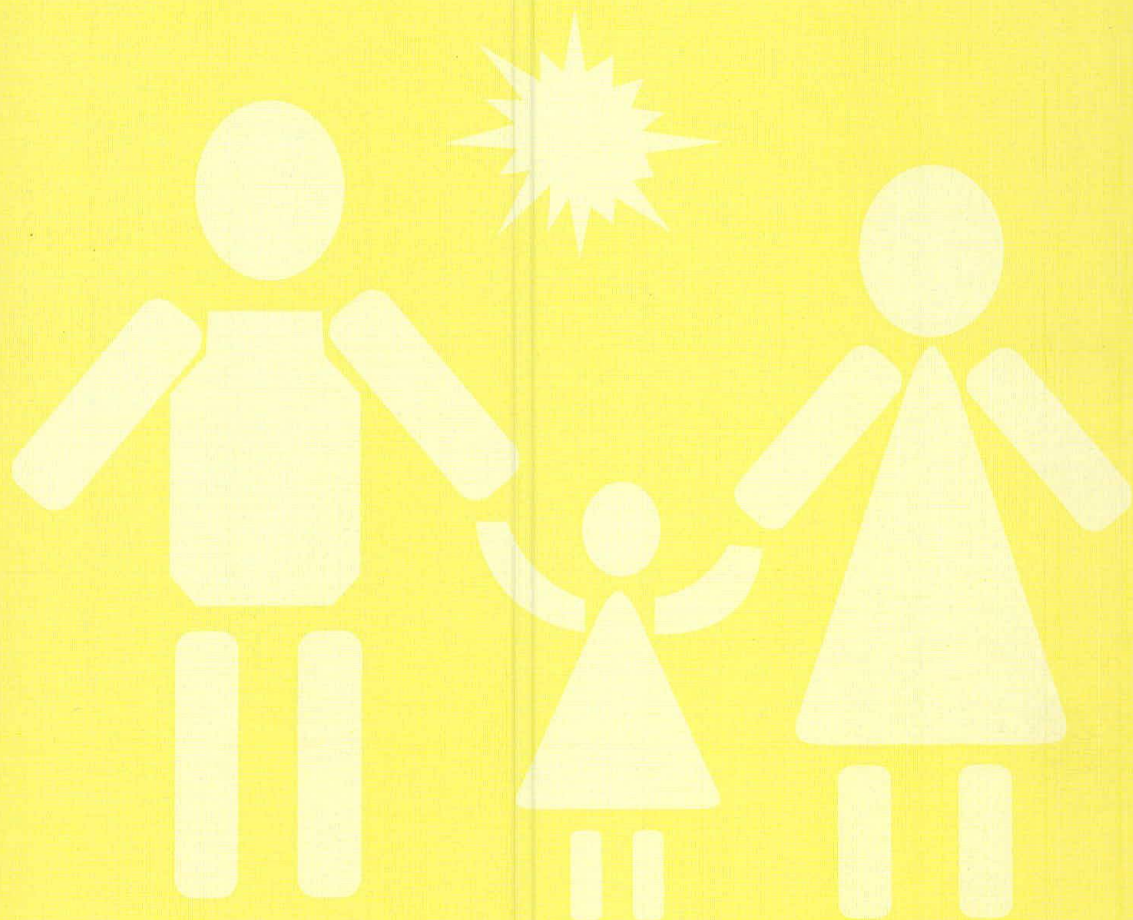


SECOND COMMON REVIEW MISSION



November - December 2008



राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

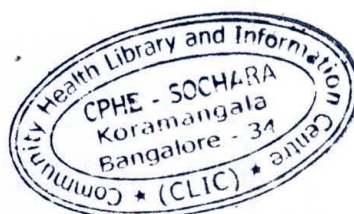
NATIONAL RURAL HEALTH MISSION

**Ministry of Health & Family Welfare
Government of India**

**Nirman Bhawan,
New Delhi-110001**

Contents

	Title	Page No.
1.	Executive Summary	
2.	Report of the Second Common Review Mission	1
3.	Findings of The Common Review Mission	9
4.	Recommendations of the Second Common Review Mission	43
5.	Key Issues across the states – A summary	48
6.	Summary Reports of findings from each state	90



Abbreviations

ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga, Unani, Siddha, Homeopathy
BPM	Block Programme Manager
CHC	Community Health Centre
CMHO	Chief Medical and Health Officer
CRM	Common Review Mission
DH	District Hospital
DHAP	District Health Action Plan
DHS	District Health Society/Director Health Services
DOTS	Direct Observation Therapy – Short-course
DPM	District Programme Manager
EDL	Essential Drug List
EmOC	Emergency Obstetric Care
EMRI	Emergency Medicine and Research Institute
FRU	First Referral Unit
FW	Family Welfare
GOI	Government of India
Hb	Haemoglobin
HMIS	Health Management Information System
ICDS	Integrated Child Development Scheme
IDSP	Integrated Disease Surveillance Project
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IMR	Infant Mortality Rate
IPHS	Indian Public Health Standards

IT	Information Technology
JNU	Jawaharlal Nehru University
JSY	Janani Suraksha Yojana
LHV	Lady Health Visitor
LLFS	Life-Line Fluid Store
LT	Laboratory Technician
MCHN	Maternal and Child Health, and Nutrition
MMR	Maternal Mortality Rate/Ratio
MMU	Mobile Medical Unit
MNGO	Mother NGO
MO	Medical Officer
MOHFW	Ministry of Health & Family Welfare
NCD	Non-Communicable Diseases
NDCP	National Disease Control Programmes
NFHS	National Family Health Survey
NGO	Non-Government Organisation
NHSRC	National Health Systems Resource Centre
NIPi	Norway-India Partnership Initiative
NRHM	National Rural Health Mission
OPD	Out Patient Department
PHC	Primary Health Centre
PIP	Programme Implementation Plan
PIU	Programme Implementation Unit
PMU	Programme Management Unit
PPP	Public Private Partnership
PRI	<i>Panchayati</i> Raj Institution
PTS	Pregnancy Tracking System
RCH	Reproductive and Child Health

RDK	Rapid Diagnostic Kit
RKS	<i>Rogi kalyan samiti</i>
RMRS	Rajasthan Medicare Relief Society
RNTCP	Revised National Tuberculosis Control Programme
RSBY	Rashtriya Swasthya Bima Yojana
SC	Scheduled Castes
SDH	Sub Divisional Hospital
SDP	State (Gross) Domestic Product
SHC	Sub Health Centre
SHRC	State Health Resource Centre
SHSRC	State Health Systems Resource Centre
SIHFW	State Institute of Health and Family Welfare
SPMU	State Programme Management Unit
SRS	Sample Registration Systems
TFR	Total Fertility Rate
TSP	Tribal Sub Plan
TT	Tetanus Toxoid
UC	Utilisation Certificate
VHND	Village Health and Nutrition Day
VHSC	Village Health and Sanitation Committee

Executive Summary

Executive Summary

The Second Common Review Mission of the National Rural Health Mission was held in November- December of 2008, 43 months after the formal launch of the programme and 27 months after the Framework for Implementation was approved by the government. Eighteen officials of the central and state government, 19 public health professionals from academic and technical institutions and 17 public health activists from civil society and 13 representatives of development partners, a total of 67 persons, participated in the mission. The Mission divided into 13 teams which visited over ten facilities in a minimum of two districts in 13 states. And at each of these sites, the Mission interacted extensively with community representatives, service providers, and officials and then after discussion with state officials submitted their state reports. These state reports have been summarized in this national report along with an analysis of general trends across states.

The Mission studied changes across 19 parameters. In this report we sum these findings up into four main headings. The most important of these is improvement in service delivery and facility functionality leading to a notion of fully functional facilities that deliver on the NRHM promise of service guarantees. The other headings are human resource development, improvements in management and strengthening of community processes.

Key Findings of the Mission:

1. The most important finding is a general increase in utilization of public health services, reflected in increased outpatients, increased in-patients and a sharp increase in institutional deliveries and greater utilization of ancillary services like diagnostics, referral transport etc. This increase is seen across states. Though Janani Suraksha Yojana is a major driver of this increase, other factors like more nurses and doctors put in place, better availability of drugs and improved cleanliness and above all the increasing will to revive public health systems are becoming the dominant contributing factors.

The increased utilization is not uniform across all facilities in all states. In six states, all of them high focus, despite an overall increase, the increase at the 1 per 30,000 PHC level is modest or absent. And in a few of these six states increases in service even at the sub-center level have been compromised by the focus on developing the 1 per 1 lakh CHC (or block PHC). This has occurred because of a conscious policy to optimally utilize scarce human resources by pooling them to viable levels at few centers, rather than spreading them thinly. Or this has occurred because of core sub-

center services being transferred to higher levels, with little plans for those who are still unable to access the higher health facility. In most of these states with secondary centers now overcrowded and reeling under the pressure of institutional deliveries, attention to revitalizing the primary health center is drawing more attention.

3. All states have seen substantial increase in numbers of service providers deployed. There is now an increased awareness of sub-critical densities of human resource in the public health system, a legacy inherited from the nineties, as one of the critical reasons for the poor performance of public health systems. Along with this some states have substantially revised and improved on key dimensions of their workforce management policies whereas other states, though seized of the issues, have yet to push through the minimum necessary changes for ensuring a motivated workforce from whom performance can be demanded. One important development is a range of incentives across states to improve availability of the workforce in hitherto underserved areas. There is concern that the major part of the increases are contractual and sustainability beyond the sanctioned NRHM period would be a problem especially where states have not fully owned the essential nature of such expansion and planned for it in state budgets.
4. Expansion of paramedical, nursing and medical education is occurring in all states and there are plans for a major acceleration of this. Lack of faculty, lack of institutions and lack of resources seriously hamper this expansion. In many states almost all recruitable staff available on the open market have been taken in- and unless the pool of new recruits is sharply increased further improvements even in service delivery would become critical. This is most important in the poorest performing states where existing human resource density is extremely low, and all these NRHM driven increases have not been enough to even catch up with the pre- NRHM levels of human resource availability in the high performing states.
5. Quality of care and preparedness of facilities have improved. However states with better baselines like Kerala, Tamil Nadu and Maharashtra have been in a position to make quicker use of untied funds and the state and district planning process for addressing these issues. Though there has been significant improvements in infrastructure, drugs, diagnostics, sanitation and hygiene , dietary arrangements etc in the high focus states the rapid increase in utilization, especially the rise of institutional deliveries tends to outpace the relatively much slower rate of expansion of infrastructure, human resource and supplies. Addressing this would require even more

flexibility in funding along with better management arrangements at the state and district level.

6. Induction of management skills, IT skills and accounting skills in a major way into every state and district level has improved the management of programme significantly. Fund flows have increased with computerization of accounting and bank transfers of funds at most levels. However states have shown very varied progress in setting up institutions that are needed to improve management and drive the process of architectural correction. This is particularly a problem in the area of procurement and logistics (where TNMSC is a national benchmark), in infrastructure development (where the Gujarat PIU is a benchmark) and in the area of technical assistance (the planned SHSRCs) and in the area of training institutions (the SIHFW equivalents and the pyramid of institutions below them).
7. ASHA programme has expanded on the ground to cover all the high focus states except Himachal Pradesh and Jammu and Kashmir, and is now being expanded to cover the entire nation. The ASHA has emerged as an enthusiastic community health worker whose effectiveness and live contact with the public health system is sustained through the JSY and her role in the village health and nutrition day/immunization session. Most states are working on improving their support systems, improving the quality and frequency of training, regularizing payments, refilling drug kits, providing for special referral support and expanding the incentive package. As these steps come into place the programme can be expected to pick up and provide a much higher level of outcomes. Most other dimensions of community participation- the village health and sanitation committee, the community monitoring programme, the public participation in *rogi kalyan samiti* and district health societies are showing good potential but in many states it is too early to comment as they are only in the take-off stage. There is scope to increase NGO participation in the ASHA programme and in strengthening other community processes.
8. Systemic inadequacies are affecting all vertical programmes, the most important of these being the poor densities of functional health facilities and consequent low human resource densities in the low performing states. In addition immunization continues to be affected by poor logistics. The efforts at integration, especially by using the district plan process to address systems – programme linkages could be strengthened.
9. Most planning for fully functional facilities or achieving IPHS norms focus on the RCH components. Other health care needs like management of acute illness, so critical to disease control programmes, of trauma, and of non communicable disease are not as

yet getting the importance due to them in planning, in resource allocation, in human resource planning or in monitoring. There is a need for high performing states to show the way forward in these areas. There is a need for these states to develop models of integration of these concerns, that could represent upto 80% of morbidities, into the district plan.

10. Hospital Development Societies are in place in all district, divisional and block hospitals and in most PHCs. These societies are functional and are an effective vehicle for untied funds and to some extent of improved facility level management and this has substantially contributed to improving quality of services. Much needs to be done however to make them more conscious of their role in safeguarding equity , along with quality of services, and to reduce their image as merely being a vehicle for user fees. The problems of user fees are poorly appreciated by both facility level service providers and these societies. However problems like lack of exemptions for the poor, non utilization of certain services, exclusions are present and were evident to the visiting mission teams..
11. Decentralisation in terms of devolution of governance powers to *panachyats* continues to be a challenge. However progress has been made on involving *panchayats* in the structures of the mission - VHSCs, hospital development committees and in district health societies. Capacities for district planning have improved substantially but the process is hampered by lack of information about the resource envelope available against which the district plan is made and a failure of states to release moneys to districts according to the approved district plan and to use the district plan as the instrument of programme review.
12. A wide variety of non governmental partners have been involved in provision of services or strengthening of the programmes. For the large part they are not-for-profit agencies who are reaching out to underserved areas through different contracting arrangements. In a few states like Bihar there is outsourcing of ancillary hospital services to local agencies and individuals against a standardized agreement. Though these are all useful supplements to the public health system there is no generally replicable model that has been seen in the states visited. In all cases of partnership, even where it is a reputable not- for-profit group involved, there is a need to have an independent monitoring mechanism in place, and careful assessment and construction of financing arrangements so that services are appropriately budgeted and sustainable and for all of this there needs to be sufficient district and state capacity.

Recommendations:

1. Work with states to finalise a clear nomenclature for the different facility levels and their hierarchical relationships to each other. This is a major constraint in planning, financing and monitoring.
2. Work with states to contextualize IPHS guidelines so as to be able to plan and set meaningful annual targets for improvement in a phased approach to reach the goal at every facility level. Also to contextualize so that service priorities under IPHS reflect the epidemiological profile in each state.
3. Renew attention on strengthening the PHC. In most states this would be based on achieving the IPHS norms in human resources for PHCs, but in states with a human resource crunch, alternative human resource management strategies based on multi-skilled paramedics would be needed.
4. Improving the quality of care and comfort of stay for the in-patients in the public hospitals especially at the secondary level, through clean toilets, fresh linen, and a friendly environment. Over time move to a system of ensuring quality improvement in all public health facilities.
5. Mainstreaming AYUSH not merely mainstreaming the AYUSH provider: Provide users with a greater choice of services by having the AYUSH service provider, and not use them as additional allopathic curative care providers.
6. Where an AYUSH doctor is being used as a substitute to a MBBS medical officer, there is a need to specify through standard protocols the level of care that can be provided by them and provide them with the training and legal framework to provide such care.
7. There is a need to urgently strengthen the ASHA support system. This includes a state level resource team capable of developing further state specific material needed and well trained and supported district and block level teams of facilitators and a system of monitoring. Streamlining of payments also needs to be strengthened and its base widened by allowing a larger number of activities to be incentivized.
8. Enhance community participation, especially representatives of user groups in the hospital development committees (*rogi kalyan samitis*), and transform their image from being a vehicle of user fee collection into an organization charged with addressing equity and quality issues.
9. Activise the formation of village health and sanitation committees and strengthen facilitation systems for this. In particular NGOs could play a major role in this.
10. Simplify the current process of community monitoring and broad base the programme participants and expand on it.
11. Improve coordination between the health mission and the directorates in the states and increase training and support inputs to directorate staff so that they are able to

participate and eventually lead in the process of change and revitalization of public health systems.

12. Work with state governments to start up 3 management organizations/ arrangements of minimum design specifications immediately – one of these being for procurement and logistics, another for infrastructure and the third for technical assistance (the SHSRCs).
13. Improve the quality of public health management through the development of a public health sector management cadre, expansion of public health education including in-service skill training and improved human resource development policies for health administrators.
14. Make improvement of workforce management policies one of the cornerstones of good governance in the states and support states to move to evolve and implement commonly agreed to policies in this regard.
15. Assist and support states to draw up and implement plans to revitalize their SIHFWs or equivalent organization and other training institutions in the states so as to ensure that in-service skill upgradation meets the quality and pace required to improve service delivery.
16. Assist and support states to draw up and implement state specific human resource development plans to expand with quality medical, nursing and paramedical education, such that the needs of the public health system are prioritized and met within the shortest time possible.
17. Build a national plan linked to the above to take on the responsibility of developing faculty and quality assurance systems for this rapid expansion in medical, nursing and paramedical education.
18. State spending on human resource component should expand, so as to slowly take in the new positions being created under NRHM. This is essential for sustainability, for better work force performance and as part of states commitment to increased public health expenditure. A wider and innovative set of incentives must be tried out and then institutionalized for attracting and retaining skilled personnel in difficult areas.
19. Link district plans to resource envelopes available for districts and also develop the practice of revising the plan document after sanction and based fund allocation and review on this.
20. Develop the district plans further so that this is used to rationalize, infrastructure and human resource and financial resource deployment to match utilization patterns of different facilities and areas.
21. There is a need to ensure, that there is a proportionate allocation and expenditure of funds for accelerating non JSY dimensions of RCH that would prepare the facilities to deliver quality services as well as address all issues of women's health. In parallel the

facilities need to be prepared for addressing neonatal care and meeting felt needs of contraception.

22. The NRHM's emphasis on human resource development should take the needs of the disease control programmes into account. Even in key district level management positions there are shortages of staff. Integration of disease control programmes and IDSP in the district plan in a technically meaningful manner is essential for improved outcomes in many programme, but especially in vector control.
23. While immunisation programmes have been given attention in states with regards to outreach and fixed day immunization services, gaps in availability of vaccines and issues in cold chain management seem to have adversely affected progress in the current year.
24. Progress beyond planning for RCH service delivery in primary and secondary facilities to plan for addressing emergencies, acute illness and even chronic illness into primary and secondary health care and through the development of appropriate referral linkages and human resource development and deployment strategies such that all the facilities within a district become like parts of a single functional unit. High performing states on RCH parameters should take the lead on this.
25. Improve the flexibility of fund allocation to facilities within a district and to districts within a state so that funds flow to facilities and districts which use them best. This is essential to expedite useful absorption of funds. However funds needed to reach a minimum level of functioning and equity considerations within regions are kept in mind- so that places already suffering for lack of human resources and sanctioned facilities are not deprived even further.
26. Engage with the private sector to provide services in thematic and geographic areas where the public system is deficient working out packages that are cost effective and transparent and subject to good monitoring practices.
27. Develop HMIS systems and capacities so that action can be taken on information derived from data analysis at the facility and at the sector, block and district level. The main challenge is the development of district level systems and capacities for use of information. The other major challenge is to be able to collect information from the private sector as well.

**Report of the
Second Common Review Mission**

The Second Common Review Mission Report

Background

The National Rural Health Mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable and accountable quality health services that would reach even the poorest households in the remotest rural regions. The detailed Framework for Implementation that defined the strategy by which this goal would be approached was approved by the Union Cabinet in July 2006. This Common Review Mission, the second one, is an assessment of the progress during the last year that have since elapsed. To put greater emphasis on the states with the more unsatisfactory health indicators, 18 states were classified as special focus States.¹ This Common Review Mission covers 9 of these 18 states and 4 of the other 11 states.

The National Rural Health Mission represents a major departure from the past, in that central government health financing is now directed to the development of state health systems rather than being confined to a select number of national health programmes. There are many considerations behind such a shift. This shift is important for improving the structure and functioning of public health systems because all national health programmes taken together account for only a small part of morbidities – in the range of about 20 to 30%. Another reason for this shift is because investment in health systems development is essential for good results even for national disease control and RCH programmes. For investment in health funding to impact on health equity and on poverty, larger funds have to flow for health systems to those very states whose ability to raise resources internally are most limited and who have a greater burden of poverty and inequity and, therefore, a greater burden of disease to bear. While the state governments bear the responsibility of planning and providing the health services in their state, the NRHM is expected to facilitate health systems strengthening and infuse new energy through this support from the centre.

The NRHM framework represents a conscious decision to strengthen public health systems and the role of the state as health care provider. The NRHM also recognises the need to make optimal use of the non-governmental sector to strengthen public health systems and increase access to medical care for the poor. There has been concern on whether such an approach is pragmatic given the poor record of performance of the public health systems. The NRHM framework is built on an understanding that low and declining public investment in

¹ The high focus states are the 8 states of the North-east- Assam, Sikkim, Tripura, Meghalaya, Mizoram, Manipur, Nagaland and Arunachal Pradesh –; the eight low performing states of Bihar, Madhya Pradesh, Uttar Pradesh, Rajasthan, Orissa, Jharkhand, Chhattisgarh, and Uttaranchal; and the two states of Jammu and Kashmir and Himachal Pradesh. The NRHM is also being implemented in the remaining 'non-high-focus states'.

health care and the many structural problems in the way the public health systems have been organised are the main reasons why the public health system has been functioning poorly and this must be addressed through increased public expenditure and through architectural correction of the public health system. Given the uneven growth of the private sector, its current situation in terms of regulation of quality and pricing of services as well as the issues of access to the poor, the public health care provider remains the mainstay of public health policy.

The NRHM is, therefore, about increasing public expenditure on health care from the current 0.9% of the GDP to 2 to 3% of the GDP in an effective manner so as to strengthen the public health services. The corollaries of such a policy directive are not only an increased central government budgetary outlay for health, but that the states also make a matching increase – at least 10% of the budget annually, including a 15% contribution into the NRHM plan, and that the center-state financing ratio shifts from the current 20:80 to at least a 40:60 ratio in this plan period. Another important corollary is that the state health sector develops the capacities to absorb such fund flows. This is why a process of reforming and strengthening the state health systems needs to go hand in hand with the increase of fund flows.

The other core objective of the NRHM, which is also central to reviving trust in the public health system, is the responsibility of creating what the framework calls, “fully functional health facilities” within the public health system. Whether it is a sub-centre, or a PHC, a CHC or a district hospital, the NRHM framework spells out a service guarantee expected of that level, and promises to provide the resources and assistance needed by states to close that gap. The outcome most expected from the Mission is that each facility is able to fulfill this guarantee.

The “architectural correction” of the public health system envisaged by the NRHM, so as to deliver on these two core objectives that would lead to the goal of “equitable, affordable, effective, quality health care”, is organised around five pillars, each of which is made up of a number of overlapping core strategies.

- a) **Setting Norms and Standards and Achieving Service Guarantees:** The first of these pillars is the setting of norms and standards for public service health delivery which match the notion of service guarantee outcomes and putting in place a mechanism of monitoring and support to ensure that this is reached. Once the norms and standards are in place the challenge is of identifying in a facility specific manner, the gaps in infrastructure, human resource, equipment, drugs and supplies and above all in service outcomes. And then the challenge becomes to ensure that states are seized of this task and have built roadmaps to close these gaps and are traversing

down these roadmaps they have set themselves. Gaps in infrastructure require an efficient mechanism of completing civil works in time with quality. Gaps in equipment are relatively easily addressed. Gaps in drug supplies need an adequate drug procurement and distribution system. Gaps in human resource require expansion of education plus workforce reforms and innovations. The NRHM has put in place the set of Indian Public Health Standards for each of the facilities from Sub-centre to District Hospital with service guarantees at each level. Most states have completed facility surveys and identified their gaps and are seized with the task of closing these gaps. The Common Review Mission itself represents the apex of a pyramid of monitoring and evaluation strategies meant to assess and ensure movement on this path to attain the fully functional health facility. In addition the NRHM framework assures the states that the center would contribute substantially to the financial and the technical resources needed for states to close this gap.

