viewed by community and the system as a key facilitatory resource for MNCH interventions. ASHA payment systems, streamlined with little or no payment delays are a huge motivating factor.
- IT based activities like m-Sehat to convert ASHA VHIR into a mobile app: nascent stages are good initiatives.
- Use of PFMS for all financial transactions has resulted in transparency and reduced grievances.

DISTRICTS/INSTITUTIONS VISITED

Facility Type	Sitapur	Jalaun
DH	Sitapur DH - Women	Jalaun DH - Women
	Sitapur DH - General	Jalaun DH - General
CHC	Mahmoodabad	Jalaun
	Khairabad	Madhaugarh
	Thambore	Kalpi
	Maholi	Kadaura
	Pahla	
PHC	Khurbal, Kamlapur, Pahl,a Sirkida	Chhiriya (24X7), Dakore
UPHC	Mahmoodabad, Sitapur-Sadar (Urban)	Jalaun (Urban), Orai, Ajnari Road (Out Reach)
Subcentre	Surecha	Ait (L1, Cold Chain)
	Kamlapur	Jagammanpur, Gayar, Kalor, Kaduria (FGD)
	Behata, Mathua, Arori, Bethara-Madho,	Sultanpura, Sahav, Rahiya, Usargaon
Village	Khurbal, Sadarpur, Surecha, Behta Mathua,	Rahiya, Kalor, Sultanpur, Usargaon
VHND	Khurbal, Behata, Mathua	Gayar,
ASHA meeting	Block Kasmanda, Maholi, Behta, Mathua; Arori	CHC Jalaun
School	-	Primary & Pre Middle School, Rahiya & Kasturba School, Kalpi
Focused Group Discussion	-	Rahiya
Anganwadi	-	Usargaon

CHALLENGES

- Lack of HR/facilities at lower levels leads to high case loads at the DH- failure of lower facilities to play a gate-keeping role.
- Overall shortfall in infrastructure- more pronounced at peripheral levels. Time to care is a persistent challenge given limited numbers of functional facilities.
- There is a high unmet need for spacing and limiting: 20% to 40%. The lack of availability of safe abortion services below the DH limits women's RH choices.
- Several guidelines developed by the MoHFW/ GoUP are generally not available in the periphery.
- Vacancies are a serious challenge among all cadres including support staff.
- HMIS & MCTS data is not being used for planning & monitoring purposes.
- Management of Childhood Illnesses is poor – access to untrained providers leads to poor management and high costs.
- Slow start to NUHM.
- There is a delay of funds from Treasury account to State Health Society Account. Governance issues and irregularities found in management of RKS/ VHSNC accounts.
- TA by external agencies plays a catalytic role for the short term, but clarity in roles, effective usage of additional HR provided by DPs needs to to be addressed at district and sub district levels.

UTTARAKHAND

REVIEW TEAM

Dehradun District	
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6.	Mr. Satya Verma, DFID
7.	Ms. Priyanka Saksena, WHO
8.	Dr. Pushkar Kumar, MH
9.	Mr. Nabeel Ahmed, PwC
10.	Ms. Amita Chauhan, NHSRC

Nainital District	
1.	Dr. J.N. Srivastava, NHSRC
2.	Mr. A D Bawari, US
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4.	Mr. KedarNathVerma, DD (NHM)
5.	Dr. Chaman Prakash, CMO-DGHS
6.	Mr. Daman Ahuja, PFI
7.	Dr. Shahab Ali Siddiqui, NHM
8.	Mr. Ratish Kumar, AH
9.	Mr. Hitesh Jhangiani, Finance
10.	Ms. Saranga Panwar, B&T Unit

POSITIVES

- ABD (Action on Birth Defects) Project, an innovation of the State for Screening of Anemia and Newborn for G6PD Deficiency and CHT was piloted in year 2012-13. With the launch of RBSK in 2013-14, newborn screening of structural birth defects was subsumed while development of screening and intervention strategies for disorders requiring blood test for primary screening- thalassemia, G6PD Deficiency and Congenital Hypothyroidism is continued under the Project.
- With the aim of providing complete health check-up and treatment to mal-nourished children, the state govt. is organizing "Vazan Diwas" on 5th of every month and Special health camp at health facility in convergence with ICDS department "khilti kaliyan".
- State has well connected ambulances network, including 95 vehicles of Khushion Ki Sawari, also being engaged for RBSK referrals
- AYUSH co-location is available in most of the facilities
- Well established infrastructure for blindness control is in place at District Hospital level. Screening Camps are being organized regularly.
- The State is ready to implement Human Resource Information Management System (HRMIS) in phased manner. It will have Training Management Information System (TMIS). The state has prepared salary rationalization plan for contractual staff.
- ASHAs payments are being made through electronic transfers. Special bonus of Rs 5000/- is given to all the ASHAs since last two years.
- Most of the VHSNCs are reconstituted as per the National Guidelines. Dolies are being arranged by VHSNCs for PWs for the Road head