- b) Innovations in human resources development for the health sector:** The central challenge of the NRHM is to find definitive answers to the old questions about ensuring adequate recruitment and retention for the public health system and adequate functionality of those recruited. Breaking a vicious cycle where poor performance of the workforce has justified poor attention to solving the fundamental problems of human resource development, the NRHM lays down a minimum human resource requirement for each facility level and follows up to ensure that states agree to a roadmap to close these gaps. The most important outcome of this is the dramatic increase in the number of nursing and allied staff being brought into the system. The contractual appointments route and local recruitments to immediately fill gaps as well as ensure local residency, incentives for staff working in hitherto underserved areas, and the use of multi-skilling and multi-tasking options are examples of innovations that seek to find new solutions to old problems. Expansion of professional and technical education and increasing access of weaker sections to such education are also a core strategy.
- c) Increasing Participation and Ownership by the Community** (also referred to as communitisation): This is sought to be achieved through an increased role for PRIs, through the ASHA programme, through the village health and sanitation committee, and through increased public participation in hospital development/management committees. The district health societies, the district and village health planning efforts, the special community monitoring initiative, and the greater space for NGO participation are also envisaged to contribute to enhancing inclusions of community perspectives in decision making.

- d) **Improved Management Capacity:** The approach adopted is of professionalising management by building up management and public health skills in the existing workforce, supplemented by inculcation of management personnel into the system. Another major component of this is the creation of institutional capacities for improved management in the form of functional programme management units, strengthened directorates of health services, strengthened and outcome oriented state institutes of health and family welfare that ensure that the workforce in every facility has the necessary skills to deliver its service guarantees, and the creation of state health resource centres that act as strategic planning and technical assistance units and as managers of change. Increased decentralisation in management, public participation and accountability in the management through participatory decision making structures, like the hospital development committees and the district health societies, is another major strategy of improving public health system functioning.
- e) **Flexible Financing:** The central strategy of this pillar is the provision of untied funds to every level – to the village health and sanitation committee, to the sub-centre, to the PHC, to the CHC and district hospital. Even the strategy of providing a resource envelope to each district and state, which the district/state has to use against an approved plan that it develops, is an unprecedented level of financing flexibility. Financing packages for demand side financing and various forms of risk pooling, where money follows the patient, are also major strategies declared by the NRHM. The *Janani Suraksha Yojana* is one major, almost overwhelming, example of the demand side financing option, so much so that in many places, the NRHM is being identified with it. But the challenge of the NRHM is to be able to build more comprehensive packages that ensure allocative efficiencies within the public health system and that address equity concerns for the entire range of curative care needs.

Since operationalising these measures involved wide-ranging administrative mechanisms to be set up, the initial years of 2005-06 and 2006-07 were start-up years, requiring steps to be devised and put in place at central and state levels. 2007-08 was the first year of full implementation, and 2008-09 led to its further strengthening. Continuing and concurrent review of planning and implementation processes has been considered crucial for such a mission that involves a large degree of flexibility and constant innovation.

Mandate and Methodology of 2nd Common Review Mission

The mode of a Common Review Mission (CRM) was set up as a part of the Mission Steering Group's mandate of review and concurrent evaluation. The last two years - 2007 and 2008- have been the crucial for the implementation of the NRHM, as many of the plans and

strategies of the NRHM were rolled out in the states. The first Common Review Mission was undertaken in November 2007 with the task of assessing progress of the NRHM in thirteen states relating to the core strategies and the central areas of concern stated in the NRHM Framework for Implementation. It was able to provide considerable clarity on the main areas of progress and key constraints that the NRHM was facing.

Now, in the third year since its launch and two complete years of implementation (dated since the approval of the NRHM framework), the 2nd CRM is an opportunity to undertake detailed analysis of how successful and how implementable are the strategies of the Mission. It is also an occasion for collating and documenting the evidence to support or question the effectiveness of different strategies in different contexts. Thus, the 2nd CRM was undertaken with the following overall mandate:

1. To review the changes in health system since launch of NRHM through field visits and spot examination of relevant records.
2. To document evidence for validating the key paradigms of NRHM including decentralization, infrastructure and HR augmentation, communitisation and others,
3. To identify the key constraints limiting the pace of architectural correction in the health system envisaged under NRHM
4. To recommend policy and implementation level adaptations which may accelerate achievement of the goals of NRHM.

Members

Each State team was composed of six members comprising the following:

1. Two Government Officials (*Any two out of the following*)
 - a. Officials of the MoHFW, GoI
 - b. Officials of state health departments (Health Secretary/ Mission Director/Director of Health)
 - c. Regional Directors of Health & Family Welfare
2. One Public Health Expert (either of the following)
 - a) Non-official member of Mission Steering Group of NRHM
 - b) Non-official member of Empowered Programme Committee of NRHM
 - c) Advisor or Senior Consultant of NHSRC

3. One Representative of Development Partners
4. Two Representative of Civil Society (*Any two members from the following*)
 - a) Representative of Civil Society Organisations
 - b) Representatives of Advisory Group on Community Action
 - c) Representatives of ASHA Mentoring Group

Each team identified a team leader and a rapporteur. While the team leader was to provide overall guidance, the rapporteur was to be the point of contact for the team and coordinate the authoring of the report of the team.

Since each team member had to spend almost 8 days on this mission, it was difficult to commit the time of so many senior persons for so long. The final list of 67 persons who made it to the mission team is provided along with the state summary reports.

State Coverage & Timeline

The 2nd CRM was conducted in two phases, one from 25th November to 5th December in 9 of the 13 states, and the other from 16th to the 21st of December in 4 states. This was necessitated by the assembly elections in 4 of the selected states.

The thirteen states covered this year were the following, selected with a view to provide a representative picture of the progress made: Assam, Bihar, Chhattisgarh, Orissa, Rajasthan, Tamil Nadu, Karnataka, Kerala, Madhya Pradesh, and Uttar Pradesh, Jharkhand, Maharashtra, Mizoram, The first ten of these states were also covered during the 1st CRM.²

On the day first day of the mission, the entire group for phase 1 assembled in the committee room at Nirman Bhavan, New Delhi, for a briefing chaired by the health secretary Shri Naresh Dayal (25th November for phase 1 and 15th December for the states covered in phase 2). After a detailed brief on the terms of reference of the mission, the various divisions in the ministry briefed the participants on the components of NRHM that they were guiding - sharing with them the copies of guidelines that the center had provided and the information they had about the progress of the programme. They also shared some of their concerns and made suggestions on what the CRM could review during their field visits.

² The 1st CRM had covered the states of Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal.

On the second day of the mission, there was a one-day briefing by the state officials in the state headquarters. During this briefing, detailed presentations were made by the state officials on the strategies adopted and activities undertaken under NRHM in the state.

On the third day of the Mission the team divided into two groups, with each group visiting one or two districts. The two districts were selected by the CRM team in consultation with the State mission directorates. The visit to the district lasted two to three days and the appraisal was done using a broad protocol that indicated the minimum number of each type of facility that should be visited and the 19 thematic areas that should be covered.

Returning from the districts, the teams engaged in further interactions with the state team and civil society members. After detailed discussions within the teams, a draft report of the main issues was made and these reports were presented to a meeting of the key officials of the state, usually in the presence of the secretary or the mission director. The reports have subsequently been finalized through email consultations between the team members. The findings and recommendations of these reports have been consolidated into this one report and these would be placed before the entire mission team at the national consultation. All state reports will be available on the NRHM website, as was done for the previous CRM.

The previous CRM had reported on 24 parameters which have this time been combined into the 19 key aspects of the health service system listed below:

- I. Assessment of the case load being handled by the Public System at all levels
- II. Preparedness of health facilities for patient care and utilization of services
- III. Quality of services provided
- IV. Utilisation of diagnostic facilities and their effectiveness
- V. Drugs and Supplies
- VI. Health Human Resource Planning
- VII. Infrastructure
- VIII. Empowerment for effective decentralization and flexibility for local action
- IX. ASHA
- X. Systems of financial management
- XI. HMIS and its effectiveness
- XII. Community Processes under NRHM
- XIII. Assessment of non-governmental partnerships for public health goals
- XIV. Systems in place for outreach activities of Sub-centre
- XV. Thrust on difficult areas and vulnerable social groups
- XVI. The preventive and promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health

- XVII. Effectiveness of the disease control programmes including vector control programmes
- XVIII. Performance of Maternal Health, Child Health and Family Planning Activities seen in terms of availability of quality of services at various levels
- XIX. Assessment of programme management structure at district and state level

The progress in the states on these 19 key aspects was to be reviewed against the timelines set for NRHM as well as the Programme Implementation Plans (PIPs) for 2007-08 and 2008-09 of the respective states. The findings on these 19 aspects are being presented in this report, organized under four broad heads -Service Delivery & Facility Functionality, Human Resources, Improving Management Systems, and Community Processes. A summary of the findings on each of the parameters across the states and the key strengths and challenges before each state are also presented.

Findings of the Second Common Review Mission

Section – I

FINDINGS OF THE COMMON REVIEW MISSION

National Overview: General patterns

The findings of this CRM have to be understood in the context of processes of institutional change, and therefore refer to comparisons with observations made during the last CRM wherever possible.

- a. There is a continuing progress in 2008 under NRHM in all the states included in the review, in terms of improved utilization of services and better functioning of facilities, in terms of community processes; and in terms of human resources for health and in terms of flexible financing and improved management.
- b. The general trend found by the previous CRM, towards increasing share of services provided by the public health sector and improving their access and quality, has continued. Whereas the earlier CRM had expressed doubts about progress in increased utilization of services in some states, this CRM observes the pattern of increasing utilization to have increased across all states. Whereas the earlier CRM could not be certain that in some states all increased utilization was not merely a direct JSY effect, this CRM notes that though JSY remains a key driver of increased utilization, the patterns of increased utilization have now clearly affected general outpatient attendance and inpatient occupancy and much of diagnostic services as well and gone well beyond what the JSY contributes to.
- c. The variations in roll out across states observed last year persist, though there is some degree of making up for time lost by the some of the relatively low performers. The trend of each state rolling out different programme components at different rates continues, and this could be a problem, particularly in low performing states where some components have yet to begin- mostly due to state level governance and management constraints. States that had better baselines and similar programmes in place had been quick to take off on NRHM strategies, and have now added several innovations to further strengthen their services. (Integration of NRHM funded health systems strategy with States with health systems development programmes under bilateral donors have been insufficiently studied by the Mission, but there appear to be areas of synergy as well as discordance, and necessary as well as avoidable overlaps).

- d. A broad categorization on the basis of achievements in strengthening of service delivery at all level of facilities³, shows that 3 patterns have emerged: In 6 states all levels have been strengthened (Kerala, Karnataka, Maharashtra, Rajasthan, Mizoram, Uttar Pradesh); in 6 states the secondary level facilities (CHC or block PHC) have been strengthened but PHCs(additional) remain weak(Orissa, Bihar, Assam, Chhattisgarh, Madhya Pradesh and Jharkhand). In 1 state, Tamilnadu, the PHCs and secondary level facilities have been strengthened but the sub-centre services have got relatively weakened. In the 6 states with additional PHCs, the improvement of sub-centres is varied. It is worth noting that there are state specific contexts and rational explanations for each of these patterns, which are explained in the next section. But it also needs emphasizing that there is an epidemiological, and sociological and experiential basis for insisting on improvements in service delivery at all these levels, and while partial improvements could be a stage in the process, the commitment to improvement at all levels needs to be reiterated.
- e. The increase in attention to functioning of public health systems along with the infusion of funds has led to many bottlenecks, almost accepted as inevitable in public systems, receiving renewed critical attention over the past two years. The Common Review Mission itself with its sweeping mandate and its broad based composition and its comprehensive public health systems focus could prove a turning point for the way health systems are perceived. The fact that the common review mission is a systems approach linked to horizontal integration at state and district levels has led to highlighting a much wider level of problems than merely programme specific reviews would have. The final report is only one part of the CRM's outcomes. The CRM has become a systematized process of dialogue between center and state, between public health experts and civil society and public health administrators, between policy makers at national and state capitals with programme implementers at the district and facility level. The final report is able to capture only a part of the richness of this dialogue as represented in the sum of all central and state level presentations and district tour reports and state mission reports and submissions on special issues made by individual members. Even all these documents taken together capture only a part of the entire dialogue that takes place. Though there are serious concerns about the NRHM becoming a stand alone vertical programme built around a set of new players, the major trend is of increasing integration of the new skills with the existing structures and of attention to cross cutting systemic improvements that impact favourably on all programmes.

³ Sub-centre and PHC as primary; CHCs, SDH and DH as secondary level.

- f. The strengthening of public health management is still in its early stages but even the modest improvements that have been made can be seen to be paying dividends, with better flow of funds and better utilization of NRHM funds by the states. Areas of improvement that are seen across the states are in induction of management, IT and accounting skills at district and block levels, better financial management largely due to computerization of accounts, and electronic transfer of funds through e-banking. The CRM also notes that there are many areas of management improvement where the NRHM has made path breaking policy advances but their impacts are not yet visible due to the time it takes to roll out these strategies. At least some of these impacts should however be visible in time for the next mission. These include creating management organizations for better procurement and logistics, and for infrastructure development, institutionalizing concurrent audit, rolling out the new HMIS reform package, strengthening the SIHFW and putting in place the SHSRCs.
- g. There has been an increase in budgetary allocation from the state treasury indicating an increasing ownership by the states. There has also been a better utilization of funds in many states- facilitated by the increased in personnel deployed for financial management. However, absorption of funds remains a challenge. In most states three factors seem to correlate with poor fund expenditure. One of these is governance issues which includes stand offs between directorates and state missions, delays or non attention to building up enough state level management structures especially for procurement and infrastructure, for technical assistance, and lack of tenure of key officials. The second is a poor density of facilities and service providers. And a third would be the highly varied utilization pattern for all the untied funds on flow. Thus though flexible financing is a great move forward, unless flexibility is further increased to be able to spend more on facilities and districts with greater turnover of services and resources, the large patches of untied funds in a few select facilities/districts/states could slow down the rate of expenditure of the entire programme. Evolving strategies to deal with this would be a major challenge in the coming year where increased demand for resources may co exists with poor ability to submit utilization certificates and unless funds can be channelized from areas of poor absorption to areas of high demand within districts, between districts and across states without losing sight of equity considerations.
- h. Several core steps for overcoming crucial human resource constraints have been operationalised, the results of some already becoming evident. The message of the IPHS norms on human resources is beginning to sink in. The most heartening feature is that state after state reports substantial additions to the numbers of service

providers- especially of nurses and doctors. Not only are we now talking of filling up contractual slots available under NRHM but also the posts under the non plan component of state budgets which have been lying unfilled for so long. In some states it is almost as if an informal freeze on recruitment and indeed on the public health system which has been put into place in 1992-92 has finally been revoked. The states of the north are now running out of doctors, nurses and paramedics available for recruitment in the general pool and further accretions are going to have to wait for the newly revived nursing training schools and the new medical colleges to turn out new graduates.

- i. Meanwhile, under the increasing scrutiny for systemic bottlenecks for poor quality of public service performance, many states notably Bihar, Orissa etc have gone in for revising the service conditions of their workforce and have begun thinking of career paths for their staff. Though in most states the depth and range of such workforce management policies is insufficient to meet the requirements, overcoming the mindsets of the past are not easy, and the fact that the states are seized with these issues must in itself be seen as a major gain.
- j. The ASHA programme has continued to expand on the ground, and given the increased space for community participation it provides, the programme is vibrant. Though there has been considerable progress on removing some of the constraints noted in the earlier CRM, there is still much that remains to be done. The *Janini Suraksha Yojana* has kept her in close linkage with the health system, giving the time and space for other support systems to be established. As these systems come into place in the coming year the programme would be strengthened yielding further measurable outcomes. Other Community processes, especially the village health and sanitation committee and the community monitoring programme are in variable stages of take off, but are clearly evident on the ground in all states. NGO participation is largely in the community monitoring programme where initial reports show that a new approach is being successfully piloted, and the MNGO programme which is functional in some states, but as a outcome based national scheme is under review. A few states are making effective use of NGOs for the ASHA programme and there is scope to expand this. The *rogi kalyan samiti* has been successful as a vehicle for untied funds and for flexible local management, but as a vehicle of community participation in management, it has yet to get going fully.
- k. There are some areas where the challenges have not yet been addressed sufficiently. One of these is to go beyond RCH prioritized services in the definition of fully functional health facilities. This could be justified in the low performing states where

addressing high maternal and infant mortality rates and high total fertility remains unfinished on the agenda. However, even in the high performing states, the development of systems for and the integration of non communicable management into primary and secondary level care remains insufficiently addressed or even conceptualized into the NRHM framework. Considering that much acute illness and trauma also needs urgent attention and that social protection of the poor requires public provisioning of services in these non RCH areas in all states, there is a need to build comprehensive facility development and human resource development approaches to match these goals.

- I. The other major challenge remains of effective decentralization. The *Panchayat* has a role in the village health and sanitation committee and some states have provided it with an effective role in the district health society and the *rogi kalyan samiti*. A greater role in governance of health facilities remains elusive and for the most part there is no consensus on this across states. The other frontier of decentralization, the district plan has also advanced further with greater capacity for the same developing in most states. The challenge is now to make the district plan an effective tool of organising the health system as a single multifunctional district level network. For this one need to base district planning on information provided before planning of the resource envelope available to it, and more pragmatically provide for a post sanction implementation-planning stage with provision for greater flexibility of moving resources to respond to needs and utilization patterns within an agreed plan.

National Overview: Key Areas of the Health System

The 19 key areas are being presented under 4 heads. Some have been consolidated from the state reports as such, while others were re-organised, so as to avoid repetition of overlapping and cross-cutting themes. We have attempted to present the major findings as the teams have reported them, however consolidation of findings from such extensive reports will always leave room for some issues getting less attention than a state specific situation warrants.

Towards Achieving Service Guarantees:

Under this head we bring together findings from all the key areas related to the changes in service delivery and facility functionality and in the utilization and quality of health services. Issues related to equity and attaining the expected standard of services receive specific focus here.

Assessment of the case load being handled by the Public System at all levels

There is a general increase in utilization of services after implementation of NRHM, which was observed last year and has further improved since.

In the high focus states, ie. those with weaker performance earlier, the increase has been dramatic. For instance, from Assam the team reports that: "NHRM represents a 'revolution' in terms of improving access of the rural poor to health care. According to one community informant, NRHM has already made a huge difference compared to the pre-launch situation, which was described as 'the near zero supply of services and immunizations'."

Data such as the following has been repeatedly presented from state after state: "Increase in OPD cases from 7,93,727 in 2005-06 to 8,80,339 in 2006-07 and to 10,05,247 in 2007-08."

The increase has been at all levels in states such as Rajasthan. In the non-high focus states, those performing better even earlier, showed that there has been an increase at all levels of services, as in Maharashtra and Kerala. In Tamil Nadu alone though there has been an increase in all levels, the shift in utilization has been more markedly to the PHCs as compared to other levels and sub-centres and ANMs (called the VHNs in that state) have lost out in terms of their role in service delivery.

However it has been relatively greater at secondary levels such as CHCs, Sub-district and District Hospitals and at the cost of the primary levels in states such as Orissa, Bihar and Chhattisgarh. "It is well evident from the community interaction that OPD services and normal delivery is an increasing trend in many CHCs and SCs. However this trend is not seen in PHC facilities. OPD services and institutional delivery in many PHCs has gone down...."

The analysis about reasons for increase in utilization has been varied across the teams:

- "due to better availability of services, better infrastructure and 24x7 availability of services."
- "main reasons for this are in the improved human resources deployed."
- "The institutions where doctors are coming regularly particularly in CHCs the increase in indoor patient load is quite encouraging."
- "the decentralisation, responsiveness to local needs, paradigm shift in health system management and availability of untied funds has improved the facilities and their credibility among members of the public. JSY, community mobilization by ASHA, and proper referral transport have contributed to a large extent in increasing the case load. However greater patient load has been noted in the district and sub-divisional hospitals and CHCs as compared to PHCs and Sub-centres. It was observed that there was a total dependence on the government health system in the absence of a significant private sector."
- "Definite improvement seen in the outpatient load of Sub-centres, PHCs and Rural Hospitals (CHCs). 24X7 Block PHCs are offering outpatient, emergency and institutional services. Sub-centres are regularly doing deliveries. (A separate labour room built from the State budget has increased the numbers) Basic reason for increase in inpatient load at PHCs and CHCs is increase in institutional deliveries partly due to JSY and also because of upgradation of the quality of the infrastructure, clean toilets, water availability, inverter for alternate source of electricity, free meals and also due to feel good factor generated by the beautification of the Centres and Hospitals and their surroundings."

The lack of increase at certain levels and in some facilities was attributable to the policies adopted in the state. In Bihar the understanding was- since in every place there is a situation of near collapse, it would make sense to start by prioritizing improvements in the main block PHC (CHC), i.e. of secondary level strengthening as priority over the primary level facilities. By concentrating available resources in these areas the quick improvement was observed. But now, as CHCs reel under the pressure, there is a rethinking going on on how to revitalize the sector level PHCs. This is the same situation in Orissa and Jharkhand and Orissa too, though Jharkhand is not yet seized of the issue. In Chhattisgarh the lack of nurse additions at the PHC level may be the main constraint- in a context where most PHCs are anyway being managed by non-MBBS providers.

The JSY's impact on services at different levels varies. It has, for example led to decrease in services by ANMs in terms of conducting deliveries in several states, and where the PHCs were not geared up, this has led to overcrowding in the CHCs and District Hospitals.

In other states where SC strengthening has received attention, the OPD care and deliveries have increased even at SC level. For example Maharashtra reports that "Definite improvement seen in the outpatient load of Sub-centres, PHCs and Rural Hospitals (CHCs). 24X7 Block PHCs are offering outpatient, emergency and institutional services. Sub-centres are regularly doing deliveries. (A separate labour room built from the State budget has increased the numbers) Basic reason for increase in inpatient load at PHCs and CHCs is increase in institutional deliveries partly due to JSY and also because of upgradation of the quality of the infrastructure, clean toilets, water availability, inverter for alternate source of electricity, free meals and also due to feel good factor generated by the beautification of the Centres and Hospitals and their surroundings."

In several cases, the facility is under-utilised due to irrational positioning of too many facilities too close to each other. "In-patient load at the Sub-district Hospitals is below optimum due to not so comparatively efficient facilities available (as told demand for services was not there due to presence of a 24X7 PHC nearby. It was informed that the State had been proposing to shift the Sub-district Hospital Bhore to an area where it was required in the same district)." The use of the district planning for rationalizing the use of resources- infrastructural and human resource- within the districts would help in achieving this objective.

Preparedness of health facilities for patient care and utilization of services

The facilities at all levels are getting strengthened in several ways. However one important observation is that given human resource constraints, improvement of service delivery at facilities that are considered to be of greater priority are often at the cost of services at the other facility levels- since the same limited human resource is shifted around.

District hospitals: In most states these have been the strongest in terms of infrastructure and posting of doctors including specialists; being situated at the district headquarter town, where the health personnel tend to cluster, and catering to the local middle-class. In several states, their infrastructure has been strengthened by health systems development projects of the World Bank from the 1990s. However there is a huge variation in terms of their quality. Several states are now in the process of obtaining Quality standards certification for their district hospitals from either the NABH or the ISO, in the 'high focus' states as well.

"District hospital at Bahraich is clean and well maintained. The ambience of the campus is good including plenty of greenery and also comprises of a committed team. There has been improvement in health facilities during the last one year. The hospital is in process of accreditation by NABH. Bed occupancy rate is more than 100%."

"District Hospital Serchhip has got a new trauma wing and blood bank building, but the DC of Serchhip made a strong case for undertaking renovation of the main hospital building. Civil Hospital Aizawl and Champhai District Hospital upgradation project initial stage has begun."

On the other hand, in some districts the district hospitals have barely reached the level of services of a PHC or CHC. In other places, there are district hospitals which function minimally despite a large infrastructure, due to shortage of personnel, or mismanagement and poor performance of the personnel posted there.

"In obstetric care the quality is seriously hampered by a lack of nurses and midwives- the ratios being extremely adverse- 13 nurses only to staff 60 beds with over 100% occupancy, to staff the heavy outpatient, and the obstetric room where only two nurses become available with 210 beds there are still only 19 nurses and midwives taken together and only two nurses in a labour room that could have upto 50 deliveries per day."

Community Health Centers: The CHCs, being later entrants in the chain of facilities starting in the 1980s, were developed by upgradation of PHCs as well as by creating new facilities and this process is still continuing. Since the upgradation processes have been undertaken at different points of time and to varying degrees, the nomenclature has tended to get muddled. Block PHC, Upgraded PHC or just PHC, Referral hospital, Rural hospital: these are terms that have been used to denote a facility that is being developed on the lines of what has been conceptualised as the first point for provision of specialist medical care, overlapping between primary and secondary level services. In some states the facility labeled PHC is on its way to strengthening infrastructure and human resources towards this. In others, the CHC is well established as a provider of secondary services. In all situations, there is a shortage of personnel, especially the specialists who are not joining the public services, and staff nurses who are not being produced in adequate numbers and few have reached the IPHS.

"Some CHCs have less than 30 beds. However, owing to increased load due to the JSY, additional wards are being constructed..."

"CHC lacking in specialist manpower, non-functional OT – referrals to District Hospital"

"Uttar Pradesh has two types of PHCs. The PHCs situated at block are called block PHCs which currently are catering to about 1 20 000 to 1 50 000 population. In the districts we visited, these PHCs are run by MO I/C and an AYUSH LMO. The third MO is not posted. These PHCs function as 24x7 facilities. Mostly deliveries are conducted by Staff Nurse and ANMs of the attached SC. The laboratory facility is grossly underutilized as only basic clinical investigations are carried out. Eventually all block PHCs will be converted into CHCs. Construction work is in progress. "

The First Referral Unit (FRU), a terminology originating from the RCH-I programme, requires a certain set of services linked to maternal health services with commensurate equipment to be available at a facility—the minimum being a set of 3: conducting caesarian section, blood storage/banking, and a neonatal care unit. The CHC, sub-divisional and district hospitals are the ones that are in a position to provide these. Since the CHC is also defined under IPHS to have all these features one could see this as a parallel terminology to the CHC. Since these three definitions of the FRU are anyway the most challenging aspects of raising the CHC to IPHS standards there are few if any CHCs which could become FRUs without also simultaneously achieving or being in a position to achieve IPHS standards. However, the review shows that in several cases, designating facilities as FRUs by the state is more a 'statement of intent' rather than actually having ensured all the 3 minimum criteria being met. What was evident was the effort to move towards fulfilling them, but the road map was not always clear or even thought out. Even the licensing of blood bank/storage had also been done on the intent rather than actual equipment and human resources (for blood storage, of a medical officer and a laboratory technician with training in blood banking) availability at the facility.

Primary Health Centres: This facility which is meant to provide the first interface with a doctor, provide comprehensive promotive, preventive and curative services, and provide supervisory support to personnel at further peripheral levels-- the sub-centre, the village health workers (now the ASHA) and the anganwadi centres – is receiving priority attention in some states such as Tamil Nadu and Rajasthan.

In others it tends to suffer because of priority to the CHC level and the DH. Doctors and ANMs are shifted or attached from the PHCs to the CHCs and DHs in order to operationalise the curative services at the secondary level, taking the basic medical care further away from the villages, and to the neglect of preventive primary care. The concept of pooling from where this practice originated also implied running the PHC with paramedical staff and providing for the medical officer to visit daily or thrice a week during office hours. But often, especially in Jharkhand the withdrawal of staff from the PHC to the CHC was not linked to these two measures leading to a net reduction of peripheral services. Now as the CHC level services picks up the attention shifts back to restarting up the PHC. The supervisory role meant to be performed by the PHC personnel for the sub-centres and village level work as well as disease control programmes has also suffered due to the shortages of personnel at this level.

The great variation in preparedness of PHCs across states and within states is also depicted in the terminology that has come into use for this level of facilities: Additional PHC, PHC (new), mini-PHC, PHC etc. These need to be differentiated from block PHC, main PHC or just PHC denoting potential or putative CHCs. These two sets differ in terms of the population

coverage norm to be followed, the number of doctors, staff nurses and ANMs sanctioned, the number of beds, as well as the supervisory duties expected from it. They also represent the process of incremental development of the facilities.

What are called PHCs in Tamil Nadu are functioning at the level of CHCs in other states

In Uttar Pradesh '24x7 PHCs' represent the conversion of facilities that were barely functional in the day for a few hours, thereby limiting the range of services they could provide and the level of trust they could invoke in the community, to facilities providing round the clock services. For this they have had to ensure availability of at least an ANM or Staff Nurse at all times along with a doctor at least on call, thereby not only conducting deliveries at night but also increasing the range of other emergency services and other indoor care they can provide.

PHCs in Bihar have been revived and are to be upgraded to CHCs while the Additional PHCs are to play the role of PHCs. The PHC (New) in Orissa are upto a decade old and are now revived with posting of Medical Officers and/or AYUSH doctors on a contractual basis under the NRHM.

In several cases, the placing of facilities too close to each other has meant that the inputs for strengthening are wasted since utilization remains low.

In a number of states, there is an effort to outsource management of the (additional) PHCs to make them functional. Bihar leads in this. The first round effort did not succeed and now there is a second round effort ongoing. This has also been tried, but in a limited way in Orissa and in Uttar Pradesh and Rajasthan. In the latter states, the outsourcing is done only where there is a NGO which offers special advantages- a niche strategy – but not as such meant for general replication. "The SDH, Sagwara is functioning very well and attracting increasing case-load. It is a unique model of PPP (through charity and managerial participation) but may be difficult to be replicated. However, this has also meant meagre case-loads at adjoining PHCs. An analysis of 'C to E' forms reveal that many minor case are being treated at Sagwara and the DH, Dungarpur which can be adequately treated at CHCs and PHCs. Minor wounds constitute a large load at these institutions, much of which can be tackled at SCs, PHCs and CHCs."

Sub-Centers: The sub-centres have received a face-lift in all states, and are providing RCH services through an ANM, the MPW (M) being a missing cadre in the facilities visited. Second ANMs have been recruited in several states, often without fulfilling the NRHM requirement of filling the MPW (M) post first, and with no specification of role or division of work between the two ANMs.

"It has been observed that most of the SC are giving better services than in the past because of the availability of untied fund and their proper utilization, In most of the SCs visited basic materials including paediatric ambu bag, delivery tray, table with mackintosh sheet, Boiler, AD syringes, needle cutter etc. are noticed as functional. General cleanliness in SCs are good except where it is functioning from a rented building. Problems for water supply, electricity bill payment are reported from SC. Another good initiative is availability of functioning telephone connection at SCs. It has been reported by the community during group discussion that the team work between ANM, *Mitanin* and AWW are exceptionally encouraging."

"Sub-centre buildings, even those in rented spaces, were observed to be satisfactory. They were equipped with labour table and other basics, but were hardly in use, either due to non-residence of the ANM, or because of referral to CHCs/hospitals under JSY. MPW (M) were not posted in any of the sub-centres visited, affecting the provision of basic curative care and the disease control programmes."

However, in some states the maternal health services of the ANM have been weakened by the JSY and the shift of site of deliveries to the higher level facilities.

Quality of services provided

Quality of services can be assessed against objective indicators of the efforts at strengthening of facilities and services, as well as the indicators of impact on health of the population. Or it can be viewed in terms of satisfaction of the users, and the provider's assessment of their work and working conditions. The CRM was not designed to assess impact on health status, and it may be too early in the roll out of the NRHM to expect such impact, but it was able to examine the changes/improvements in parameters that contribute to quality. It also reflected on perceptions of the users and providers of services.

Patient satisfaction: Patient satisfaction was in almost all places very positive. In some settings, the recent memory of a complete lack of services and the current changed situation was upper most in people's minds. In other settings where services had been available and in use even earlier, there was an appreciation of the improvement in quality of the physical surroundings, the availability of doctors, of drugs and of a more woman friendly environment.

Provider satisfaction: Provider satisfaction was more qualified, but even then on the whole very positive. There was a strong and positive sense of change, of things having been achieved, of their being able to deliver more services. There was much dissatisfaction with service conditions and payments at all levels and with different issues related to support services. One recurrent expression was "the work load has improved so much but there is little improvement in staff or facilities to manage this increased workload."

However, where "no substantial improvement in physical infrastructure was seen, the doctors and nurses also commented about the requirement of better infrastructure. The local community including patients on the other hand gave a mixed response. While they noted the improved infrastructure, the quality and range of services was still felt to be inadequate."

The CRM teams in almost all states observed some improvement in the levels of cleanliness, provision of waiting space for patients, etc. but cleanliness of toilets was still wanting. Also noted was the need for attention to procedures for registration, patient flow and information through appropriate signages, to waste disposal and other aspects crucial for a patient friendly facility. The shortage of human resources and thereby of the expected services was also noted as an issue of quality. Of course, wide differences were evident through the reports in terms of quality of infrastructure and functional processes of the facilities, as reflected in these quotes:

"All facilities were well maintained with proper cleanliness, disposal pits constructed (using RKS funds) – paramedical and group D staff trained in IMEP at District Hospital."

"Overall some improvements have been made in the services like cleanliness, waste collection, electrification and water supply, but are inadequate. While there were extra sweepers appointed from untied funds and maintenance grants, there is still scope for improvement in the cleanliness of toilets and availability of water supply in some hospitals. Many hospitals have colour coded bins supplied but the practice of segregation of hospital waste at source is not practiced by all the staff."

"the infrastructure is old and requires repairs. New building is under construction. OPD patient load is very high, institutional delivery load is also very high. Drug supply is adequate. However the PHC has only 4 beds which require to be augmented, and there is no referral transport service available. Laboratory services are inadequate. Bio-medical waste management facility is available."

"There are many facilities below the district level which are not as per the recommended norms and nomenclature viz. State Dispensaries, Subsidiary Health Centres and Mini-PHC. Block PHC is the administrative unit for health activities of the block. Availability of specialists was not as per norms. At one CHC, Surgeon, Physician, Pediatrician and Radiologist were not available while 2 Gynecology & Obstetric specialists, 2 Anesthetists and 1 Dental Surgeon were available. At another CHC, Dental surgeon was available but dental chair was not available. Here, there were no facilities for sterilizations and MTP. At a District Hospital, eye surgeon was available but not doing eye surgeries due to lack of facilities."

The efforts for improving services have been made through regular staff, contractual staff as well as through contracting out of services. The arrangements differ widely across states,

especially in terms of the terms and conditions of the private providers of the outsourced services. "There is a systematic effort to provide generator support, pathology diagnostics, X-ray and soon ultrasound as well, ambulance services, laundry services, diet services and cleaning and sanitation services, and monitoring services by outsourcing each of these services. This has kick-started all these services, and today these services are available either from the outsourced person or from the facility's own resources in the majority of facilities visited.

The fear expressed by one of the teams seems to echo the general finding in the high focus states that, "given the problems of the past, expectations of providers and even of the public had been set at very modest levels. The system is in danger of stabilising at this low level of expectations and outputs, and even as one appreciates the effort that has gone in to reach this level, there is a need to set the benchmarks higher. There is much more that needs to be done, if the increased patient load and utilization of services was to manifest in increased outcomes."

Utilisation of diagnostic services and their effectiveness

Significant improvement in diagnostic services was observed, even in the high focus states. While this was across all levels of facilities, the degree to which diagnostic technologies had been made available at the primary level varied widely across the states. Those with well endowed PHCs presented a picture unimaginable in others:

In Maharashtra, "All 24X7 PHCs are provided with lab providing basic facilities; semi-auto analyzer and special services like ECG, X-ray in these PHCs; DHs have ECG, X-ray, Ultrasound with CT-Scan. These services are available at reasonable user cost. Use of pregnancy diagnostic kit for early diagnosis of pregnancy, hemoglobin, urine for albumin and sugar test to rule out anaemia, diabetes and pregnancy induced hypertension." In Tamil Nadu, the diagnostics are at a level that it seems to require an examination of the extent of their rational utilisation in all facilities, "The Block PHCs are provided with Scan and all the 235 upgraded PHCs are provided with ultra-sonogram, X-ray, ECG and Semi auto analyser."

In the high focus states, despite the shortages of Laboratory Technicians in some states, they have worked out mechanisms for ensuring services: "There was an effective pooling of lab technicians from malaria, TB, HIV/AIDS for efficient handling of investigations and diagnostic workload in the DH/SDH/ CHC level. Blood banks at the DH are functional with a lab technician. However basic infrastructure is often found lacking, such as water supply and registers for lab technician are not in place. ...Lab facilities are not available at PHC (N). X ray facility is not available at Sub divisional hospitals and CHC levels."

"The state has made sincere effort to improve access to quality diagnostic services through public private partnerships. Outsourcing models have been developed to contract-in private providers for offering clinical laboratory as well as X-ray services from the premises of public hospitals and PHCs. While these innovations are noteworthy and are in the right direction, some operational constraints were noted during the field visits." The shortcomings included the private providers' reluctance to set up laboratories in PHCs, the overlap of both public and private in some settings, and the lack of basic quality protocols as well as bio-medical waste management practices in both public and private laboratories visited.

User charges are still being taken for diagnostics in most states, though generally below the market rates. BPL are exempt from the charges.

Drugs and Supplies

All states report significantly better availability of drugs and other consumables from the situation in the past. The availability of drugs was also displayed on the wall of DH/CHCs/ PHCs as a measure to improve confidence of the public. But medicines and other consumables are still found to be inadequate in many facilities since the increase in supplies has not been commensurate with the increase in patient load. Also logistics systems are slow to develop and there are frequent stock out of high volume drugs in a situation where patient attendance and therefore drug utilization is constantly rising. In the high focus states, putting in place a district warehouse for drugs with a trained storekeeper and a demand responsive system of drug distribution remains a priority.

"Inadequate budget for the drugs (Rs.1 Lakh for CHCs, 0.5 lakhs for Block PHC & 16000 for PHC (N) have put 'out of pocket' burden on patients including for emergency surgery and treatment." "Despite steep increase in state expenditure on pharmaceuticals during the past few years, the per capita public expenditure on pharmaceuticals (around Rs. 8 per capita) is too low compared to the about Rs 49 per capita (USD 1) recommended by WHO."

In states where the system strengthening is still in take off stage, like in Jharkhand the existing picture presents the contrast: "There is shortage of drugs and other supplies at most of the health facilities including district hospital. At all places patients have to purchase I/V drip sets and sutures. Inj. Magnesium sulfate and MVA kits were not available at PHC/CHC/FRU. Ayurvedic drugs are not provided for use by Ayurvedic Physicians and these doctors were found to be prescribing allopathic drugs only. Supplies of Dental consumables are poor. At one place Dental X-ray Unit was available but X-ray films were not available."

Generic Drugs were found to be "available in institutions (PHC/CHC/DH) through Cooperative Store and LLFS – 30-50% cheaper than MRP." In many states, the *Rogi kalyan samitis* are providing free medicines for the BPL families. But access to essential drugs mainly requires

increasing the list of essential drugs supplied in the facility and making outside prescription unnecessary.

AYUSH Services for Facility Functionality

Almost all the CRM States have started with collocation of AYUSH practitioners in PHCs, CHCs and DHs except in Bihar (where the AYUSH infrastructure is still weak in the public sector) and Kerala (where the state has more AYUSH facilities than modern medicine). Some states have reached high levels of co-location like Maharashtra and Rajasthan whereas others have done so very partially such as Assam and Jharkhand.

However, at least in Orissa, Maharashtra, UP and MP, the CRM teams have observed that the AYUSH doctors are working as an arrangement for 'substitution' of the allopathic doctors rather than as 'co-location'. In Orissa, the Mobile health units are also being managed by AYUSH doctors. Almost all the states with co-location reported that the AYUSH drug supply is inadequate and none of the report mentions the presence of AYUSH paramedics.

Systems in place for outreach activities of Sub-centre

The regular schedule of household visits by an MPW, male or female, is not in place for a number of years. Partly this seems to be due to the missing MPW that was in withdrawal since the nineties and partly this has been attributed to the high coverage population that many sub-centers have to attend to and partly it is due to the Pulse Polio drives which is reported to take up as much as a 100 days of their time in some states. The emphasis under the NRHM, is therefore on an increase in outreach activities through the ASHA who is the main plank for home visits and through the Village Health & Nutrition Days organized at the ICDS *anganwadi* centres where the family comes to the outreach center to be met by the ANM on a fixed day every month. Both these strategies are working reasonably effectively, though in many states the VHND is primarily an immunization session and ANC clinic where ASHA, AWW and ANM come together.

"Fixed VHNDs at the *Anganwadis* are increasing ANC registrations, immunization, growth monitoring & nutrition counseling activities. 6 Mobile health units are in place managed by AYUSH doctors."

In Tamil Nadu, there is a different trend with the sub-centre beginning to lose out in service delivery, and the ANM becoming more a mobiliser than a care provider, "The lone VHN (ANM) at the SHC is pre-occupied with mobilisation of women for ANC, PNC, Immunisation programmes at PHCs and transportation of pregnant women to the PHC for delivery. The ANMs are further engaged in the school health and adolescent health programmes and thus leaving hardly any time for domiciliary visits and other outreach programmes of SHCs. The

outreach programme VHNDs at *Anganwadi* Centres is not visible in any of the districts visited." However the understanding is that the health seeking behavior of the public is now requiring that a doctor needs be available for even immunization to happen- and reportedly this is the situation in Kerala also. This may be the reason why the state of Kerala has preferred the ASHA who is a mobiliser to a second ANM. This needs to be explored further and the implications for this for high performing states which are still far short of 100% immunization and seeing reversals in this needs to be understood.

Thrust on difficult areas and vulnerable social groups

States have identified the 'difficult areas' as either the ones that are 'hard to reach' because of the terrain and poor communication infrastructure or the ones with a high proportion of population from the 'vulnerable groups'. The identified vulnerable groups are the tribal populations, Scheduled castes and families Below Poverty Line. Mobile medical units, creating higher density of facilities for better coverage, and giving the personnel 'difficult area allowance' are some of the measures to ensure services in these difficult areas and to vulnerable groups. Some of these initiatives have been taken under the NRM and some were already part of the regular services and have received additional support from the NRHM.

"Tribal Area Sub-Plan (under the treasury, outside the NRHM) has substantial effect in the tribal areas with additional funds for construction of Sub Centres and also additional salary support for the 2nd ANM. Most of the Sub Centres in Dungarpur (TSP district) has two ANMs."

"The KBK districts are clearly identified as underserved districts and special provisions have been made to strengthen services, such as special incentives for health staff serving in KBK plus districts. A few 'hard to reach' areas in other districts too are managed by NGOs under PPP. However, all districts need to map the most vulnerable pockets and ensure convergent services for them."

In the non-high focus states, several NRHM schemes were not applicable for the whole population but operationalised only in the difficult areas. For instance, in Maharashtra, "the ASHAs in the beginning were only for tribal areas, multi speciality training on priority of nurses and doctors posted in tribal and extremism affected areas, separate batch of girls for nursing schools from tribal areas with higher stipend (twice of the regular), Rs. 1000/- pm higher payment to nurses in tribal areas and Rs. 1500/- pm higher payment (both contractual and regular) working in extremism affected Nagpur Division. Exact per month payment of ANMs is ANM in rural area sub-centre- Rs. 7000/- pm, ANM in naxal area sub-centre- Rs. 7500/-pm and ANM in unreachable Sub-centre – Rs. 10,000/- pm."

Effectiveness of the disease control programmes including vector control programmes

Operationalisation of the disease control programmes has been strengthened by the improvement in the service system as a whole. The various programmes are also interacting and supplementing each other in some aspects, such as use of Lab. technicians across programmes. The shortage of personnel at various levels is leading to other innovations as well, for instance for Anti-Malaria activities in Orissa, "Time taken for reporting of positive cases of malaria by the laboratory is three weeks to one month, with gross shortage of Laboratory Technicians. LTs were also allocated to the State by Gol from the Malaria budget. There are problems in finding candidates who are trained in malaria (MLT), so the state has decided to engage the candidates and train them in Malaria Microscopy and rename the post. The state may consider opening institutions for the training of LTs to meet the emerging demand of LTs at the sector level PHCs.....The posts of MPW (M) are vacant and contractual appointment is underway, which is expected to result in improvement in surveillance and delivery of treatment to the patients. ASHAs, who have received additional training as per the state's needs, are facilitating detection of Malaria/TB/Leprosy cases. They make blood slides for malaria and give them to the ANM. For TB and Leprosy, they are familiar with the symptoms and signs and counsel the suspected cases to go for medical help." Similar human resource problems are being faced even in states such as Tamil Nadu, "There are no shortages of laboratory chemicals at the microscopy centres as well as sub-district hospitals. The case detection rate and availability of Laboratory Technicians are of concern in tribal and underserved areas. There is acute shortage of male Health Workers and the services of available 400 NMS can be utilised for implementation of DCPs. In most of the upgraded PHCs, alternate arrangements are made for taking x-rays, ECGs and other routine investigations. The ICTC technicians are also providing additional support."

The Revised National Tuberculosis Control Program is doing well in all the states, with adequate detection and cure rates. It was thought that some attention is required now for improving detection rates, especially focussing on unreached groups and spatial pockets, "The RNTCP is reported to be doing well as per programme parameters. However, the fact that this is a mountainous area with many areas unreached is an indicator that the state needs to be looking actively for uncovered groups and areas, and not go by nationally-determined indicators of performance."

State specific problems are being dealt with as priority, for instance Kala-azar in Bihar, sickle-cell anemia in Maharashtra and non-communicable diseases in Kerala. "The supply of anti KA drugs has improved in Bihar where Kala-azar contributes to 80% of nation's disease burden. Inconsistency in treatment protocols and non familiarity of treating doctors with the current program treatment guidelines are major concerns in this program."

The IDSP is working in some states, with start up of data entry and collation on-line from the field and laboratories. Use of the data to track disease patterns and outbreaks is yet to begin in any appreciable way. "The State and district level IDSP is being strengthened, with appointment of data entry operators, data managers and district surveillance officers in place. However, the Rapid Response Team needs to be further strengthened for outbreak investigation & further action. The P, S and L forms are being routinely submitted. However, issues with data validation and feedback for prompt action still remain to be addressed at various levels. The State and District labs still need further strengthening."

Performance of Maternal Health, Child Health and Family Planning Activities seen in terms of availability of quality of services at various levels

Maternal and child health services have moved at a varying pace over the period of the NRHM. In all states, there has been a continuing increase in number of deliveries conducted in institutions. Institutional deliveries have increased in the 13 states included in this CRM. This is evidenced in all visits made and confirmed by the changes in the DLHS data for these states. Institutional strengthening for this has also happened to varying degrees.