DISTRICTS/INSTITUTIONS VISITED

Sl. No.	Facility	Dehradun	Nainital
1.	MC		Sushila Tiwari Memorial Hospital, Haldwani (SNCU & AFHC)
2.	DH	Govt. Doon Hospital, Dehradun, Female Hospital, Dehradun	DH Nainital, Male & Female, Homoeopathy unit at Base hospital, Haldwani
3.	SDH	SPS Rishikesh	
4.	CHC	Doiwala, Chakrata, Sahiya, Vikasnagar	Bhimtal, Ramgarh, Garampani , Siyalbari
5.	PHC	Kalsi, NayaGaonPalio, Add. Chidderwala	MotaHaldu, Padampuri, Okhalkanda, Dhari
6.	SC	Khandarwala, Chidderwala, Palio, Sherpur, Sabhawala, Selaquai, Bhawuwala, Tilwari	MotaHaldu, HalduChaud, Hadiagaon, Patlot, Khanshyun, Thupli
7.	AWC	Khandarwala, Sherpur II, Majri I	Gunigaon
8.	VHSNC	Organised on Saturdays –Non CRM day	Gunigaon, Suyalbari, Naul
9.	Schools	Primary & Middle School Badripur, Vikasnagar	Govt. Inter college, Padampuri, RajkiyakanyapurvaMadhyamik School, Gunigaon
10.	NUHM	UPHC – Majra, Kargi, Chukkuwala& D.L. Road.	Shani bazar, Rajpura
		Spl. Outreach Camp - Brahmin wala, Mehboob Nagar Colony	
11.	MMU	NA	Located at Karayal
12.	Others	108 Call Centre, State Drug Warehouse, Dehradun	Rajakiya Allopathic Chikitsalaya, Khanshyun, Ayurveda Dispensary , Nawabi road and Phutkuwan, Haldwani

CHALLENGES

- State should augment service delivery through provision of entitlements, skill up-gradations, recruitment drives, strengthening procurement systems and removal of bottle necks in funds flow.
- State should implement Free Drugs & Diagnostics Schemes on priority basis to decrease OOPE.
- State needs to prioritize RMNCH+A trainings followed by continuous supportive supervision and ensure essential commodities as per 5X5 RMNCH+A matrix.
- Regular mentoring & supportive supervision at different levels needs to be strengthened .
- Region wise cluster meetings of ASHAs can be held at to reduce actual expenditure by ASHAs in commuting for meetings.
- Regular analysis and review of data at higher levels to allow immediate actions & HMIS/MCTS data should be used for planning purposes at all levels.
- State needs to ensure timely implementation of PFMS in the State.
- Implementation of Quality Assurance Programmes & Kayakalp needs to be expedited in the State.
- Grievance Redressal mechanism should be established and implemented across the state including system for beneficiary & ASHAs.
- Convergence of NUHM with various disease control and non-communicable disease programs needs to be strengthened.
- The meeting of SHM & DHM should be held at regular intervals.

WEST BENGAL

REVIEW TEAM

Cooch Behar		Purba Medinipur	
1.	Dr. Sila Deb DC(CH-I)- MoHFW	1.	Dr. Charu C. Garg, Advisor, NHSRC
2.	Ms. Neha Kashyap, MoHFW	2.	Mr. Vipin Joseph, MoHFW
3.	Dr. Vartika Sharma, NSHRC	3.	Dr. Satyajit Sen Sr. RD Kolkata
4.	Dr. Ajay Patle, NRU	4.	Dr. Ambrish Dutta, PHFI
5.	Mr. Arvind Kumar Pandian, USAID	5.	Mr. Veeresh Narayan, PWC
6.	Dr. Vijay Arundas, AGCA	6.	Ms. Pallavi Kumar, UNFPA
7.	Dr. Sanket Kulkarni, AD-IDSP	7.	Dr. Nupur Basu Das, CINI
8.	Dr. Surendra Yadav, SAATHI	8.	Mr. B S Chauhan, ACP-FP
9.	Mr. Rajneesh Upmanyu, MoHFW	9.	Dr. Atreyi Ganguli, WHO