However, the same degree of attention has not gone to child health initiatives. The unmet need for contraception also raises issues about performance of basic services by facilities.

Maternal Health:

Preparedness for Institutional Deliveries: The facilities providing the services for increased institutional deliveries vary across the states, as already discussed. Where the primary level facilities are not geared up, the deliveries are all reaching the secondary level facilities—the CHCs (or their equivalents which are being termed PHCs in some states), SDH and DH—which face severe over-crowding, shortage of beds and therefore inability to keep the mothers for 48 hours post-partum. They are also not able to provide the services for mother and child that are possible if full use is made of the opportunity provided by a mother and new born being with the health system.

Ante-natal care has been strengthened by the early identification of pregnant women by the AWW and ASHA. However, the quality of ANC remains a challenge. The Orissa team observes "the ANMs at Sub-centres are now working mainly as 'ASHA managers' and data providers for the HMIS, at best providing some ANC and contraceptive services. Even the quality of ANC services is severely limited by the fact that in most cases, neither weight gain, BP nor Haemoglobin are being monitored. Only prophylactic dose of IFA is being given with no one receiving the therapeutic dosage. Institutional deliveries are happening at the CHCs and above since the PHCs do not have MBBS doctors or Staff nurses. The most vulnerable ST families still depend upon home deliveries which the ANMs are NOT conducting. This is

evident in the data provided at district level, and at the sub-centres visited. Dai training has been discontinued but the home deliveries are being conducted by the dais (TBAs). In this way, a 'de-skilling' of ANMs and no support for dais is likely to weaken the service delivery system at the peripheral level, especially for the more vulnerable sections who are unable to travel to institutions at a distance, despite JSY support. Mechanisms for linking of TBAs with ANMs needs to be evolved for reaching skills of ANMs in yet the underserved areas / population groups."

In states where all round facility strengthening has happened, the ANMs are performing deliveries at sub-centres, homes and PHCs. ANC is limited by attention to it as an activity in some of these states, but as in Tamil Nadu and Maharashtra, ANC is utilised as an opportunity to build rapport with the mothers and their families, introduce them to the delivery facilities in the public sector, and provide all the requisite care.

The deliveries conducted in SCs are considered institutional deliveries only if they have facilities as per IPHS. The PHCs upgraded with 3-4 ANMs/SN for provision of 24x7 maternity services often lack the medical backup and so, "in order to meet the short fall of doctors at these PHCs, particularly Lady Medical Officer (LMO), the mission has decided to recruit 428 lady doctors from Indian System of Medicine in order to post them at the 24x7 facility and given them adequate training in EmOC."

In settings where the ANC contact with the health system had been satisfactory and the facilities have been made woman friendly, it was reported by the CRM team that, "During the interviews with the recently delivered women in the health centers and hospitals, it was evident that they prefer to stay for 2 to 3 days in the health facility for normal deliveries".

Post-natal care has been a relatively neglected area, with mothers going home within a few hours after delivery, as reported from most states. This is the period when both mother and neonate are at high risk of morbidity and when a large part of the infant and maternal mortality occurs. "The mission found that the operationalisation of block level PHCs and the increased focus on additional PHCs was providing a platform from which access to maternal health, child health and family planning services had been expanded."

The payments for JSY are being made in time in some states, but mothers face much delay in others. Referral/emergency transport for pregnant women was observed to have been operationalised in most states, thereby actively facilitating the women's access to institutions for delivery. In some states, it was observed that the private institutions empanelled for deliveries under JSY, do not provide adequate care for the new born or keep records of the child's health.

There has, reportedly, been increase in incomplete abortion coming to institutions, attributed by the MOs to Misoprostol misuse by unqualified practitioners. This is an observation that is a cause of concern, since both the woman's morbidity and maternal mortality may increase, and must be examined. The expansion of safe abortion services is also slow.

Child Health

The teams found that the monthly Village Health & Nutrition Day (VHND) was being conducted in most states at the AWC with involvement of the ASHA, ANM and the VHSC, operationalising the AWC as a major site for child health related activities before school-going age and the school health programmes can impact on the age group. These points provide for inter-sectoral convergence on child malnutrition, illness or disability detection and immunization. It also provides opportunities for interaction with mothers. However, in some states the VHND strategy has not yet taken off, and in some others it serves only to implement the immunisation programme. "The immunization programme had reached through to sub-centre/AWC level and appeared to be operating well. Fixed weekly immunization days have been are being held in AWCs and sub-centres... However, other child health interventions are not consistently emphasised, and supplies (including ORS) were not uniformly available in all centres visited." Even the new born corner was not found in most facilities conducting deliveries.

The focus on, and skill development for, dealing with childhood illness is envisaged through the IMNCI, but the planned training is largely to the ANM and too slow to make significant impact. Nutrition Rehabilitation Centres are being set up in some states for the grade III and IV malnourished children—"The NRCs in the District Hospitals visited were excellently run and maintained. This is a very encouraging endeavour to tackle the issue of malnutrition in the area". However, the numbers do not match the level of need as per NFHS data on malnourished children, so as observed by one team, "The State has initiated the setting up of Nutrition Rehabilitation Centers in 2 districts, but a more comprehensive approach is needed, integrating preventive, promotive and curative nutrition interventions." The rolling out of facility based care at the PHC and CHC level is also too slow and too varied across the states. There is need for a composite planning linking the IMNCI training for home and facility based care, SCNU, ICDS and NRC as well as the maternal services.

A systems approach to maternal and child health could try to take together all the strategies at the sub-center together into one single training package and at the PHC into another single package and at the CHC and district hospital into a third single package and then build training and support strategies based on this rather than introduce so many different packages at so many different rates across the state. However child health has benefitted from the large

increase of ASHAs and nurses in the system as almost all of them are geared to provide some services to the sick child.

Family Planning

The assessment of progress in family planning services was mixed.

One heartening development was that achievements in NSV are impressive against targets and coverage with this is rising. This needs to be sustained with more mobilization efforts as in absolute terms NSV is only still a small part of overall sterilizations. Male participation in family planning needs to be promoted further, and the MPW (M) may be a vital cadre for this. Tubectomy figures in some states seem to be declining. Even where it is happening the increase is nowhere near the type of increase being seen for JSY. Much of the problem could be on the supply side as fixed day per week sterilization is not yet achieved in many centers. However in contrast to the last visit more facilities have reported this to be happening.

The ANM seems to remain the mainstay of the contraceptive services for spacing methods. "All centres have a list of eligible couples. There is a) very high uptake of the oral pill as evidenced from the NFHS-3 (10% of ECs) and the DLHS-3 (12%)." "Large numbers of women are on the oral pill records of health workers, but the quality of service is wanting. Counseling is cursory, and an extra pill packet is not given (to prevent stock-out at the level of the user); drop-outs are not methodically contacted. Going by the records, it is possible that several women run out of pill supplies." "IUD insertions are being done by all ANMs, while there is an increasing use of oral pills without any monitoring of side-effects."

Infrastructure

There has been a face-lift of a large number of facilities in all states, with extensions, repairs and maintenance works. This was observed in the high focus and non-high focus states. For example the mission to UP observes, mostly clean, green and well maintained district hospitals and CHCs and committed team, committed District Magistrate, excellent improvement during the last one year. Very spacious HSC buildings, generators and inverters are available and in Tamil Nadu, all the PHC premises have a new look as most of the civil works were completed including provision of toilets, water supply and uninterrupted electricity including generators. The PHCs are well equipped with ILR, Deep Freezers, Sterilisers, Autoclaves, Semi/Auto analysers, Calorimeters, emergency lights, water filters etc. The PHCs are having patient's privacy by provision of curtains, cots, mattresses in good condition. The linen supplies were inadequate as three sets are provided per bed and during the rainy season these supplies are inadequate.

In some states, quality of civil works leaves much scope for improvement and delays are reported in undertaking or completing projects. Most states have set up or are in the process of setting up an infrastructure or construction wing in an attempt to facilitate rapid infrastructure development. A few states still do not have an infrastructure development plan. Shortages of electricity and water supply still afflict facilities in many states but generators obtained through the RKS funds have helped.

Systems of referral/emergency transport have been developed in most states but a few still do not provide for this facilitation of access to life-saving services. There is also a constraint of transport for field workers and the supervisory tasks of MOs.

Equity Issues

Several initiatives have been taken by the states for the poor and marginalized groups. Waive of user fees and free supply of medicines is one of the prime strategies to ensure access of services to the BPL families being adopted in all states. As long as user charges and inadequacy of drug supplies exist, this is an essential measure. However, since evidence from various parts of the world has shown that user fees act as barriers to access by the poor, women and girls as well as other marginalized groups, its effectiveness needs to be assessed to ensure equity. Almost every state mission has observed this problem in the nature of persistent user fees and their impact on access:

The mission from Bihar reports, "In the district hospital, user charges for most services are found to be generally high and they are even comparable to private hospitals. All BPL cardholders are excluded from user charges. However for those poor who do not carry a BPL card, the decision for exclusion is made at the level of civil surgeon on case-by-case basis. One would wonder how many poor could access civil surgeon's office to avail such benefits."

"There is a need to do more here especially in exemption in user fees, more so for the outsourced services. No user fees are charged from BPL families. Despite this and the JSY, institutional deliveries amongst SC/ST are less than others and were found to be largely performed by TBAs. Since travelling distances to access services is more difficult for these sections of society strengthening sub centers and PHCs will contribute to equity in access and availability of health services."

Mechanisms for social insurance are being put in place to some extent but are in too much of a flux for the teams to observe their benefits. In Rajasthan, which had an effective mechanism, it was found that, "Social protection scheme includes Rajasthan *Swasthya Bima Yojana*, which involved premium subsidy provided from NRHM, and government hospitals reimbursed by the state insurance department for free treatment given to BPL card holders. This scheme was stopped by the launch of RSBY under the Ministry of Labour, under which

smart cards are printed, but the scheme is presently non-functional with no payment made to the Insurance Company (ICICI-Lombard). Meanwhile the GoR launched a comprehensive social insurance scheme, which included health called *Bhamashah* scheme but that was also stopped because of the issue of non-compatibility of cards (with software support from Infosys) with the RSBY software. So, presently the health insurance for protecting the poor from catastrophic expenditure is non-functional."

The CRM team found that "one of the commendable achievements of Tamil Nadu state is the low out of pocket expenses incurred by rural in-patients (Rs.637) in comparison to Rs. 2610 in Karnataka, Rs.2170 in Andhra Pradesh and Rs.2174 in Kerala. The accessibility of facilities and service is very good in the plains for the rural, BPL and SC population. The services in tribal areas are provided through MMUs and the residents have sought for daily availability of VHNs and weekly visits by MOs."

Reflecting on the IPHS:

Finally, there is also the issue of imperatives of the high goals set by the IPHS. While it may be possible for some non-high focus states to meet those standards, they seem to be skewing the service structure by making states shift personnel to where the gaps are more as per the IPHS, thereby away from the primary and into the secondary level facilities. While there is a rationale for making 'at least some facilities fully functional' if it is not possible to do so for all, the moot question is whether the quantum of human resources required by the IPHS is essential for ensuring the basic service provisioning or is some of it useful only once the basic service provisioning is in place for further improvement of quality and effectiveness.

Thus, there is an obvious need for rationalisation of health facilities in all the states, but more so in those with major constraints. This includes consideration of the spatial distribution of facilities, human resources and skills as well as equipment against the service guarantees expected for each and every village and residential clusters within villages. The processes of decentralized planning and implementation within the health service system must lead to such a rationalization. Now that the planning and management systems are gearing up, and the medical officers too are getting involved in decentralized planning for the Block/District/State Action Plans annually, such steps will have to be part of the next phase of the NRHM if further gains are to be obtained and the gains are to be sustained. Of course, this would have to supplement the ongoing efforts at facility strengthening.

Facility strengthening is happening due to the improvements in infrastructure, infusion of health care providers, the support from availability of funds at all levels and improved fund

flow, better data management and availability, as well as enhanced community mobilization and facilitation of access to services.

Health Human Resources

A large number of health personnel have been added to the public health system under the NRHM. This has been the singular most important system strengthening process, since in previous decades infrastructure development projects such as the Health Systems Development Projects, and programmes for service delivery such as the RCH-I, had been undertaken but there had been little infusion of human resources. If anything there had been a depletion of some health cadres, such as the MPW (M) and the needs for operationalising the new infrastructure had enhanced the human resource gaps, such as of specialist doctors and nurses. The NRHM brought renewed attention to the issue and requirements were identified in terms of numbers of the various professionals and para-professionals, based on the vacancies in the already sanctioned posts as well as new estimates for reaching the IPHS specifications. Skill sets were also identified as needing renewal, reorientation or development de novo. The CRM has once again highlighted the progress made on this front in the last two years.

The CRM has also found that the human resource gap still remains the singular most important challenge in strengthening the public health system and meeting the NRHM goals. Medical professionals available in the country, especially specialists, are not joining the public services. Some specialties, such as anaesthesia and psychiatry, have very few professionals being produced in the country. Nursing colleges are far short of requirements, and ANM-Training Centres have been non-functional for about a decade in several states, leading to non-availability of staff nurses and ANMs for recruitment. Paramedical personnel such as Laboratory Technicians are again too few, or not trained and registered as per standards. Few of the cadres have an orientation or training in public health planning and management.

All states have taken steps in the last two years to deal with this problem, for meeting service needs in the immediate and for long-term outputs. The results were evident: even in a well functioning health system such as Kerala—"Many doctors, specialists and nurses have been employed in hospitals, CHCs and PHCs under the NRHM on a contractual basis and they have added to the services in these centers."

In the high focus states, most SCs have two ANM, the second ANM being recruited under TSP by the state government. The second ANM is generally located at an underserved area and not at the Sub-centre itself. These are positive developments. All facilities had pharmacists and lab technicians.

Consultants desired under SHRC are in place, and also SPMU, DPMU are functional. Strengthening of District PMU is in progress and establishment of Block PMU is proposed. One Block Accounts Manager is in position.

This situation has come about through a number of initiatives for recruitment, improving working conditions and attracting personnel to the public services, in-service and pre-service trainings for multi-skilling and multi-tasking of the present personnel as well as producing more.

Recruitment

Procedures for recruitment have been simplified and powers delegated for local contractual appointments; appointment of retired nurses on contractual posts, power of appointment given to the THOs and medical superintendents, walk-in interviews. The Rural Medical Officer (RMO) cadre has greatly increased availability of MOs at PHC level and this is a positive step. The introduction of Compulsory Rural Service for MBBS and post-graduate doctors is a major step in providing health care in rural areas.

Improving service conditions

The emoluments of cadres have been enhanced through several mechanisms. A 'hardship allowance' Rs. 1000/- additional payment to nurses in tribal areas, Rs. 1500/- (both contractual and regular) for those working in extremism affected division and Rs. 1500/- additional to doctors working in extremism affected division.

"Entry level post for doctors upgraded to Jr. class - I, specialist pay increased from meager Rs. 150/- to Rs. 3000/- per month. Additional allowances are being offered to doctors serving in KBK districts Rs. 8000/- at block level and below, Rs. 5000 at district level, contractual 18,000/- instead of 12,000/-. Post-mortem allowance of Rs. 500/- per case..... A proposal for restructuring of cadre of doctors for creating better promotional avenues is under active consideration. A rational transfer policy for doctors being formulated."

"The state (Tamil Nadu) has standardized the rules and regulations for appointments, transfers and promotions through annual counselling.

Pre-service education/training, In-service Training & Multi-skilling

The capacities of existing training institutions for intake numbers have been enhanced and new colleges/centres are being set up. Under PPP all nursing schools to increase their capacity. They would be provided beds from SDH/DH and PHCs, fees of Rs. 25,000/- to be paid as loan for students entering into 5 year bond, monthly stipend for girls from tribal areas.

Three new medical colleges have been set up in the state. Additions have been made in the under-graduate curriculum e.g. the IMNCI.

Multi-speciality training on priority of nurses/doctors posted in tribal and extremism affected areas.

With multi-skilling of health care providers, one limitation has been the poor retention of skills and performance based on the training. A process of review followed by modifications in the selection of in-service candidates for the training has effectively to better retention and performance, for instance in the case of LSAS in Orissa - 1st batch: Selection of trainees was done by the CDMOs, retention and performance of trainees was low. 2nd batch: applications were sought from in-services doctors; retention better but still low. 3rd batch: Applications sought for specified FRUs, interviewed and counseled for selection of those interested. Retention and performance review will include giving an honorarium if found to be practicing LSAS.

However, many of the multi-skilled personnel like EmOC, LSAS trained doctors are not able to perform due to various inherent systemic reasons.

There is also a shortage of training faculty and an added problem if the trainers are transferred frequently. Frequent transfers can adversely affect a district since they may lose trainers. In Dungarpur, 2 of the 4 Master Trainers of IMNCI have been recently transferred severely affecting their training schedules.

Workforce management Issues:

The CRM teams have highlighted several workforce management issues that states need to address: in designing and operationalising such HR measures:

Appropriate postings and transfers: Poorly planned transfers which lead to non-functioning of human resource compelled by personal reasons. *At Kuttichal PHC there was only one doctor as doctors were said to be refusing to work in the area. However, according to the doctor, his wife, also a doctor was posted in another district. Coordination in postings will help the situation.*

Rational/transparent transfer and postings policies & procedures need to be formulated and operationalised.

Clear role definition: Within the system and for each person at a facility, there is need to define the roles and responsibilities, *"There is lack of clarity on role division between the two*

FHWs and the one or two MHWs posted at a sub-centre. Outreach village or home visits do not appear to be regular or as per a defined beat programme”.

Career progression opportunities: *Career progression pathways and options need to be built into the system. “A system of bridge courses to upgrade ASHA to AWW to ANM to Graduate Nurse and to Postgraduate Nurse should be set up as an incentive for better performance and for career progression.*

Rationalised and equitable emoluments: *While planning for incentives and salaries, entire staff in the hard areas needs to be considered at the same time, “ANMs under TSP are contractual; drawing hardship allowance under NRHM in tribal/desert areas. Contractual LTs (under RCH II) not drawing hardship allowance. The allowance is not available to DPMs and BPMs either. These ‘anomalies’ were reported to the CRM.”*

Training policy and planning: *The teams noted the need for a comprehensive training policy and infrastructure to enable ongoing training and re-training of personnel. “There is no system of nursing in-service education for the state as a whole. This is the appropriate time to set it up while the state is developing its human resources at a rapid pace.” For the presently planned trainings e.g. SBA, IMNCI etc. also it was observed that the numbers were grossly inadequate and a larger number of trainings requires to be undertaken.*

Integration of contractual staff and regular cadre: *mechanisms for integrating the new contractual appointees into the state health services will be required to sustain the progress made under NRHM.*

Community Processes in the National Rural Health Mission:

The National Rural Health Mission continues to expand the extent and quality of community involvement. Significant progress has been made in addressing many of the gaps identified in the first Common Review Mission Report.

The flagship of community participation is undoubtedly the ASHA programme. Emboldened by its welcome in the high focus states of the NRHM, the programme was extended to cover all states in October of 2008. Of the 13 states visited by the CRM, nine were high focus states with the ASHA programme well in place and 3 were high performing states with ASHA programme either limited to tribal areas - Karnataka and Maharashtra and Kerala . In only one state ,Tamil nadu, has the programme yet to be initiated. In every one of the high focus states visited ASHAs have been met with and the programme has been assessed with in some detail. The reports are unanimous in the appreciation of the work being done by ASHAs, their enthusiasm and their potential.

The Assam report states " The ASHA programme has created a groundswell for NRHM in the state, they are the face of the NRHM and have a visible and audible presence, with their dresses, umbrellas, radio and JSY contact. They will now be given cycles, which will give them a visible presence on rural roads. ASHAs are verily the wheels of NRHM in the hinterland."

The progress on some parameters which relate to what the system should do for supporting her are not uniform and are facing constraints. Thus on training Chhattisgarh, Orissa, Assam, Rajasthan, Madhya Pradesh have all completed their 4 modules or on the 4th training round which represents about 15 to 19 days of training (much more in Chhattisgarh), Uttar Pradesh, Bihar and Mizoram however lag behind with only 7 days of training in each.

ASHA payments are reported as regular in Orissa, but in most other states there is a 3 to 6 month delay. The problems seem most acute in Jharkhand and Chhattisgarh.

Drug kits have been procured and distributed in all states except in UP and Bihar. This is a very good progress since the last year when only one state had done so. However the challenge now is to refill the drugs as and when they get exhausted- which means a very good system of procurement and logistics and expanding the funding for this component both from central and state budgets. More information on patterns of usage and financing would be essential as also the task of improvement in logistics.

The other area where there is slow though steady improvement is in the support structure. The district community mobiliser/coordinator is in place and in Chhattisgarh, in Orissa and in Uttar Pradesh . Appointments are in process in Madhya Pradesh, Rajasthan, Jharkhand and yet to be brought onto the agenda in Bihar. Sub-district facilitators are in place in Chhattisgarh and in process in other states. A state level resource center providing support is critical, but has been established in only three of the nine high focus states visited- Chhattisgarh, Orissa and Jharkhand. There is considerable need for urgency in this area for without such support experience shows that it is difficult to sustain outcomes from the programme. The Madhya Pradesh team states "there is hardly any recognition or consideration of ASHA support by state health department, and it was at large felt by the team during their interaction with officials from SHCs, PHC, CHC and district health systems."

One very encouraging feature reported from many states is a diversity of support and encouragement activities like presentation of sarees, umbrellas, or radios or cycles to ASHAs . In Assam a radio programme specifically beamed at ASHAs also provides support

On Village Health and Sanitation Committees, the programme has moved forward steadily. The most time consuming step is the issue of an order at the state level stating the terms of formation of these committees. Once this step is completed, the VHSCs are rolled out and the

funds transferred – the entire process taking a few months after that. This stage has been reached in Kerala, Maharashtra, Tamilnadu, Mizoram, Chhattisgarh, Orissa and Uttar Pradesh. In Jharkhand, Rajasthan, Madhya Pradesh, Assam the VHSCs are formed and the programme is at the stage of fund transfer. In Bihar the snag is at the state level as the enabling order is still to be issued. There is not enough information on what the funds have been used for across the states but where funds have reached and guidelines are in place, preliminary reports suggest that the money is well spent on a variety of local necessities- most often related to drinking water or drainage.

The other major challenge is increasing the role of communities in management through different instruments of decentralization. Of these the most universal and most functional are the hospital development societies. This is functional in all states, though the role given to the elected *panchayat* varies. In some states they had become solely a vehicle of user fee collection. Under the NRHM the process of these societies as vehicles to provide space for communities in governance and management and as a vehicle of improved facility level decision making was emphasized. Upto now, much of the energy had gone into registering them and making them functional. Now the mission *notes* it would need to be focused on providing more space for user participation and making them more equity conscious and less user fee dependent. As a rule where untied funds are given to an functional RKS and basic guidelines are in place, these untied funds get utilized well. This was the case in most states.

On the core challenge of communitisation, on the issue of the health facilities being placed under the *panchayats*-only Kerala and Karnataka have such a situation in place. All the others are able to involve *panchayat* leaders in all the four above steps- ASHA selection, use of untied funds at the sub-center, the village health and sanitation committee and the RKS- but this involvement stops short of actually reporting to them or being paid by them. In Bihar the *panchayat* leadership role in the RKS is being stepped back and in Assam it is being headed by local MLA.

NGO involvement in NRHM varies. In most states they participate in the MNGO scheme, the ASHA scheme and in capacity building for VHSCs. The effectiveness of the MNGO scheme needs to be studied further and though missions mention MNGOs in different roles, the scheme itself does not draw attention. The one special form where community participation and NGO involvement is very visible is in community monitoring. Of the states visited community monitoring had taken place and where there was a positive response to it was in Assam, Karnataka, Rajasthan and Chhattisgarh. Though the potential for replication is not clear some reports suggest, "community monitoring can be beneficial if kept simple." There is possibly a need to persist with this and work on further approaches as well as a limited scaling-up to fully understand the potential of this component.

In conclusion, the NRHM has brought the role of public participation in the health sector center stage and multiplies the forms and intensity of community participation. This has no doubt contributed to better utilization of services and better health awareness. The process of decentralization and public participation in governance however remains a challenge.

Improved Management:

This has four distinct components: the induction of management skills and the strengthening of existing management capacity, the building of better financial management systems, and putting in place a robust health management information systems the creation of structures for professional public health management and technical assistance. We consider below each of these:

Induction of Management Skills:

Every state visited had put in place a team of contractual staff with management qualifications for programme management (the district programme manager) and with IT qualifications for data management and with financial qualifications for financial management. Only Tamil Nadu which has a health administrative cadre had not done so, and Kerala had used these positions for putting in place officers identified as more dynamic, from within the medical cadre itself. One advance in this year over the previous is the coming into position of contractual block management staff in Assam, Bihar, Chhattisgarh, Jharkhand, Karnataka and Kerala,

In most states, these cadres were performing well and had made themselves invaluable. There was still the problem of integration of the contractual management staff with the regular medical administrative directorate staff- but the problem is now articulated as a change that needs to come in the directorate. The need for this contractual staff inputs is no longer in question. The coordination of the directorate with the state mission directors office has now become the central management challenge. There is no doubt that in terms of sustainability and in terms of technical quality of the programme and even in effectiveness, personnel with management functions under the directorate need to be better oriented, better qualified and better supported to play a leadership role. But it is also clear that without the induction of new blood, the stimulus to change the old styles of functioning, and move to a measurable performance output mode of functioning is unlikely to occur. The deliberations of the National Workshop on strengthening public health management (held at Puducherry) therefore assume an immediate relevance for this discussion. The consensus arrived in that workshop could inform the way management in the state directorates and in the districts are strengthened.

The CRM also points out that given the contribution this contractual staff is making there should be more attention given to their human resource management- both in skill

development and also in performance review and incentivisation and increments in compensation packages.

Systems of financial management:

There are four key dimensions of improvement in financial management.

One is the addition of financial staff, especially at the block and district levels. This has happened across the states. With NRHM has come the simple recognition that to handle the vast volume of accounting at the district and block and even sub-block levels, a large number of persons with accounting skills have to be inducted- and the lack of this was a critical bottleneck.

The second change promoted successfully by NRHM is the e-transfer of funds to district level and increasingly further down to block and facility level. This is a move that creates substantial time savings and transparency.

A third major area of improvement is in the introduction of concurrent auditing. Here progress has been slow. States like Madhya Pradesh, Kerala, Karnataka, have made strides forward in this- but the other states continue to lag behind in this and would perhaps need more support and persuasion to be able to put this in place. Monthly financial reporting has started has however started up and is seen in most of the states reported and even this should be computerized and web-enabled over the coming year.

But the fourth is the core improvement- the actual increase of expenditure with timely submissions of audited statements and utilization certificates so that fund flow is streamlined. Despite considerable increase in systems across the 13 states, it may be noted that the poorest states- Bihar, Uttar Pradesh, Jharkhand, Chhattisgarh all continue to have a poor absorptive capacity for funds- though it is precisely these states that need to expand their public expenditures on health sharply.

HMIS and its effectiveness:

Progress in HMIS was assessed at a time when a major changeover of the system has just been initiated. What the CRM has picked up were largely the current state of affairs and the need for a paradigm shift.

Almost all state teams reported that the analysis and use of information is very weak. In most states data collection however is ongoing and though there is much improvement in quality needed, this is not the central problem. In many states computers are available in block level and in all states they were available in the district level. In states like Kerala and Maharashtra and Tamil Nadu they were available in the PHC level also. Some states had started entering data into the web-portal, but at the time of visit most states had yet to do so. It was thus clear

that of all the many problems that HMIS faces the central, most widespread and persistent problem is the poor analysis and use of the large amounts of data that is on flow and secondary to this the problems of validity and reliability.

This poor use of data, noticed by all teams, is also related to design features. For one the use of indicators instead of raw data elements generates "information" as different from "data" and this facilitates the use of this information. Secondly the systems should be able to support data analysis and display at every level, including the level of data entry. It should also have in built feed back systems, as tools of programme management and improving data quality. And thirdly it emphasizes the need for capacity building and the need for coordination at the periphery between the IT specialist, the Public health practitioner and the demographer.

One other issue raised was that data usually bypassed the sector PHC and was aggregated only at the block level. The need for training staff on this was noted by all. Persisting multiple formats were reported by a few teams. Potentially this could be a major area of improvement in the coming year and the spin-off effects of this turn key improvement on all aspects of programme management could be immense- if we get it right.

Institutions of Management and of Change:

The other major thrust areas in management are the need for special vehicles for management of procurement and logistics, an institutional structure to manage infrastructure development, a revitalization of the state institutes of health and family welfare to lead in in – service skill development and of the state health systems resource center to drive forward the process of architectural correction.

Over a year of striving what seems to have been achieved is a broader understanding of why such organizations are needed. However in terms of really getting them going on the ground- the progress has been decidedly modest.

Procurement and Logistics Organisation

The TNMSC model in principle has been accepted as the benchmark for an effective procurement and logistics system. In this period, Kerala has also gone in for such a system and Karnataka has made some major changes in this direction. Madhya Pradesh has declared an existing agency- the Laghu Udyog Nigam as deemed to be its procurement agency, but this agency is not coordinating logistics which, though an improvement falls far short of the requirements. Orissa has set up a state drug management unit which streamlines some aspects of procurement. Though many other states have committed to making such an institutional change, few have actually done so. The benefits of a TNMSC like system for improved governance and decreased wastage, to better availability of drugs and supplies , to

a higher per capita public expenditure on drugs, and a reduced out of pocket expenditure for the poor patient at the public hospital are all well acknowledged and documented. The urgency is to push harder for this fundamental change.

Infrastructure Management Organisation

In many states serious crisis of poor expenditures relates to money locked up in infrastructure development. This is further compounded by the problem of poor quality of civil works and the failure to make water and electricity arrangements as part of the same development costs. There is evidence to show that a separate cell or unit charged with this task organized this work with greater efficiency and speed. In this period Bihar and Madhya Pradesh has created such a cell and Karnataka and Kerala have created engineering wings within the health department. Given the huge gap in crucial health infrastructure there is a need to put such a system in place, other states would need to give this much greater attention.

State Health Systems Resource Centers and SIHFWs

This is another key management strategy of the NRHM. This is an area where there has been partial progress. Many states have recruited consultants for providing in house technical assistance in many areas. Others have created centers for some of the functions- like Jharkhand has created an outsourced *Sahiyya* resource center and Orissa has constructed a community processes management unit within the SPMU. However no state except Chhattisgarh has a full fledged state health systems resource center in place. The CRM identified many areas where states require technical assistance in many areas- in improving quality of training, in better quality of district and state planning, in planning for child health more effectively, in building up drug distribution systems, in designing BCC programmes, in quality assurance programmes, in human resource planning , in building up health management systems etc. Though these can be initiated with the help of external consultants and agencies there is a need to build up technical capacities within the state to sustain and develop these programmes further. If there is no self reliance built up in technical capacity the long term sustainability of public health systems would be compromised. There is also a need to institutionalize such technical capacity in an institution that the state supports so that there can be an institutional capacity with institutional memory of the planning and development process. This is distinct from the role of the SIHFW though these institutions can be collocated. There is also a need to strengthen SIHFWs in most states, and indeed this area would need a special review.

Recommendations of the Second Common Review Mission

Recommendations of the Second Common Review Mission

1. **Standardizing Nomenclature:** Work with states to finalise a clear nomenclature for the different facility levels and their hierarchical relationships to each other. This was not an issue earlier, but now with central funding flowing to states to meet norms and a monitoring system where this relationship is critical, confusion on names would be a major constraint in planning, financing and monitoring. One aspect of this is defining a sub-center as being embedded in every PHC and CHC, to look after the outreach activities of the section where the facility is situated. This would alter calculations of requirements for staff as distinguish between the facility's outreach services and the services provided in the facility premises.
2. **Contextualising IPHS:** Work with states to contextualize IPHS guidelines so as to be able to plan and set meaningful annual targets for improvement to reach the goal of service guarantees at every facility level in a phased approach. Contextualisation should also mean review of guidelines to ensure that service priorities in each facility level should reflect the epidemiological profile in each state.
3. **Revitalizing the sector PHCs:** Some states have shown that it is possible to place Medical Officers at PHCs, such as Rajasthan and Tamil Nadu. Others could attempt to reach this stage but, as a start ensure that at least the paramedical and nursing personnel placed there are multi-skilled to provide primary level curative care as also arrange at least for a visiting doctor. Pooling of medical officers at the CHC (block PHC level) should not become a reason for collapsing the sector PHC which is essential for the provision of many services.
4. **Improving the quality of care and comfort of stay for the in-patients in the public hospitals especially at the secondary level, through clean toilets, fresh linen, and a friendly environment.** Over time, move to a system of ensuring quality improvement in all public health facilities.
5. **Mainstreaming AYUSH not merely mainstreaming the AYUSH provider:** The main purpose of bringing AYUSH services to the mainstream facility is to provide users with a greater choice of services. But using an AYUSH service provider to provide non AYUSH services defeats the purpose- and needs to be restricted, even where the provider may be willing to do so.
6. **AYUSH providers in allopathic care:** Where an AYUSH doctor is being used as a substitute to a MBBS medical officer, there is in addition to the above, the need to

specify through standard protocols the level of care that can be provided by them and provide them with the training and legal framework to provide such care.

7. Supporting the ASHA: There is a need to urgently strengthen the ASHA support system. This includes a state level resource team capable of developing further state specific training material, well trained and supported district and block level teams of facilitators and a system of monitoring. Streamlining of payments also needs to be strengthened and its base widened by allowing a larger number of activities to be incentivized.
8. Pro-Poor RKS: Enhance community participation, especially representatives of user groups in the hospital development committees (*rogi kalyan samitis*), and transform their image from being a vehicle of user fee collection into an organization charged with addressing equity and quality issues. This requires a greater awareness of the limitations and problems of user fees and a greater willingness to exempt the poor or where needed completely eliminate all but the most token forms of it.
9. Getting VHSCs going: Expedite the activation of village health and sanitation committees and strengthen facilitation systems for this. In particular, NGOs could play a major role in this.
10. Community Monitoring: Simplify the current process of community monitoring and broad base the programme participants and expand on it. Ensure serious consideration of the findings and issues raised; also view it as a process of dialogue with the community.
11. Coordination at the top: Improve coordination between the health mission and the directorates in the states and increase training and support inputs to directorate staff so that they are able to participate and eventually lead in the process of change and revitalization of public health systems.
12. New Institutions: Working with state governments to start up 3 management organizations/ arrangements of minimum design specifications immediately – one of these being for procurement and logistics, another for infrastructure and the third for technical assistance (the SHSRCs). National workshops with groups of states with similar situations to help them design organizational structures most suited to their situations would be useful to move this process along.

13. Professionalising Management: Improving the quality of public health management through the development of a public health sector management cadre, expansion of public health education including in-service skill training and improved human resource development policies for health administrators.
14. Improved Workforce Policies: Make improvement of workforce management policies one of the cornerstones of good governance in the states and support states to move to evolve and implement commonly agreed to policies in this regard. A state watch on the performance of different indicators of good governance would be a useful supplement.
15. Revitalising SIHFWs and Training Institutions: Assist and support states to draw up and implement plans to revitalize their SIHFWs or equivalent organization and other training institutions in the states so as to ensure that in-service skill upgradation meets the quality and pace required to improve service delivery.
16. State Specific Human Resource Plans: Assist and support states to draw up and implement state specific human resource development plans to expand with quality medical, nursing and paramedical education, such that the needs of the public health system are prioritized and met within the shortest time possible.
17. National Plan for faculty development: Build a national plan linked to the above to take on the responsibility of developing faculty and quality assurance systems for this rapid expansion in medical, nursing and paramedical education. This would be a very valuable support for the low performing states and it would need assistance from the high performing states, catalysed by the center.
18. State spending on human resource component should expand, so as to slowly take in the new positions being created under NRHM. This is needed for long term sustainability, for establishing better work force policies for increasing the range of incentives need to draw skilled human resources and retaining them in under-served areas and for increasing states commitment to increased public health expenditure.
19. Resource Linked District Plans: Build on the district plans by linking district planning efforts to a better understanding of resource envelopes that are being made available to it. Also, on a more pragmatic level develop the practice of revising the plan document after the national sanction and based on this making a state sanction to the

districts and place this revised post sanction district plan in the public domain as well as use it to guide action.

20. District Plans to rationalize resource allocation: Develop the district plans further so that this is used to rationalize infrastructure, human resource and financial resource deployment to match utilization patterns of different facilities and areas.
21. There is a need to increase budgetary allocation to core system development issues, even for maternal health. Much of the funds gets absorbed in *Janini Suraksha Yojana*. There is a need to ensure, that there are proportionately adequate funds allocated and expended in non JSY activities of RCH that prepare the facilities to deliver quality services as well as address other dimensions of maternal health. Though much has been done to ready facilities for the JSY inrush the rate of increase of JSY has outpaced all of this. Expanding facilities and human resource to meet this increased load of the most vulnerable becomes a national emergency. There is also a need to focus on preparedness of facilities in providing neonatal care and meeting felt needs for contraception.
22. Low human resource densities due to failure to create adequate facilities, due to failure to create adequate number of posts in sanctioned facilities and due to failure to fill up vacancies have all taken a toll on disease control programmes. The NRHM's emphasis on human resource development should take the needs of the disease control programmes also into account. Currently even in key district level management positions there are shortages of staff. The lack of integration of disease control programmes in a district plan in a technically meaningful manner is also a challenge that could lead to improved outcomes on many programme, but especially in vector control. For these reasons and more every effort should be taken to further integrate disease control programmes and IDSP into the NRHM so that these divisions are convinced of the technical merits of such a decision. This is not yet happened at district and often even at state levels.
23. While immunisation programmes have been given attention in states with regards to outreach and fixed day services, gap in availability of vaccines and issues in cold chain management, seems to have adversely affected progress in the current year. Lack of minimum required facilities and human resource densities also contribute to limiting progress in a significant way.

24. **Going Beyond RCH:** Progress beyond planning for RCH service delivery in primary and secondary facilities to plan for addressing emergencies, acute illness and even chronic illness into primary and secondary health care and through the development of appropriate referral linkages and human resource development and deployment strategies such that all the facilities within a district become like parts of a single functional unit. In states which are high performing on RCH parameters this should emerge as the immediate priority, but even in other states this is necessary to provide considerable social protection for the poor from the increasing costs of care and also to increase the effectiveness of all disease control programmes.
25. **More flexibility to flexible funding:** Improve the flexibility of fund allocation to facilities within a district and to districts within a state so that funds flow to facilities and districts which use them best. This is essential to expedite useful absorption of funds. However when going into such flexible financing there is a need to ensure that the funds needed to reach a minimum level of functioning are not compromised and equity considerations within regions are kept in mind- so that places already suffering for lack of human resources and sanctioned facilities are not deprived even further.
26. **Engaging with the private sector:** Engage with the private sector to provide services in thematic and geographic areas where the public system is deficient working out packages that are cost effective and transparent and subject to good monitoring practices. The experience so far has been very mixed. This review shows a multitude of good partnerships with motivated, largely not for profit institutions, but there are few examples of any link with the commercial private sector that are seen that could be recommended for nation-wide replication.
27. **Information for Action:** The main challenge is to develop HMIS systems and capacities so that action can be taken on information derived from data analysis at the facility and at the sector, block and district level. This would also increase validity and reliability of data collected nationally. The development of the national web-portal and the rationalization though important milestones, must be seen as only initiating steps. The main challenge is the development of district level systems and capacities for use of information. The other major challenge is to be able to collect information from the private sector as well.

Key Issues across the states –

A summary

State Reports in Brief

Key areas state-wise

Theme – I

Assessment of case load being handled by the system at all levels

	State	Key Findings
1.	Assam	NRHM a revolution in access to health services. It has made a huge difference. Significant increase in institutional births and outpatient visits. Significant increase in IPD cases as well. Evening OPD started in many places.
2	Bihar	The increased utilization of services is reflected in increased number of persons provided every type of service that is available – be it outpatient care, be it in patient care, be it institutional delivery services, be it emergency services, or surgical services, lab services, etc. Every Block has a 24X7 facility with at least 6 doctors and nurses. Close monitoring facilitates service guarantees. High case load in Block PHCs and District/Sub District Hospitals. Additional PHCs still to be made operational.
3.	Chhatisgarh	OPD services and normal deliveries show increasing trend in Health Sub Centres and CHCs. No increase in PHCs due to shortage of doctors and nurses. Well functioning CHCs with regular attendance of doctors has increasing indoor patients as well. District Hospitals have increasing case load. Uneven performance in family planning services.
4.	Jharkhand	Evidence of increased case load at the Block PHCs in spite of unsatisfactory basic infrastructure and hospital beds at that level. Increased in patient load in District Hospitals. Slight fall in OPD in one District Hospital perhaps due to better functioning of Block PHCs and Sub Centres. <i>Sahiyyas</i> very active. Institutional deliveries yet to pick up on a very large scale. In patient care also picking up with more functional facilities.
5.	Karnataka	Institutional deliveries have increased from 60% in 2005 to 79% in the current year – perhaps on account of JSY and State Government initiatives like Madilu (post natal care kits for BPL), Prasuthi Ariake (ANC benefits for BPL), etc. Many NRHM initiatives are recent. OPD load suggests substantial increase in case load at PHCs. District and Taluka Hospitals have high

		case load. FRUs under utilized.
6.	Kerala	Outpatient case load is good in all hospitals, CHCs and PHCs. State wise data suggests that OP cases have shown increase in 2007-08. Inpatient cases are variable. Inpatient cases can increase if full range of services is provided. Not all CHCs providing 24X7 services. Wide variation among facilities and their load. Need to focus on life style diseases (diabetes, hypertension).
7.	Madhya Pradesh	NRHM represents a revolution. There is a significant increase in IPD and OPD case load at health facilities. JSY has increased the credibility and confidence of the people on the government health institutions. There are trained and skilled manpower to support health facilities at many institutions. Khargone, a tribal district, has reached 71% institutional deliveries. Increase in OPD and IPD has been so significant that a decision to increase bed strength by 6000 beds has been taken in the State.
8.	Maharashtra	Definite improvement seen in the outpatient load of Sub centres, PHCs and Rural Hospitals(CHCs). 24X7 Block PHCs are offering outpatient, emergency and institutional services. Sub Centres are regularly doing deliveries (labour room construction has increased numbers). Increase in in patient load due to JSY as also facility upgradation, clean toilets, water availability, inverter for alternate source of electricity, free meals and also due to feel good factor generated by the beautification of the centres with NRHM funds. Sub District Hospitals need improvement. .
9.	Mizoram	IPD/OPD attendance appears to be the same over the last three years. Presence of Regular Medical Officers has made positive impact on IPD/OPD in PHCs. Little Sub Centre delivery. ANM doing home delivery. Increase in institutional delivery at PHC/CHC after JSY. Utilization of delivery facility at District Hospital has gone up but up gradation is not commensurate with the increased load.
10.	Orissa	NRHM has transformed public health service delivery in the State. The decentralization, responsiveness to local needs, paradigm shift in health system management and availability of untied funds has improved the facilities and their credibility among members of the public. JSY, community mobilization by ASHAs, and proper referral transport have contributed to a large extent in increasing the case load. However, greater patient load has been noted in the district, sub district hospitals and CHCs as compared to PHCs and Sub Centres. Increased number of deliveries, OPDs and bed occupancy reported from

		the districts visited. Sub Centres weak, limited services.
11.	Rajasthan	Increase in institutional deliveries. Almost all PHCs reporting institutional deliveries. Some Sub Health Centres also conducting institutional deliveries. Well performing Health facilities attracting increased case load, cases of malnutrition and large number of non communicable disease cases as well.
12.	Tamil Nadu	Since the inception of NRHM, the PHC case load has increased remarkably – daily OPD by 17% and inpatients excluding deliveries by over 100%. The average Op attendance is 60 to 230 in the PHC. Discharge two ays' after deliveries and diet is supplied through SHGs. The SDHs and DHs are well equipped.
13.	Uttar Pradesh	NRHM has infused a new life into the flagging health sector in UP. Huge upsurge in institutional deliveries. Sub Centre has one ANM but active in most places. OPDS also show increasing trend because of better maintained facilities. District Hospitals very well maintained. Some CHCs have also started providing surgical services. Increase in 24X7 PHCs.