POSITIVES

- West Bengal Store Management Information System is promising. Very few stock outs were reported at the facilities visited
- AYUSH system well established, especially homeopathy is very popular.
- Rogi Sahayaks manning the help desk at SDH/ DH level is a good practice. Patient feedback surveys are being carried out at facilities to understand gaps in service delivery.
- Almost 95% JSY payments are through DBT, which is an achievement in itself.
- Infrastructure, equipment, drugs and other supplies are available as per the 5*5 matrix at almost all the facilities.
- Maternal Death Review (MDR) mechanism is well in place and it is reviewed from the block to district level.
- As per the newer initiatives, programs related to deworming, calcium supplementation during pregnancy is being practiced, but screening for syphilis during pregnancy needs special focus.
- SNCUs in the State have very high occupancy rate and they are able to survive 90% of pre-term babies and LBWs.
- Due to improved surveillance infrastructure over the years, and by pro-active monitoring of programme, AES-JE cases have not been rising alarmingly. Vaccination for JE has been undertaken as per NVBDCP guidelines and adult vaccination has also been started.
- Handholding of service delivery staff by supervisory cadre is good and record maintenance is good at the peripheral level.
- KAYAKALP program has been rolled-out and in a short span of time 20 district hospitals had completed a self, peer and external assessment of the facilities against six parameters.

DISTRICTS/INSTITUTIONS VISITED

Type of Facility	Cooch Behar	Purba Medinipur
District Hospital	MJN District Hospital	Tamluk District Hospital
SDH	Dinahata, Mathabhanga, Toofanganj Toofanganj Marthabanga	Contai and Haldia
CHC /BPHC	Boxirhat, Sitalkuchi, Ghoksadanga	Bupantinagar, Ramnagar II, B Mugberia, Bararankua, Bhagabanpur, Bhagabanpur-II, khejuri II, Kharipukeria, Mahisadal RH, Shilaberia RH,
PHC/ UPHC	Shalbari, Chotto Shalbari, Gopalpur	Heria, Dakshin Damodarpur, Jaunka, Natshal Geondone UPHC, Nandarampur UPHC, Tentulberiya, UPHC 57, Borrough - -7,
Subcenters	Shalbari- II, Bakla, Sitalkuchi, Kismat karala, Gopalpur	Bupantinagar, Ramtarakhat, Gobindpur, Bararankua Bhagabanpur I, Mahammadpur II, Balarampur, Kalikakundu, Natshal, Nimtouri, Shilaberia, Nakibasan, Ramnagar II
Villages/ GAK/ Primary School/ Training Centre	ANM-TC, Cooch Behar Nutrition Rehabilitation Center, Cooch Behar	Kalika kundu Aanganwadi center, Focus group discussion

CHALLENGES

- High rate of C- sections in both the districts (Cooch Behar 30% & East Medinipur 44% in both Public & Private)(16% & 26% in public facility)
- District data reveals around 15% (HMIS) delivery at home. Only 0.1% home deliveries are SBA attended.
- Skill of SNs need to be improved in conducting deliveries and managing high risk. (SBA training)
- Skills of new born resuscitation found poor, every new-born kept under radiant warmer without assessing need.
- At Labs, no integration– mostly functioning under vertical programs - state action initiated for multitasking of staff.
- Poor quality of Intrapartum care in private as well as in referring hospitals (Cooch Behar). As Out-born newborns admitted with BA/MAS/sepsis are of adequate birth weight (2.7 to 3.3 kg).
- Admission criteria not followed in many cases as NRC meant for sick SAM children. Basic equipment not in place. Low cure rate, investigation and clinical supervision not followed after admission for sick children.
- There is presently no formal ASHA meeting above the Sub centre level, and no support structure for the ASHAs at the sub-block, block, district or state levels. VHNDs are being conducted as merely immunization days.
- Funds utilization for several NVBCDP is poor and needs to be improved.
- Grievance Redressal System, in forms of complaint boxes in facilities, but not functional.
- West Bengal incurs OOP expenditures higher than national average. To reduce out of pocket expenditures, patients have been provided free drugs, free diagnostics to some patients, free diet, ANC, PNC in public facilities. Interviews with patients revealed that medicines were generally available for free or subsidized at fair price shop. However, expenditures on diagnostics continue. Evidence of informal payments and transport expenditures were also found during patient interviews. Fair Price Shops, providing drugs at a subsidized rate at SDH and DH level in State are being publicized within the Health Facilities.

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NATIONAL HEALTH MISSION
Mission of Health and Family Welfare
Government of India
Nirman Bhawan, New Delhi

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