Theme – II

Preparedness of health facilities for patient care and utilization of services

	State	Key Findings
1.	Assam	While human resource has increased, there is a still a long way to go in fully preparing facilities for all kinds of morbidities. Physical infrastructure and availability of ambulances has improved. Blood storage arrangement not functional in many First Referral Units. Family Planning services need more attention. Basic diagnostic tests being done – need to provide for a larger range of test services. Need for better equipped emergency rooms. Shortage of drugs. Need to expand range of services in Village Health and Nutrition Day.
2	Bihar	Patient satisfaction was in almost all places very positive – the recent memory of a complete lack of services and the current changed situation being upper most in people's minds. Provider qualification was more qualified, but even then, on the whole, very positive. 'The workload has increased so much but there is little improvement in staff or facilities to manage the increased workload.' The system is in danger of stabilizing at a low level of expectations and outputs. Increase in services up to the Block PHC level. Additional PHCs still a big challenge – very poorly functional. APHC works like a Sub Centre with an outpatient dispensary.
3.	Chhatisgarh	Improvement has taken place in Health Sub Centres, CHCs and District Hospitals. PHCs are the weakest link. CHCs not providing First Referral Unit services in most places. Improvement with untied grants in infrastructure, equipments, drug supply, water supply, contractual staff etc. Unsatisfactory utilization of ambulance services. Lab facilities functional with minimal services. Large human resource shortages affecting preparedness, besides irrational placements.
4.	Jharkhand	<i>Sahiyyas</i> have been trained up to third module and have drug kits with them. ANMs are in place at the Sub Centre with basic facilities like BP equipment, stethoscope, etc. Immunization through VHNDs is a priority. Medicine availability at Block PHC and District Hospitals has improved leading to higher case load. Doctors on contract besides the regular doctors at PHCs and Additional PHCs. Many of them providing service 24X7 in spite of a various adverse housing facility in remote areas. Poor infrastructure is a serious concern. While large scale new construction has started under NRHM and the Finance

		Commission grants, it will take some time before they are all completed.
5.	Karnataka	Concerted efforts to improve the health facilities from funds from different sources. Availability of untied funds has made a significant difference in the preparedness of health facilities at all levels. While facilities are well equipped, utilization services is not very high in PHC/CHC.
6.	Kerala	Uneven preparedness of facilities leading to uneven utilization rates. Assured services can reduce congestion in higher order facilities.
7.	Madhya Pradesh	Facilities do not have staff as per Indian Public Health Standards norm. District Hospitals were adequately staffed. The Specialists at CHCs and blood storage facilities there need priority attention. Janani Express vehicles in all FRUs help in referral transport. Lab services available in all facilities. Keeping in view the sudden increase in patient load especially under JSY scheme, the infrastructure in terms of staff and other facilities are under a great strain which is affecting adversely the quality of service and has reduced attention to other programmes. Mobile Health Units doing well.
8.	Maharashtra	Extremely committed health functionaries in coordination with public representatives have been able to deliver good quality services. 30% PHCs have reached IPH Standards. Nurses, doctors and Specialists have been appointed. Well stocked drugs and consumables, laboratory facilities for conducting diagnostic tests. Water quality checking at Sub Centres. Blood storage facility in IPHS PHC and CHC.
9.	Mizoram	Medicos and Para medics available at all levels – except Specialists. Young doctors in position, appear confident and capable of handling most conditions. Need to better utilize time of health workers at Sub Centres. District Hospitals better equipped. Some equipment not fully utilized. Lack of Specialist manpower at CHC. All PHCs well equipped in lab facilities with regular tests being done. Rapid Diagnostic kits with ASHAs but not with health workers. All facilities well maintained with proper cleanliness, disposal pits constructed (using RKS funds) – paramedical and Group D staff trained in IMEP at District Hospital.
10.	Orissa	Urgent need to up grade infrastructure. Inadequate budget for drugs leading to out of pocket expenses. Utilization of untied funds, maintenance grants and RKS grants to improve preparedness of health facilities was very impressive in both districts. 1153 AYUSH doctors at PHCs and CHCs to provide



PH-110
11657 P08



		OPD services. Substitution rather than co location in the absence of the MBBS doctor in PHC (N).
11.	Rajasthan	Sub Centres getting prepared for institutional deliveries with labour rooms. Good institutions attracting high load. Large number of surgeries in District and Sub District Hospitals. Significant number of non communicable diseases are being identified and treated at primary and referral levels. PHCs and CHCs handling larger case load and prepared to do so. All PHCs have an MBBS doctor and 40% have an AYUSH doctor as well.
12.	Tamil Nadu	The PHCs, Block PHCs, upgraded PHCs, Sub District Hospitals and District Hospitals are adequately equipped for the routine works and emergency situations. All the facilities are provided with adequate number of Specialists, Doctors, Nurses, VHNs, Pharmacists, Lab Technicians, and other support personnel on regular, service placement or contract basis. The PHCs, SDH, and DH are able to meet the requirements for lab investigations, x-ray, ECG, ultrasonogram, etc. All Sub Centres and PHCs are provided with requisite drugs and other supplies. Need to improve quarters at PHCs.
13.	Uttar Pradesh	While cleanliness has improved, shortages of Nurses, Doctors, Specialists hampers preparedness to deliver quality care. Rationalization of posting and stable tenures needed for preparedness to improve further. Need to focus on expansion of nursing services. Sub Centes and PHCs have started using untied grants. More than half the ASHAs are very active in the community. Village Health and Sanitation Committees have been set up though getting the cooperation of PRIs is proving difficult in many areas.



11221

Theme – III

Quality of services provided

	State	Key Findings
1.	Assam	Substantial improvement in infrastructure. Need for further improvement of quality and range of services. Wards were patient friendly with clean linen, sufficient lighting and clean toilets. Segregation of waste with deep burial. Complaints about CHCs have reduced as they are functioning well.
2	Bihar	Over 100% Bed occupancy in District Hospitals. Lack of nurses and mid wives hampers quality of care. Mamta programme for women volunteers in hospitals is an innovation to meet the nursing shortages in hospitals. Additional of more trained and well supported nurses into the system would be the single most important step that could be done to improve quality. Lack of beds and nurses in Block PHCs. Excellent outsourced ambulance service helps in shifting patients. Conversion to 30 bed PHCs is needed on a priority wherever more than 5 deliveries take place every day. Standards of cleanliness would require substantial improvement. In all facilities visited there are efforts to improve amenities – lighting, wiring, water supply, patient waiting halls, toilets, drainage, etc. but these are rather sporadic. Need to use untied funds at all levels. There is a systematic effort to provide generator support, pathology diagnostics, x-ray and soon ultrasound as well, ambulance services, laundry services, diet services and cleanliness and sanitation services. Need to monitor outsourcing arrangements more effectively to ensure full compliance to agreements.
3.	Chhattisgarh	Health Sub Centres are giving better services than in the past, thanks to untied funds and their proper utilization. Functional telephones at all Health Sub Centres. <i>Mitanin</i> help desk in health facilities is a good initiative in bringing poor households to facilities. CHCs and District Hospitals provide bed nets to protect from mosquitoes. Infection control measures have started but pits are provided only in a few places.
4.	Jharkhand	Block PHCs are basically six bed hospitals with very modest basic features. New buildings will take a little time for completion. OP services have improved due to availability of medicines. Contract doctors have improved availability of human resources. Shortages of nurses. Sub Centres are quite well equipped though own building is a constraint. <i>Sahiyyas</i> are active though performance based payments are not timely.
5.	Karnataka	Staff Nurse and Medical Officer availability has increased. Drugs largely available. Quality Assurance thrust in Tumkur leading to

		efficient use of untied funds. Untied funds being used imaginatively for client convenience – TV, Plants, CD players, waiting halls, etc. More attention needed on toilets – not very clean. School Health programme improving access.
6.	Kerala	Wide variation in the quality of services between similar type of institution. Related to the motivation, commitment and skill of the head of the facility. PHC buildings have been renovated. TVs and DVD facilities in many hospitals in Wynad district. Display of list of medicines. Need to monitor services from the point of input versus services.
7.	Madhya Pradesh	NABH accreditation for District Hospitals is under way. Quality assurance is receiving attention in the system.
8.	Maharashtra	Sub Centres well equipped with infrastructure and equipments and untied funds. Hospitals have become women friendly. Clean and well equipped labour rooms. Waste management satisfactory. <i>Panchayat</i> representatives involved.
9.	Mizoram	PHCs and Sub Centres are well managed. Cleanliness is good. District Hospital needs improved facilities.
10.	Orissa	Overall some improvements have been made in the services like cleanliness, waste collection, electrification, water supply but are inadequate. While there were extra sweepers appointed from untied funds and maintenance grants, there is still scope for improvement in the cleanliness of toilets and availability of water supply in some hospitals.
11.	Rajasthan	Most institutions have received a face lift with the untied funds of NRHM. Toilets were clean and functional and many CHCs had functional power back ups. CHCs are still not able to provide Caesarean section service. Blood storage is an issue. No or limited surgeries at CHCs. Waste segregation and facility level disposal are being done at most institutions; pits were found to be constructed and in use; bio medial waste was being brought back from outreach sessions.
12.	Tamil Nadu	Almost all facilities are well maintained and upkeep of facilities is of satisfactory levels. Family Health Clinics in all 385 Basic Emergency Obstetric Centres thrice a week.
13.	Uttar Pradesh	Nursing cadre shortages hampers quality of care. Women not staying 48 hours after delivery. While cleanliness and basic infrastructure improvements have improved the quality of services, quality of care requires far greater thrust on nursing services.

Theme – IV

Utilization of diagnostic facilities and their effectiveness

	State	Key Findings
1.	Assam	Range of diagnostic services available at various levels has improved substantially. Much more needs to be done to improve the technical skills of the Lab. Technicians.
2	Bihar	Diagnostic services through PPPs. Outsourcing by contracting in private providers. Private partner not showing that much interest at operating it at the Block level. Non availability of regular Lab technicians. Inadequate attention to quality and biomedical waste management.
3.	Chhatisgarh	District Hospitals and CHCs have functional laboratory facilities. Not functional in PHCs due to lack of manpower. Pregnancy testing kits and rapid diagnostic kits are available in most facilities. Convergence of lab services of RNTCP, general health services and vector borne diseases.
4.	Jharkhand	TB Programme Lab Technicians at a number of Block PHCs. Integration of lab services is taking a little time. Diagnostic centres being established in District Hospitals. Modern equipments procured or in the process of being procured.
5.	Karnataka	7 Regional diagnostic labs under the Karnataka Health System Development project. Lab Technicians are largely in place with adequate equipments and reagents. X- ray and ultra sound at Taluk Hospital. Water testing facilities. Lab investigations for ANC not available at PHC. No RTI/STI testing. Utilization of diagnostic equipments by ANMs at Sub Centre is low.
6.	Kerala	State has appointed Bio Medical Engineers to ensure that the equipments are in working condition. Overall the equipments are good.
7.	Madhya Pradesh	In most of the facilities one Lab Technician is available for doing all the investigations for all the programmes.
8.	Maharashtra	All 24X7 PHCs are provided with lab providing basic facilities. Semi auto analyzer, ECG, X ray facilities. Services at reasonable user cost. 30 Public Health Lab services for water quality monitoring, industrial waste/effluents examination, etc.
9.	Mizoram	Diagnostic facilities available but not as per Indian Public Health Standards. Need for proper maintenance strategy for equipments. Need to build strong accountability of suppliers at purchase stage

10.	Orissa	There was an effective pooling of Lab Technicians from malaria, TB, NIV/AIDS for efficient handling of investigations and diagnostic workload in the DH/SDH/CHC level. Lab facilities are not available in PHC (N).
11.	Rajasthan	Lab services suffer from staff shortages. Rapid Diagnostic Kits for malaria, IDD kits and haemoglobin kits available with ANMs. Pregnancy testing kits available with ANMs and ASHAs.
12.	Tamil Nadu	The essential investigations are available in all PHCs, Sub District Hospitals and District Hospitals. The Block PHCs are provided with scan and all the 235 upgraded PHCs are provided with ultrasonogram, x-ray, ECG and semi auto analyzer. Blood storage facility in 20 PHCs by TANSACS.
13.	Uttar Pradesh	Lab Technicians are available for basic tests. Need for better coordination and convergence among all the programmes.

Theme – V

Drugs and supplies

	State	Key Findings
1.	Assam	Less than satisfactory in 2008-09. Medicine availability in 2006-07 and 07-08 was better. Supplies expected to improve December 2008 onwards.
2.	Bihar	Improved supply of essential drugs is the most notable achievement by the State and this has significantly contributed to the increased use of public facilities noted during the past few years. The new rate contracting system and enforcing presence of distribution depots of the suppliers within the State through which the districts place orders, has tremendously improved the availability of essential drugs at public facilities. At least 15 drugs were available in most PHCs. Sub Centres without drugs. Local procurement to meet stockouts. Per capita expenditure on drugs is Rupees 8 after steep increase. Needs to substantially increase with improved availability of drugs at Sub Centres as well. Logistic systems need to be fully operationalized.
3.	Chhatisgarh	State level e- procurement is in place. Some delays in supplies. Proper mechanism for receipt, storage and indenting of drugs. Need for warehouses at district level. Availability of drugs is satisfactory. Occasional replenishment by Jeevan Deep Samiti is made. <i>Mitanins</i> got drugs but delays in replenishment. Recent efforts at streamlining equipment management.
4.	Jharkhand	Rate contract system with funds being released to PHCs. Availability has improved considerably at all levels. <i>Sahiyyas</i> have also been given medicine kits but arrangements for replenishment is not in place. Essential drug list and standard treatment protocols has been prepared for the state.
5.	Karnataka	A State Drugs, Logistics and Warehousing Society has been established that acts as an official procurement agency to meet all requirements of health and family welfare department. Indents collected at the beginning of year. Rate contracts after call for tenders. 14 Drug warehouses in the State. 14 more taken up for construction. Use of untied funds to procure drugs in case of shortage has helped. A very sound procurement system with very few stock outs. Need for review of drug list to make it more rational. ASHA drug kit

		replenishment needs attention.
6.	Kerala	Setting up of the Kerala Medical Services Corporation is a major step. Operation from April 2008. process of procurement and distribution of medicines and supplies has been streamlined. Computerization, pass book system and essential drug list has been established. Systematic and regular testing of all batches of medicines. Need to standardize the indenting procedure. Need to increase storage space.
7.	Madhya Pradesh	The State has developed a drug policy. TNMSC model is being implemented in the State. Separate drug cell has been formed and Laghu Udyog Nigam has been appointed as procurement support agency. Procurement through e – tendering has reduced cost of supplies and improved quality. Distribution of procured medicines and materials is done through outsourced warehouses. 21 warehouses are under construction under NRHM funds.
8.	Maharashtra	Drugs and supplies are in abundance in the Sub Centres, PHCs and in CHCs. They are well stocked in newly made racks and cupboards with proper marking for easy retrieval. Vaccines are also available (except measles) and in proper condition stored in IPL and deep freezer.
9.	Mizoram	Medicines are centrally procured and distributed based on indents. There are shortages. Need for effective inventory management.
10.	Orissa	Most of the health facilities had drugs and pharmaceuticals available as per allocations but the budget per facility is inadequate and needs to be enhanced. A State Drug Management Unit has been set up for procurement of medicines and this has improved timely procurement and availability. However, mechanism for transparency and need based distribution of drugs to districts/facilities is yet to be put in place. Emergency drug tray was found to be adequately stocked in most facilities.
11.	Rajasthan	Generic drugs available in Hospitals and facilities at 30-50% lower than MRP through cooperative stores. List and price of generic drugs displayed in all facilities. ASHAs provided drug kit. Replenishment from Sub Centre. Indenting needs to be more timely to prevent stock out situations. Shortage of high cost antibiotics for weeks. Injectables and fluids show no stock out.
12.	Tamil Nadu	Role model supply system of TNMSC. It is very effective in

		ensuring adequate supplies of drugs and other routine supplies of all health facilities. EC Pills and IUDs are not available.
13.	Uttar Pradesh	While drugs are available, the allocation of drugs is very less compared to the need on a per capita basis. There is a need to increase the drug budget and develop sound system of logistics, inventory management and forecasting. Preparation of essential drug lists and use of generic drugs needs to be encouraged alongside efforts to set up TNMSC like corporation for procurement and logistics of drugs and equipments.

Theme VI

Health human resource planning

	State	Key Findings
1.	Assam	There are shortages of doctors and para medics and efforts have been made to rationalize through regular posting and by contractual appointments. Incentives have worked for the contractual but there is resentment among the regular doctors – need for incentives for regular staff and for career progression. Need to rationalize placement of ANMs. Many ANMs at higher level institutions. Need for cadre review of doctors and paramedics to retain good human resource.
2	Bihar	The availability of human resources has increased substantially in Health Sub Centres, PHCs, DHs and Medical Colleges. Shortage of Specialists, Nurses and Lab Technicians still exist. Very innovative new cadre rules have been approved for doctors with well defined career progression. Contractual appointment policy is in place. Need to improve and expand nursing education as a top most priority.
3.	Chhatisgarh	Chhatisgarh has serious human resource shortages. Lack of rational and transparent transfer and posting further aggravate the problem. Recent effort to post Rural Medical Assistants in difficult areas from the 3 year course students. Large scale shortages of Nurses, Lab Technicians Para medics, Specialists.
4.	Jharkhand	Large scale shortages of Specialists and Nurses. Efforts have been made to rationalize postings of Specialists at Block, Sub District and District Hospitals. Need to create Specialist cadre and undertake rational and transparent policy of transfers and postings. Gradation list not yet prepared in Jharkhand state leading to lack of transparent criteria in key postings of doctors. State needs to look at Bihar's new cadre rules and create a similar system. ANM School and Nursing schools need further strengthening with increase in intake. Jharkhand has a tradition of nursing services and women workers migrating in search of work. Nursing will improve skill levels of migrant women workers. 1200 doctors being recruited through the Jharkhand Public Service Commission. Appointment in final stage.
5.	Karnataka	Medical doctors, para medics, nurses reasonable available in facilities visited. Contract appointment of Specialists, Doctors, staff nurses, ANMs and Lab Technicians has been made to

		meet shortfall. In sourcing in FRUs. MBBS doctors trained in Emergency Obstetric care and life saving anaesthetic skills have been posted to designated FRUs. Signs of improvement in availability of HR. ANM Training Centre need attention. A cadre management and service condition of doctors is an issue.
6.	Kerala	Various category of human resources have been added on contract under NRHM and this has added to services. Medical Officers as DPM working well. Compulsory Rural Service for MBBS and Specialists is a good step. NRHM Coordinators not integrated into health system. More rational systems of deployment needed.
7.	Madhya Pradesh	There are large scale shortages of Specialists and Nurses in the State. Contractual support structures for programme management are in place at the State and the district level. The block level structure is being put in place.
8.	Maharashtra	Several steps to improve availability of Nurses. Second ANMs provided. MPW Male already there. Shortage of Anaesthetists. Need to rationalize posting of Specialists to ensure service guarantees. Capacity of government nursing schools has been developed. Decentralized appointment on contract. Multi speciality training on priority for nurses posted in tribal and extremist affected pockets. Higher payments in tribal and naxal areas.
9.	Mizoram	Availability of doctors and nurses has increased due to contractual appointment in NRHM. Specialist shortages persist. 2 ANMs in Sub Centres. Need for in service nursing education. Need to invest in mobility of non doctor supervisors as well. Increased staffing of Lab technicians leading to increase in service availability.
10.	Orissa	Shortage of MBBS doctors, Staff Nurses, Specialists and Lab Technicians plague public health services. The State has taken several immediate and long term initiatives to meet this HR crisis in the State. 3 new Medical Colleges have been set up in the private sector. Cadre reforms and up gradation of entry level post of doctors as Junior Class –I plus allowances in difficult areas likely to attract more doctors. Cadre restructuring under active consideration. Multi-skilling going on. Proposal for 8 GNM Schools and 13 ANM Training Centres.
11.	Rajasthan	Shortage of Specialist at FRU/CHC. The Rural Medical Officer cadre has greatly increased availability of MOs at PHC level. Shortage of Lady MOs. Multi-skilling under

		progress – needs to be utilized better. 2 ANM in tribal areas is a very good development. Very few refresher courses for ANMs. Need for synergy among training institutions.
12.	Tamil Nadu	During the last two years 4263 nurses were appointed on contract basis in the rural health centres. Life saving Anaesthesia skills imparted to 106 MBBS doctors who are posted back to Block PHCs. All VHNs given Mobile Phones. Cadre reforms to promote posting in rural areas. Satisfactory HR position.
13.	Uttar Pradesh	Human resource is the real challenge in UP. Huge shortage of Nurses and Specialists. Some rationalization is improving availability of services of Anaesthetists and Gynaecologists. This alone will not be enough. Need to expand nursing and medical education services on a large scale. Some District Hospitals could be considered for up gradation in to Medical Colleges in a time bound manner. Three year courses as in Assam and Chhatisgarh could be considered.

Theme VII

Infrastructure

	State	Key Findings
1.	Assam	While lot of buildings have been constructed or are under construction, there is a need for greater rationalization of capital investments in order to ensure full utilization. While facility surveys have been completed, the up gradation is often not based on felt-needs.
2	Bihar	Infrastructure wing under the State Health Society has been created. Progress on construction is tardy. State exploring options for faster pace of construction and maintenance. Quality supervision of construction is weak.
3.	Chhatisgarh	Unsatisfactory infrastructure. PWD and Chhatisgarh Infrastructure Development Corporation doing buildings. Lot to be done. Many Sub Centres in rented buildings. Many new construction works are under progress.
4.	Jharkhand	A very unsatisfactory infrastructure. Large scale construction has been taken up in the last six months which will take a few more months for completion. It is likely to improve the position for infrastructure. Block level PHCs need up gradation into 30 bedded CHCs on a priority. Accommodation for doctors and nurses also needs priority attention.
5.	Karnataka	State is pooling infrastructure resources from different sources. Impressive physical lay out of PHCs/Taluka Hospitals, and newly constructed Sub Centres. Need to focus on quality of construction in a few places. Facility Surveys undertaken and gaps identified. Engineering Cell of Health Department doing the construction.
6.	Kerala	Building and equipment infrastructure coming from many sources. Engineering wing of NRHM Kerala for planning and monitoring. Equipment bought should be audited for their utilization. A State wide emergency ambulance system needs to be established.
7.	Madhya Pradesh	Infrastructure Wing has been established under the Health Department and large scale construction works have been undertaken. 1747 Sub Centre buildings, 193 PHC buildings, 101 CHC buildings, and 7 District Hospital buildings are under construction at present.
8.	Maharashtra	Excellent construction of new infrastructure and

		repair/upgradation of the existing infrastructure. Gardens and landscaping. Staff Quarters in good condition.
9.	Mizoram	Construction cell in NRHM Directorate is over stretched due to the volume of work. Need for assessing need for engineers. Local people's committees may be involved.
10.	Orissa	Huge backlog of construction activities under NRHM and State funds. A separate engineering unit set up last year. Work allotted to 8 Government PSUs. Progress unsatisfactory. Need to prioritize Health Sub Centre construction along with ANM's residential quarter.
11.	Rajasthan	Good progress in construction. Emphasis to construction of residential quarters at PHCs/CHCs is a positive step. Out of pocket expense for referral transport.
12.	Tamil Nadu	All the PHC premises have a new look as most of the civil works have been completed. Need to improve residential quarters. Need for an infrastructure division within the health department as PWD has many other responsibilities.
13.	Uttar Pradesh	Infrastructure in District Hospitals, CHCs and OHCs has vastly improved in the last few years. There is a lot more to be done. Construction is going on at many places. A large number of Health Sub Centres need new buildings or repair. Site selection for PHCs must be near habitation for their optimal use. Large gaps in infrastructure need to be addressed on a priority.

Theme VIII

Empowerment for effective decentralization and flexibility for local action

	State	Key Findings
1.	Assam	20,309 VHSCs formed. Started late due to PRI elections. Need for capacity building. <i>Rogi kalyan samitis</i> in most places. Good community participation in programmes. Village Health and Nutrition Days have attracted community participation.
2	Bihar	<i>Panchayats</i> are represented in the RKSs and the District Health Society. Involvement of <i>Panchayats</i> in NRHM is still not a priority. RKSs have been formed and are functional. VHSCs not formed as yet. Block Health Manager and Data Assistant working under the RKS. District Health Society meets regularly and proceedings are well maintained.
3.	Chhatisgarh	Good participation of <i>Panchayati Raj</i> Institutions in the decentralization agenda. VHSCs constituted under the umbrella of the PRIs. <i>Jeevan Deep Samitis</i> in facilities. Good use of untied grants in 2008-09. PRIs need to be made more active in <i>Jeevan Deep Samitis</i> .
4.	Jharkhand	<i>Panchayat</i> elections have not been held in Jharkhand since 1978. There are no elected PRIs. Therefore NGOs have been enlisted in selection of <i>Sahiyyas</i> and in the constitution of the Village Health Committees. Wherever the NGO selection has been a good one, the performance of the <i>Sahiyyas</i> and the Village Health Committees has been good. In other places, selection of NGO has hampered local processes. Procurement of drugs, untied grants to local institutions, has helped in the process of decentralization.
5.	Karnataka	PRIs are on board. Members of <i>Panchayats</i> as members of Arogya Samitis. CEO of Zila Parishad in District Health Society. All facilities from the Taluka downwards are funded through the <i>Panchayat</i> system. Indifference to health among <i>Panchayat</i> members perceived by doctors, leading to delayed decision making. Good use of untied funds at all levels. District Health Society meets regularly.
6.	Kerala	Ward Health and Sanitation Committees have been operationalized. Untied, annual maintenance grants and RKS funds being regularly used to upgrade facilities and services. PRIs are part of RKS and are involved. <i>Panchayats</i> are

		involved in the running of Sub Centres.
7.	Madhya Pradesh	VHSCs being formed and accounts being opened. Not fully operational as yet. RKS in all facilities. Untied funds being used under direction of ANM. Need to improve the involvement of the Sarpanch.
8.	Maharashtra	Excellent involvement and cooperation of PRIs. VHSCs are fully functional. Untied funds used for cleanliness and beautification. SHGs involved in providing meals in PHCs. ANM providing meals to delivery cases at Sub centre. RKS meetings are held regularly. Sarpanch, members of VHSC, Gramsabha, and employees of health <i>panchayat</i> and ICDS involved. In preparation of Village Health Plans.
9.	Mizoram	Village Health and Sanitation Committees operationalized in all villages. Active involvement of youth, women and senior citizen groups in activities such as awareness for malaria, improved sanitation, etc. Need for regular meeting and monitoring of financial progress. RKS operational with active involvement of Village Council members. Good use of untied funds. District Health Society meetings not regular.
10.	Orissa	Untied funds at different levels have contributed significantly to addressing local needs effectively and towards empowerment of local action and convergence. 11774 VHSCs set up (Gaon Kalyan Samiti). NGOs supporting the process. PRIs, women's SHGs and ICDS AWWs are being involved in the functioning of RKS, GKS and in the health system.
11.	Rajasthan	Untied funds being utilized at all levels – the pace of utilization needs to increase. MRS formed at all levels. VHSCs formed but their money is still with the Sub health Centre. Need to make VHSCs more active.
12.	Tamil Nadu	VHSCs established for 12,618 villages and 2540 town <i>panchayats</i> . VHSCs meeting regularly and the record of discussions are maintained. Untied funds well utilized. Patient Welfare Societies in PHCs. Active District Health Missions. Need for empowerment of DMHOs. Community monitoring in a few facilities.
13.	Uttar Pradesh	PRI sa re involved but health functionaries complain of non – cooperation in many places. Village Health and Sanitation Committees have been set up under the umbrella of PRI. Sub Centres have joint accounts.

Theme IX

ASHA

	State	Key Findings
1.	Assam	26,225 ASHAS have completed Module IV training. ASHA programme has created a groundswell for NRHM and ASHAs are the visible and audible presence. JSY work popular. Most of them earned less than Rs. 10,000 in one year. Medicine kits provided but no arrangement for replenishment. Popular weekly radio programme.
2	Bihar	ASHA programme is in place and the ASHAs are almost without exception, enthusiastic and functional. In most facilities they were seen in the labour rooms and maternity wards with the patients they had accompanied. Delays in performance based payments. Training for 2-4 th module is delayed. ASHA programme is doing well in spite of the constraints. Succeeding due to local innovations. The Muskaan programme and the JBSY provide specific task for ASHAs.
3.	Chhatisgarh	60,000 <i>Mitanins</i> in Chhatisgarh. Trained and deployed in every hamlet. Active in the field. Wide appreciation of <i>Mitanins</i> role in society. Comprehensive support structures. <i>Mitanin</i> help desks in all CHCs and District Hospitals. High degree of skills and competence among <i>Mitanins</i> . Irregular replenishment of drugs. Competition with ANMs for family planning incentives.
4.	Jharkhand	The <i>Sahiyyas</i> of Jharkhand have been selected by NGOs, through Village Health Committees. They have done three modules of training. Good modules have been developed in the local contexts. Medicine kits have been made available to them. <i>Sahiyyas</i> see themselves as a representative of the local community and not as an administrative assistant of the ANM. This has helped in keeping their community links strong. Performance based payment processes need streamlining.
5.	Karnataka	2150 ASHAS are in place in C category districts. Well designed training programme for ASHAs. ASHAs have ID cards. Need to create support systems for ASHAs. More communication material needed for ASHAs.
6.	Kerala	8435 ASHAs in place. Selected by <i>Panchayats</i> . ASHAs confident and aware of the NRHM programme. Performance based payment made regularly. Need to increase performance

		based payment criteria. Regular drug kits still to be provided.
7.	Madhya Pradesh	ASHAs are effective and knowledgeable. Accompanies JSY cases. Resource Persons at the District level for training. ASHAs involved in making blood smear slides in fever cases. Incentives not worked out for malaria work. Some issues of relationship of ASHAs/AWWs/ANMs. Need for more NGO involvement in the ASHA programme.
8.	Maharashtra	ASHAs working in tribal areas. Third module training going on. ASHAs are well motivated and enjoy the confidence of the community. Block level ASHA libraries established in three Blocks.
9.	Mizoram	ASHAs are active. Rapid Diagnostic kits for malaria provided to them. Facilitate community leadership.
10.	Orissa	34,252 ASHAs selected. Induction training completed for all. 48% ASHAs have completed up to fourth module. ASHAs provided with drug kits. Posters providing details of ASHAs payments displayed in all facilities. ASHAs were found to be rooted in the community, highly motivated, and the competencies and skills were good. Good teams work with women SHGs and AWWs. Role in nutrition and women's empowerment.
11.	Rajasthan	ASHA <i>Sahyoginis</i> are of the ICDS programme and their involvement in institutional deliveries, etc. is low. Closely linked to <i>Aanganwadi</i> Workers. The involvement of ANMs with ASHAs needs strengthening. 15 day training for ASHA <i>Sahyogini</i> – State may like to assess need for change.
12.	Tamil Nadu	Not implemented in Tamil Nadu as yet.
13.	Uttar Pradesh	More than half the ASHAs are very active in the field. The community knows them and uses their support in seeking health services. Two rounds of training has been completed. Performance based payment criteria needs to be widened to include a larger number of activities for performance based payments. Training needs to be speeded up. Role clarity vis-a-vis ANM and AWW will help. ASHA is a key person in the Village Health and Sanitation Committee.

Theme – X

Systems of financial management

	State	Key Findings
1.	Assam	The capacity of the State to utilize funds made available to it under various components of NRHM has consistently increased. Good State level leadership and active role of District Health Missions. Need to improve financial record keeping. District PMUs have good data. Need to strengthen capacity at State level. Civil works and tender process take a little time and that is fund utilization takes a little time.
2.	Chhatisgarh	Though State Health Society account is opened, many disease control programmes still operating through old accounts. State share process initiated but not transferred to State Health Society as yet. Audit of 2007-08 completed. Core banking from District to Block level. Slow progress on approved activities in 2008-09.
3.	Jharkhand	Vacancies at the Block and district levels have all been filled up. Efforts to strengthen the state level set up has also been made. Financial performance has improved and levels of expenditure has picked up with large scale construction activity.
5.	Karnataka	Delegation of administrative and financial powers in February 2008. Accounts with SBI and SBM. FMG constituted. Electronic transfer of funds from State to district. Single audit report in the State. Concurrent audit in place in 6 districts.
6.	Kerala	E banking facility across the State. The facility is operational, and allows for transparency, audit and speed of operations. ASHAs given electronic cards for financial transactions.
7.	Madhya Pradesh	Expenditure reporting found to be satisfactory. Monthly Audit of District Accounts and reporting by e-mail has helped. Use of computers in PHCs. Substantial increase in utilization of funds.
8.	Maharashtra	Societies have merged. SPMU and DPMUs are functional. Block Monitoring Committee in place. FMG at State level providing guidance to field units. Timely reporting of financial statements.
9.	Mizoram	System of financial management in place with specific personnel at various facilities. Delays in JSY payments.

10.	Orissa	Increased pace of utilization of funds. Financial reporting is timely. Transfer of funds through e-banking. Financial guidelines under NRHM disseminated to all districts.
11.	Rajasthan	Finance team strengthened at all levels. Electronic transfer of funds up to Block levels. Monthly financial reporting from Blocks to districts, districts to States has been initiated. Tally software has been introduced but use is at nascent stage.
12.	Tamil Nadu	E transfer of funds to districts. Untied grants released to all. VHSC members need to be trained regarding accounting procedures.
13.	Uttar Pradesh	DPMUs have been established recently. Block and PHC level staff strengthening needed for better financial management. E – transfers to districts with the support of SBI. Need to further streamline processes of reporting and their timeliness.

Theme – XI

HMIS and its effectiveness

	State	Key Findings
1.	Assam	Data system is weak. Information is collected but rarely analyzed. State has partially operationalized the web based district data system. Post 2005 the Data Manager at the district has a lot of data.
2	Bihar	Data Centres at State,, district and Block level. Outsourced system. Daily information is available. Cellphone connectivity has also been established. Holds everyone in the system responsible. A little over intrusive but then it serves the purpose.
3.	Chhatisgarh	Data generation through Block level, bypassing PHCs. New formats being used in State level reporting. Most programmes retaining vertical reporting formats. Feedback mechanism not in place to improve the MIS process. Sub Centres have up to date records.
4.	Jharkhand	While basic data is being collected manually, its analysis and utilization varies. Need to create a strong HMIS for monitoring performance of facilities, especially surgical procedures at Block level facilities.
5.	Karnataka	Detailed State proforma. Web based system introduced in one district. HMIS needs to be harmonized with NRHM needs. Need for training staff.
6.	Kerala	The current manual HMIS is not meeting the need. The State in process of developing new HMIS. Need for Nodal information officers at each level. CHCs and PHCs have computers.
7.	Madhya Pradesh	HMIS operational. Need to make it more effective with capacity building at all levels.
8.	Maharashtra	Very well functioning web based HMIS formats, user friendly software for data entry, analysis and report generation at different levels and trained health staff in use of software database are the features of the State HMIS.
9.	Mizoram	HMIS data being collected. Not stable as yet. New staff deployed.
10.	Orissa	Comprehensive HMIS reporting formats have been introduced since April 2007. Need to improve quality of data.

		Feedback to PHC and Sub Centre needs to be strengthened.
11.	Rajastha	Integrated HMIS is in pilot phase covering RCH, IDSP and NDCPs. Data validation build into the system. Testing phase is over. To be expanded State wide in 2009-10.
12.	Tamil Nadu	Has good MIS. Computers in PHCs.
13.	Uttar Pradesh	Weak area in UP. Data is collected but not adequately analysed at the right level. Efforts needed to ensure that the new web based HMIS takes deep roots early and facilitates analysis at each level.

Theme – XII

Community processes under NRHM

	State	Key Findings
1.	Assam	Need greater support and capacity building. RKS functional. VHSCs constituted. PRIS involved at each stage but greater efforts at capacity building is needed.. NGO sector needs to be involved more.
2	Bihar	While access to services at Block PHC has considerably increased, the formation of community process institutions like the Village Health and Sanitation Committees, Sub Centre level committees, etc, is still pending. <i>Rogi kalyan samitis</i> have been formed in most health facilities.
3.	Chhatisgarh	92% VHSCs already constituted and accounts in the joint signature of <i>Mitanin</i> and <i>Panchayat</i> Secretary has been opened. Low utilization of funds so far. Monthly Village Health and Nutrition Melas being held. <i>Mitanins</i> working in tandem with ANM, AWW, SHGs, etc. Community monitoring has been initiated.
4.	Jharkhand	Largely led by the NGOs through the <i>Sahitya</i> programme. Large presence of NGOs has helped. <i>Rogi kalyan samitis</i> have been formed. Sub Centres are utilizing their untied grants.
5.	Karnataka	Community monitoring through VHSCs in four districts, with support from Karuna Trust. Need for more effective systems of monitoring. Simplify village report card. Evidence of PRI members say in use of untied funds.
6.	Kerala	Ward health and Sanitation Committees meet regularly and maintain minutes. <i>Panchayats</i> provide fund for electricity, medicines and glucometer. Need to orient <i>Panchayat</i> members about NRHM.
7.	Madhya Pradesh	Satisfactory involvement of the local communities and PRIs in RKS and other institutions. ASHAs are effective. Indicates useful selection criteria.
8.	Maharashtra	7887 ASHAs in tribal areas. ASHA selection in other areas has started. Support mechanism for ASHAs in place. VHSCs established in 82 % villages. Maximum utilization of village health funds is on providing safe water supply and thereafter on Village health and Nutrition Day.

9.	Mizoram	ASHA in place everywhere. 7 day training. Need for refresher training. ASHA mentoring group has met only once. Needs to meet more often. VHSC operational in every village. Need to involve other than health department functionaries.
10.	Orissa	Community processes are strong. ASHA selection, role of PRIs in GKS and RKS, Village Health and nutrition Days have all created platforms for community action.
11.	Rajasthan	Begun involving VHSCs in microplanning. Involvement of community representatives in management structures needs to be further increased. NGO programme is weak.
12.	Tamil Nadu	Strong community participation through VHSC, RKS, etc.
13.	Uttar Pradesh	PRIs are involved. RKSs have been set up. VHSCs have been set up. Need for training of PRI/community leaders to improve their contribution in decentralized management of health system.

Theme – XIII

Assessment of non-governmental partnerships for public health goals

	State	Key Findings
1.	Assam	NGOs involved in Boat Clinics – doing very well. NGOs in community monitoring programme. There could be greater involvement.
2	Bihar	The mother NGO programme is not operational. The State has a number of PPPs. It has very little Ngo involvement at present. Efforts to run APHCs through NGOs has not been very successful so far.
3.	Chhatisgarh	State Health Resource Centre playing a key role in community based health sector reforms. Playing a creative capacity building role in many areas. Large scale NGO partnerships in the <i>Mitanin</i> programme, blindness control programme, MNGOs and FNGOs for RCH. NGO Jana Swasthya Sahyog running very good hospital in Bilaspur district.
4.	Jharkhand	Sahiya programme and Mobile Medical Units have made use of NGO presence. MMUs are run by <i>Vikas Bharati</i> . Doing very well with wide coverage.
5.	Karnataka	Large scale involvement of NGOs. 49 PHCs outsourced to NGOs.
6.	Kerala	Few NGOs involved. Community monitoring is not formally introduced.
7.	Madhya Pradesh	Need to further increase NGO involvement.
8.	Maharashtra	Large scale involvement of NGOs in programme. MMUs by NGOs. Training and capacity development through NGOs. Community monitoring through NGOs. NGOs working for TB/ HIV/AIDS.
9.	Mizoram	Active village level involvement of youth, women and senior citizens through VHSC. MMUs provided to some NGOs. Mother Ngo scheme to strengthen government efforts. Young Mizos Association and Mizo Women's Association are active.
10.	Orissa	Good NGO participation in NRHM activities. NGOs involved in ASHA training, community processes for setting up of GKS in a campaign mode, referral transport and management of a few PHC(N) as a PPP arrangement, PRI sensitization, organizing health melas, etc. 17 MNGOs and 88 FNGOs cover 2891 villages in 22 districts under the MNGO programme.

11.	Rajasthan	Clearly spelt out NGO and PPP policy in the State. EMRI ambulance service, MMUs, social marketing of sanitary products as examples.
12.	Tamil Nadu	Donations to hospitals as PPP. Many local initiatives.
13.	Uttar Pradesh	Very few partnerships. Need for building detailed criteria that facilitates NGO involvement. PPPs being proposed for Medical Colleges.

Theme – XIV

Systems in place for outreach activities of Sub Centre

	State	Key Findings
1.	Assam	Some of the Sub Centres in the State were found to be functioning very well with a resident ANM, high quality buildings and good use of untied funds. Variation across centres. Many Sub Centres in rented buildings. Non resident ANM in many places. Need to speed up Sub Centre construction. 108 Ambulance system operationalized in a few districts. The Male Worker is needed at the Sub centre level.
2	Bihar	ANMs in place in Sub Centres. Untied funds given but not yet utilized. Need more confidence to spend. Engaged in the Muskan programme.
3.	Chhatisgarh	Besides VHNDs, biannual child health months has led to significant increase in coverage of outreach services. While ambulances are available, their utilization for referral cases was low.
4.	Jharkhand	Sub Centres are doing better than in the past. VHCs are getting active and funds have started reaching them. Mobile Medical Unit has expanded access in remote areas.
5.	Karnataka	Streamlined outreach through fixed monthly putreach plans. VHNDs getting institutionalized. Mobile Health Units operational in KHSDP. EMRI planned for emergency ambulance service across the State. Health Workers (Male) being trained..
6.	Kerala	WHNDs are regularly observed. IEC materials are innovative and well displayed. Sub Centre kit supply needs to be regular. EC pills not available. JPHNs need periodic training to cover all aspects.
7.	Madhya Pradesh	Village Health and Nutrition Days effective. Sub Centres doing outreach services. Need to widen land include larger public health challenges as well.
8.	Maharashtra	Fixed day services in village for iummunization. Village Health and Nutrition Days.
9.	Mizoram	VHNDs held regularly – more educational rather than service function. MMU operational under District Hospital.

10.	Orissa	Fixed Village Health and Nutrition Days are increasing ANC registrations, immunization, growth monitoring and nutrition counseling activities. Mobile Units are in place. Second ANMs have been provided for outreach activities in remote areas. Absence of MPW Male limits the activities.
11.	Rajasthan	Coordination with AWW is good as Sahayogini is a ICDS functionary. VHNDs held regularly.
12.	Tamil Nadu	100 Mobile Medical Units with 100 doctors on contract. 63,715 camps in 2007-8. Effective school health programme.
13.	Uttar Pradesh	Sub Centres need the MPW Male and the second ANM. The load on a single ANM is heavy. Fixed day services have started with good results. Mobile Medical Units to improve outreach services yet to begin.

Theme – XV

Thrust on difficult areas and vulnerable social groups

	State	Key Findings
1.	Assam	Special efforts are being made to address health needs of tea estate workers and people living in tribal and char areas. Need for a robust plan. There is the challenge of attracting good human resource in remote areas.
2.	Bihar	Exemption from user fee needed for the poor.
3.	Chhatisgarh	Chhatisgarh has difficult areas. Proposal for creation of Rural Medical Corps with special pay to address remote area needs, waiting for Cabinet approval. Rural Medical Assistants have already been posted in tribal areas.
4.	Jharkhand	Tribal areas with large area with active Naxal issues. Difficult working conditions for doctors and apra medics. Many of them are providing service in these difficult areas. Untied funds has helped them to activate the health facility and make it clean. VHC and Sahiyyas have helped in improving the outreach of services.
5.	Karnataka	219 PHCs identified as remote. Additional financial incentives to doctors and staff nurses. Priority to C category and tribal districts is commendable.
6.	Kerala	Tribals form 1.14% of State's population. ASHAs in tribal areas. Sick cell anaemia project targeted at tribal population. Comprehensive Health Care Scheme for tribals provides for full reimbursement.
7.	Madhya Pradesh	Mobile Health Units in tribal areas has helped. Need for more focused attention. More direct publicity of free services for the BPL/SC/ST needs to be highlighted.
8.	Maharashtra	Tribal area focus in ASHA programme. Additional financial incentives for tribal and naxal areas. MMUs in difficult areas.
9.	Mizoram	Mizoram has difficult and remote areas that need special initiatives. Perhaps efforts like NGOs managing remote PHCs (as tried out in Arunachal Pradesh) could be tried out in Mizoram.
10.	Orissa	Needs to be more pro- actively sought and encouraged.. Special provisions for KBK districts.
11.	Rajasthan	Tribal Sub Plan provides for additional funding in diffucult areas. 2 ANMs in difficult areas.

12.	Tamil Nadu	Accessibility and availability of services is very good. Good outreach through MMUs.
13.	Uttar Pradesh	Need to expand outreach services through camps. More nurses and Male Health Workers needed in the field.

Theme – XVI

The preventive and promotive health aspects with special reference to inter-sectoral convergence and effect on social determinants of health

	State	Key Findings
1.	Assam	Newly elected <i>Panchayat</i> members an opportunity for convergence. Road map for their capacity building is needed. Need for more involvement of health department functionaries in inter sectoral convergence.
2	Bihar	Nutrition rehabilitation programmes have begun. Emphasis on the Vitamin A campaign.
3.	Chhatisgarh	AYUSH co – location has not happened as yet. Intra health sector convergence is also an issue in Chhatisgarh.
4.	Jharkhand	VHNDs are popular. Rapid Diagnostic kit for malaria has helped. ANMs have these kits.
5.	Karnataka	Good convergence with NACP – III and ICDS in VHND. Water quality monitoring being undertaken. PPP for vector surveillance.
6.	Kerala	WHNDs are regularly observed. United funds of WHSC used for source reduction and vector control. The absence of malaria, filarial, dengue and Chikanguniya this year may indicate success of such activities.
7.	Madhya Pradesh	Greater community led action needed for preventive and promotive health.
8.	Maharashtra	School Health Programme (353 teams at Taluka level) in coordination with education department, geriatric scheme implemented in cooperation with volunteers from Kishori Shakti Yojana and senior citizens attending the sessions at Aanganwadis and doing exercise, constitution of VHSCs in partnership with the water and sanitation committees, VHSC funds for improvement of amenities in Aanganwadi Centres, safe water supply, RKS funds utilized for drinking water facility, viable partnership with ICDS through ASHAs in tribal areas, 438 Child Development Centres to treat Grade – III and Grade IV malnutrition, partnership with Public Health Labs for water quality testing, are all an affirmation of the convergence in the State.
9.	Mizoram	Measures of vector control are good with involvement of VHSCs.

		Convergent efforts in the VHNDs. Need for dental services.
10.	Orissa	NRHM implementation has clearly contributed to better linkages of health staff with ICDS, Total Sanitation Campaigns and Self Help Groups. The team work of ASHAs, AWWs and ANMs in organizing the Village Health and Nutrition Day is a good platform for convergence.
11.	Rajasthan	Need for greater coordination.
12.	Tamil Nadu	Good coordination at the field level.
13.	Uttar Pradesh	School Health Programme and Saloni programme for adolescent girls has been started. The Village health and Sanitation Committee can also greatly enlarge preventive health thrust. Need for systematic capacity building.

Theme – XVII

Effectiveness of the disease control programmes including vector control programmes

	State	Key Findings
1.	Assam	Thrust is on RCH. Gains in disease control programmes are incidental. Malaria cases and deaths have reduced mainly due to use of rapid diagnostic kits and insecticide treated bed nets. ASHAS are trained in use of Rapid Diagnostic Kit and in blood slide making. TB and leprosy programme reported to be doing well. No district level laboratory under IDSP.
2	Bihar	Disease control programmes now with the Directorate. In the absence of adequate financial delegation the programme has slowed down. Technical protocols need to be more widely discussed. Supply of anti malaria drugs has improved. Inconsistency in treatment protocols. Need for doctors' orientation on programme treatment guidelines. One round of spray for vector control. Social mobilization of communities needs to be speeded up. Case detection less than 50% for TB. Cataract surgeries are not being regularly undertaken in District Hospitals. No shortage of leprosy drugs reported. IDSP is just starting.
3.	Chhatisgarh	Section wise GIS mapping for malaria. 1,55,620 bednets distributed in 2007. Rapid Diagnostic Kits distributed in Bilaspur and Dhamtari. <i>Mitans</i> trained in using Rapid Diagnostic Kits and in making blood slides. Vacancy of MPW Male affecting Malaria surveillance. Though malaria infected, District Malaria Officers and Inspectors are not there. Poor monitoring of NLEP. Unequitable and insufficient distribution of eye surgeons.
4.	Jharkhand	TB programme has picked up and services are available. Rapid Diagnostic kits have helped in timely detection of falciparum cases. In patient cases of malaria seen.
5.	Karnataka	Good progress on the disease control programmes. API has reduced and deaths are low. Convergence of NVBDCP, TB and HIV/AIDS noticed at PHC/CHC level. Vision centres are functional. IDSP working very well.
6.	Kerala	Commendable that State has set up innovative programme for the community to manage terminal illness. Use of NGOs/Volunteers for pain and palliative care is commendable.
7.	Madhya Pradesh	Thrust on RCH activities. Need for wider public health focus to cover all disease control programmes as well.

8.	Maharashtra	Well run. Good coordination with NRHM. Rapid diagnostic kits and other testing facilities available. ASHAs in tribal areas taking blood slides of malaria. RNTCP has linkages with all ICTC and ART centres.
9.	Mizoram	Malaria control programme is effective. Fever and malaria cases have come down. RNTCP doing well. Blindness programme is less active because of lower awareness.
10.	Orissa	High incidence of malaria but no District Malaria Officers. Absence of MPW Male makes it difficult. MPW being appointed on contract. Time take for reporting cases by laboratory is three weeks to one month. Insecticide treated bed net useful but in short supply. GKS needs to be involved in the vector control activities actively.
11.	Rajasthan	Malaria areas well provided with active search and malaria drugs. Rapid Diagnostic Kits being used in PHCs but not by ANM/ASHA. TB detection and cure rates above the targeted levels. IDSP formats at District/CHC/FRU levels.
12.	Tamil Nadu	Working very well.
13.	Uttar Pradesh	Still functioning separately. Need for integration. Need for improvement in the Malaria control programme.

Theme – XVIII

Performance of maternal health, child health, and family planning activities seen in terms of availability of quality services at various levels

	State	Key Findings
1.	Assam	Large number of new born care centres at PHCs. Utilization still low. Institutional births up to 60% from 37% before NRHM started. Home births need attention as well. Full coverage of immunization has improved.
2	Bihar	Access to maternal, child and family planning services has expanded. However, unmet need remains high. The Muskan Abhiyan for immunization and institutional deliveries seems to have worked well.
3.	Chhatisgarh	Institutional deliveries yet to catch up. More needed to be done on child health. Nutrition not a priority as yet.
4.	Jharkhand	JSY yet to pick up. Institutional deliveries are slow to pick up even though ANC registration has increased. More confidence needed in the health facility and its service guarantee. Sub Centre deliveries are taking place.
5.	Karnataka	PHC Taluka Hospitals have shown improvement in physical infrastructure to deliver RCH services. New born care needs attention. SBA training, MTP and LSAS needs quality assurance. Training of EmOC and LSAS for Medical Officers has shown good progress though coverage needs to be widened. Special efforts to simplify BPL certification has helped. E banking has improved efficiency of JSY payments. Improvement in immunization coverage is visible. Maternal deaths are being investigated.
6.	Kerala	PHCs, CHCs, Taluka Hospitals providing services for family planning. Only few CHCs providing 24X7 delivery services. Public awareness of JSY and immunization is satisfactory.
7.	Madhya Pradesh	Substantial increase in institutional deliveries. Efforts made in child health as well. . Improvement in family planning services.
8.	Maharashtra	Significant increase in institutional deliveries, good quality facilities and cleanliness contributes to popularity of the public system. Simultaneous attention to maternal and child health needs as also malnutrition. Pregnancy testing kits are

		available in Sub Centres.
9.	Mizoram	ANC done regularly at all facilities. Incidence of low birth weight is very low. Need to improve new born care facilities in CHCs and PHCs. Regular immunization at all centres. High offtake of oral pill for family planning. EC pills not available. Young doctors trained in minilap providing services at PHC/CHC. Quality of IUD services could be improved. .
10.	Orissa	PHC strengthening needs to be emphasized for preventive and curative services. Thrust on CHCs/SDH and DHs. 61% of all institutional deliveries in 2007-08 were JSY supported. Major gains made. Quality of maternal care needs immediate attention. Discharge within few hours of the delivery. 341 institutions that have been selected for 24X7 services need to be operationalized on a priority basis. FRU operationalization needs to be given priority. Childhood illness care at primary level needs strengthening. Nutrition Rehabilitation Centres in two districts. Contraception performance has improved marginally. NSV achievements are impressive. Increase in incomplete abortions coming for referral.
11.	Rajasthan	While maternal health has received attention, child health needs more focused attention, especially neo natal mortality. Need for birthing kit in JSY delivery centres. Shortage of vaccines this year.
12.	Tamil Nadu	Excellent MCH services. Pending JSY payments. Increase in family planning services at PHC level.
13.	Uttar Pradesh	Upsurge in institutional deliveries. Thrust on Child Care programmes. Family Planning services need improvement, especially IUDs and emergency oral pill availability.

Theme – XIX

Assessment of programme management structure at district and state level

	State	Key Findings
1.	Assam	149 BPMs, 149 BAMs, 454 PHC Accountants in place. Need for coordination between NRHM and the Directorate of Health. PMUs at all levels playing a significant role in planning and monitoring. Most of them are young and enthusiastic. The regular cadre of health personnel still not fully involved. Cleavages between public health system and NRHM.
2	Bihar	Programme management units at State, district and Block levels. These units are functioning well. Need to expand supportive supervision.
3.	Chhatisgarh	SPMU/DPMU in place. Need for more coordination with the Directorates in an effective and efficient way. Block level Programme Management teams being put in place.
4.	Jharkhand	SPMU, DPMU and BPMU has helped the programme in developing a system at the field level. Need for closer integration with the mainstream health administration.
5.	Karnataka	SPMU/DPMU is in position. BPM appointments in process. Merger of NRHM and KHSDP enhances efficiency.
6.	Kerala	SPMU and DPMU functional. Block Coordinators in each Block. More integration of Directorate may help.
7.	Madhya Pradesh	State and District Health Societies established and functioning with management skills.
8.	Maharashtra	SPMUs and DPMUs are fully functional. Taluka Health Offices strengthened with additional human resources. Directorate staff fully involved in programme implementation.
9.	Mizoram	SPMU and DPMUs in place. State Programme Manager to join shortly. Presence is a strong support to the district health administration.
10.	Orissa	SPMU strong. Good working ethos. DPMUs active, professional and vibrant. Good team work with district and block medical teams exist in the State. The professionalization of health systems management in NRHM in Orissa has been a major factor in enabling the paradigm shift and effective decentralization of health management.

		District Health Action Plans prepared by the district teams.
11.	Rajasthan	SPMU DPMU structure is well established and provides useful support to the programme. Need for closer integration of the Directorate of Health activities.
12.	Tamil Nadu	Implementation of the programme in the State is exemplary. The District Health Mission meetings are not being held as envisaged under NRHM. There is no DPMU and BPMU as yet. Block PHC has an Office Superintendent, DMHO from the public health cadre.
13.	Uttar Pradesh	SPMU is active. DPMU and BPMU being set up. These skills are acutely needed. Divisional PMUs have been set with SIFPSA support.

**Summary Reports of findings
from each state**

ASSAM

THE REVIEW TEAM:

1. Dr.Tarun Seem, Director, Nirman Bhavan, New Delhi
2. Dr. Dr Anil Kumar, CMO, Nirman Bhawan, New Delhi
3. Ms.N.Angami MSG, Covenor & Ex-President, Oking Hospital, Kohima, Nagaland
4. Sh. Gerard La Forgia, World Bank, New Delhi
5. Sh.Shyam Astekar, ASHA Monitoring group, School of Health, Nasik

THE DISTRICTS/ INSTITUTIONS VISITED:

1. Savisagar District
2. Bongaigaon District

Progress under NRHM	Areas of improvement
<ul style="list-style-type: none"> • Increase in general utilization of OPD and indoor services, institutional delivery, and immunization. • Improved infrastructure, ambulance and logistics: construction of new PHCs, proper Cold Chain maintenance, waste management. • VHSC, RKS, instituted at village and facility level. • ASHAs are active, involved in VHND, JSY and immunization activities. • NGO participation in RKS and Community monitoring. • Weekly radio programme popular. • Dibrugarh boat clinic is a good initiative for island communities. • Special efforts being made for services to tea plantation workers. • Malaria cases and deaths have reduced mainly due to use of rapid diagnostic kits and insecticide treated ed nets. 	<ul style="list-style-type: none"> • Strengthening Delivery services: still weak in SC and non existing at night in PHC • Further strengthening of infrastructure, drug supply, emergency facilities, OT, blood storage facilities, lab services, mental health services. • Incentive disbursement of JSY, HR policy and rational postings of specialists, performance based payment schemes and referral audits • Augmentation of AYUSH services. • Rational utilization of RKS fund for patient care. • Strengthening of ASHA programme through Resource Centre, mentoring group and telephone helpline • Training in basic financial management to doctors as part of professional development course • Develop a long-term master plan for capital investments in districts • Encourage involvement of NGO support

BIHAR

THE REVIEW TEAM:

1. Dr P K Srivastava, Joint Director, NVBDCP, GOI.
2. Dr. Jagvir Singh, Joint Director, IDSP, NICD, New Delhi
3. Dr.T.Sundararaman, Executive Director, NHSRC, New Delhi
4. Sh.Billy Stewart DFID India, British High Commission,
5. Prof. Rajesh Kumar PGI Chandigarh Professor & Head, Comm. Med. PGI, Chandigarh
6. G.N.V Ramanna, World Bank, New Delhi

THE DISTRICTS/ INSTITUTIONS VISITED:

District Muzaffarpur Sadar Hospital, Referral Hospital, Saraiya **PHC:** Bochaha, Saraiya, Paru, Marwan **APHC:** Kuffin, Karza, Dawoodpur **HSC** - Pokharaira. Phulwariya, Kala Azar Medical Research , DHS office and data center, ANM Training School, Nutrition rehabilitation Centre , ASHA training camp, AWC of Karza village

Vaishali District : Lalganj Sadar Hospital : **PHC:** Vaishali, MSF run hospital , Central District Drug Ware House

Gaya District: Lady Elgin Zanana Hospital, District health society office, Pilgrim Hospital, ANMTC Magadh Medical College **PHC**, Belaganj. Khijarsarai. **APHC**, Kudwan., Bodh Gaya., **HSC** Mohanpur.

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • Increased utilization of most services - outpatients, in patients, institutional delivery at block PHCs and district hospitals with over 100% bed occupancy • Efforts to improve amenities & infrastructure; outsourcing arrangements for X ray & cleanliness. • Improved supply of drugs, establishing generic medical stores at Block PHCs. • Increased human resources in SCs, PHCs, DHs; innovative HR policy, additional ANM at SC. • Nutrition rehabilitation programmes, <i>Muskan ek Abhiyan</i> immunization program • Availability of Kala-azar kits • District health society meetings held and well recorded, RKS in place. • Societies of disease control programs have been merged with the health society, • State initiated data centres and NRHM HMIS system both in place 	<ul style="list-style-type: none"> • Addl. PHC strengthening for institutional deliveries; provision of referral transport; Enhancing use of Untied Fund • Filling of Regular vacant posts particularly nursing & specialists; HR policy, improvement of service conditions, skill upgradation • Higher allocation for drugs and management structure for procurement; supply chain including contraceptives to be improved. • Rationalization of public and private lab services at BPHCs by workload; quality protocols in Labs • Vector control and programme management; Timely supplies • New treatment protocols for KA should be disseminated • Child health interventions to be prioritised • Supervisory mechanisms from district level for outsourced activities • Enhancing the range of beneficiaries exempted from user fee • Bridge courses to upgrade ASHA to AWW to ANM to Graduate Nurse and to Postgraduate Nurse to be set up • Public Health Cadre to be create • Quick disbursal of incentives to ASHA • NGOs need to be monitored for outputs or quality • Formation of VHSCs • Active involvement of RKS members in funds utilization & facility development; involvement of DHS in planning process • Functional coordination between the State Health Society, Directorate of Health and program divisions

CHHATISGARH

THE REVIEW TEAM:

1. Dr. R S Sharma, Joint Director, NVBDCP, Govt of India.
2. Dr Kaushik Ray Barman, Senior Consultant - Public Health Planning, NHRSC, New Delhi
3. Dr. Pavitra Mohan, Health Specialist, UNICEF India Country Office, New Delhi.
4. Dr. Joe Varghese, Senior Programme Coordinator, Christian Medical Association of India, New Delhi

THE DISTRICTS/ INSTITUTIONS VISITED:

District Bilaspur: Sanatorium and Eye hospital (CHC Gourella), District Hospital, Bilaspur **CHC:** Kota, Pendra **PHC:** Ganiyari, Kenonchi, Amadand, Andhiarpur, Seepat **SC:** Gobripat, Kenwachi, Dahibahra, Bacharwar, AYUSH Dispensary Pendra Regional FW Training Center-Bilaspur, DPMU, Keonchi, AWC, Jan Swasthya Sahyog Kendra, Ganiyari

District Dhamteri: Dist Hospital, **CHC:** Kurud, Nagri **PHC:** Bhakhara (Kurud), Megha (Magarload), Bade Kareli (Magarload) Dugali (Nagri), **SC:** Bhakhara, Koliari, ANMTC

District Raipur: Directorate of H & F W, SIHFW, SPMU Medical college CHC, Abhanpur

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • Increasing trend of OPD, normal delivery at CHCs and SCs, decline of malaria cases, infrastructural and service improvement at SCs are seen • Exceptional teamwork between ANM, <i>Mitanin</i> and AWW • Innovative Initiatives: Recruitment of LT through JDS (RKS), Rural Medical Assistants initiative in tribal districts, Centralised drug procurement system, equipment management program, partnership with Red Cross drug stores, Telephone facilities for SC, • Strong workforce of 60,000 <i>Mitanin</i> high degree of skills, <i>Mitanin</i> help desks, • Sishu sanrakhan mah, VHND, Swasth Panchayat Scheme, Block Leprosy Awareness Campaign • 92% VHSC are formed and account opened for most of the VHSC • Bal Hriday Suraksha Yojana started with PPP mode • Representation of other dept in SHS & DHS • Sickle Cell test camps for screening have been launched in the state • Usage of bednets in indoor of facilities • SPMU, DPMU working enthusiastically in tandem with directorate and district officials 	<ul style="list-style-type: none"> • More focus for PHCs, 24x7 services & SNCU operationalisation ; Emergency drugs availability, MMU for outreach activities should be streamlined ; SC & PHC level facility survey, infrastructure upgradation • Replenishment of supplies for <i>Mitanin</i> dawa Peti, • sensitisation of PRI leaders in JDS activities , merger of subaccounts, state budgetary contribution to SHS account, operationalising E banking from dist to block should be done on priority basis • Institutional strengthening infrastructure development wing, proper procurement policy, condemnation procedure, training instt, HR policy, Public health capacities in all personnel, More co-location with AYUSH • Develop cohesion and rational distribution of work among State health mission, SHRC, SIHFW & other training institutions, & directorates • streamline JSY based incentive distribution are to be planned • Timely Fund disbursements from state to districts, DHAP based financial disbursement adopting ROP process for districts • Merger of sub accounts under SHS, transfer of state contribution to NRHM pool, decentralization of financial power need to be expedited • Strengthening and sensitization of VHSC & PRI leaders, Village level planning process, social auditing, community monitoring need to be considered • Frequent reshuffling of administrative and technical officials to be reviewed

JHARKHAND

THE REVIEW TEAM:

1. Shri Amarjeet Sinha, (JS), MOHFW, GOI New Delhi
2. Dr.Dinesh Baswal (AC) Training, MOHFW, New Delhi
3. Dr. G. K. Ingle, Prof, Maulana Azad Medical College, New Delhi
4. Dr. Manoj Kar, Advisor, NHSRC, New Delhi
5. Dr.J.N.Sahay, Advisor, NHSRC, New Delhi
6. Dr. Nupur Basu, Member, National AMG, Delhi

THE DISTRICTS/INSTITUTIONS VISITED:

Hazaribagh District: District Hospital, **PHC:** Chouparan Barakatha Ichak Addl. PHC Basaria HSC Chaikela, Thuthi, Kalabad, Silvar, Mahesra, ANM Training Centre, AYUSH Centre, AWC Chaikela, HFWTC Hazaribagh
Mobile Medical Unit, Chanda, Community Monitoring, Sadan Sahiyyas
District West Singhbhum, Sraikela: SDH, Chkradharpur, Sadar hospital (Saraikela), **PHC:** Sonua, Tantanagar, Zikpani **APHC:** Keraikela, Hatgamaria, **SC:** Kokcho, Singhpokharia, ghaghari, Narsanda, Lupungutu, **Others:** AUYSH Disp Chaibasa, ANMTC, AWC jodapokhar

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • Increase in caseload at some Block PHCs and sub-centres • Doctors on contract at PHCs and Addl. PHCs. • Infrastructure up-gradation initiated. • Essential drug list and standard treatment protocols prepared • Sahiyyas (ASHAs) are functioning well • Community monitoring with NGOs has been piloted in 15 villages • RNTCP and NVBDCP shows an increase in number of patients where as decrease in number of leprosy cases • Strong NGO support for Sahiyyas & Community processes • MMUs serving unreached population. 	<ul style="list-style-type: none"> • Focus on facility strengthening; Non-functional PHCs to be revived • Improvement of drug supply, enhancing OPD services • Hospital quality management needs to be strengthened • JSY guideline still not clear to the health providers • Compensation package for Sahiya needs to be improved; replenishment of drug kit • Deployment of District Sahiya Facilitators • Emphasis should be given to preparation of District Health Action Plan involving multiple stakeholder • HR Policy necessary • Nurses shortage to be met with setting up of Nursing and ANM schools • Residential accommodation for staff at facilities • HMIS to be strengthened

KERALA

THE REVIEW TEAM:

1. Mr. Amardeep Singh Bhatia, Director, Nirman Bhawan, New Delhi
2. Dr. Ratan Chand, CD (Stat), Nirman Bhawan, New Delhi
3. Dr. K. S. Jacob, MSG, HoD, Psychiatry, CMC, Vellore
4. Dr. Narendra Gupta, AGCA, Secretary-PRAYAS, Rajasthan
5. Mr. Sunil Nandraj, WHO, New Delhi

THE DISTRICTS/ INSTITUTIONS VISITED:

District Thiruvananthapuram: Women and Children's Hospital, Thycaud, Fort Hospital
CHC: Vizhinjam, Kesavapuram, Kanyakulangara **PHC:** Kunnathukal, Kuttichal, Pulluvalla **SC:** Pazhayakunnum, Aramanoor, Karali, Muttukadu
Others: Directorate of Health Services, Kerala Medical Services Corporation Limited, Kerala State Institute of Health Training Centre Tribal Health Camps, Pancode

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • Marked improvement in infrastructure and human resources by the utilization of NRHM funds. • Increased availability and quality of medication and marked reduction in cost of drugs after the setting up of the Kerala Medical Services Corporation Limited. • The Compulsory Rural Service for doctors is a major step forward. • Initiation of the computerized HMIS. • Successful setting up and use of the e banking system. • Good Outreach facilities. (WHND, Newsletter) • A state-wide community based Pain and Palliative Care program for terminal illness in the community • The initiation of comprehensive health insurance scheme in collaboration with Department of Labor. • The selection process for ASHAs has been good. 	<ul style="list-style-type: none"> • There is wide variation in the performance between districts, district/ taluk/ subdivision hospitals, CHCs, PHCs, and Sub-centers. Need to monitor the services from the point of input vs. services and improve poorly performing regions. Increase in the no. of field level functionaries in underserved areas is urgently needed. • There is a need to focus on Non-Communicable Diseases • A state wide emergency ambulance service needs to be established. • A disaggregated analysis of data from health surveys can be used to identify disadvantages groups (E.g. females, SC, ST, etc) for focused action. • Equipment bought should be audited for their utilization and the value addition to services • The NRHM coordinators seem not to be integrated into the health system • Maximising AYUSH facility utilization owing to its strong presence (the State has more AYUSH facilities than Modern medicine).

KARNATAKA

THE REVIEW TEAM:

1. Smt. Ganga Murthy, Economic Adviser, Ministry of Health & F.W.
2. Dr. V.R. Muralidharan, Prof, Humanities & Social Sciences, IIT Chennai
3. Shri A.K. Shiv Kumar, UNICEF, New Delhi
4. Dr. Dinesh Agarwal, UNFPA, New Delhi
5. Dr. Aditi Iyer, Research Consultant, IIM, Bangalore
6. Dr. Deoki Nandan, Director, NIH&FW, New Delhi

THE DISTRICTS/INSTITUTIONS VISITED:

Tumkur District: District Health & F.W. Office, District Hospital, titpur general hospital, **PHC:** Nittur , Chelur, Biligere, Honnavalli, Kodigenahally **Sub Centre:** Somalapura, Thimmalapura,, ANM Training Centre, Chikkamalur AWC, Goudi

Raichur District: Raichur, General Hospital, Dist. Health & F.W. Office., Sindhanur General Hospital, Lingasugur, General Hospital, **CHC:** Kavithal, Mudgal, **PHC:** Matamari, Kallur, Kurdi, Hatti, Sirwar, Kalmala, **Sub Centre:** Mallat Meganapur, ANM Training Centre, ASHA Trg. Centre, Drugs Logistics Centre

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • OPD, Institutional deliveries increasing in Sub-centers & PHCs • Infrastructure created for facilities is impressive • Significant initiatives for postnatal care, investigation of maternal deaths, spacing methods • Fixed monthly outreach plans at Sub-Centres. • Medical doctors, paramedics and staff nurses availability improved in public services, • Public Health system at district level is under purview of the <i>Panchayat</i> system • District Health Action Plans created in all district; meetings of DHS take place regularly . • Well designed training program for ASHAs • Concurrent audit in place in 6 districts, • Web based HMIS introduced on pilot basis • Community monitoring through VHSC piloted in 4 districts • PHCs outsourced to NGOs, showing mixed results • Good convergence with NACP III and ICDS in VHND • Suvarna Arogya Chaitnya School Health Program • Holographic maternity card 	<ul style="list-style-type: none"> • District Hospital, FRU to be strengthened • New Born Care and Management of sick new born at peripheral facilities needs strengthening • Coverage to be widened for EMOC and LSAS trained MOs • Quality Assurance needs focused attention • Greater guidance and closer monitoring to untied fund utilization • AYUSH doctors role to be clearly defined and oriented about NRHM • Human Resources in health sector to be framed • ANM training centres to e strengthened • Quality of construction to be improved • Conflict between ASHA/AWW/ANM for incentive to be sorted-out • Accounts for disease control program to be merged • E-transfer of funds to block level • Capacity Building of Samiti members for utilization of funds

MAHARASHTRA

THE REVIEW TEAM:

1. Dr.A.C. Baishya (NE-RRC), Guwahati
2. Sh. Rajesh Kumar, FMG Nirman Bhawan, MOHFW, New Delhi
3. Sh.T.V.Antony, MSG Former Chief Secretary, GOI
4. Dr.K.B.Singh GTZ India, New Delhi
5. Ms. Sushma Rath, PAO. NHSRC, N Delhi

THE DISTRICTS/INSTITUTIONS VISITED:

District Pune, Raigad-District hospital, Alibaug, Sub-dist H, Bhor, **CHC: Manchar** **PHC:** Nagothane, Khedshivapur, Ambavade, Dimbe **SC:** Kikawi, Shinoli **Others:** Public Health Laboratory, Zila Panchayat Pune, SHRC, State Transport Depot

District Nashik Thane-District Hospital Nashik, District Hospital Thane, Kalwan SubDist. Hospital **CHC:** Rural Hospital, Vani **PHC:** Karanjali, **SC:** Rasegaon, Ambegarh, Manur **Others:** ANM/GNM training school, Regional FW Training Centre (Nashik)

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • improvement in OP load sub centers, PHCs and CHCs and institutional deliveries. JSY redressal Cell at district head quarters are existing • 30% of SC and PHCs upgraded to IPHS, additional Blood storage facilities in them • All 24x7 PHC with basic lab facilities, semi-auto analyzer, ECG, and X-ray • Well stocked with drugs and supplies with proper storage conditions • Free meals for mothers at institutions are executed. • Excellent involvement of PRIs, RKS and VHSCs regularly participate in meetings and take part in PIP preparation • ASHAs well motivated and enjoy the confidence of the community Support mechanism for ASHA in place. VHSC formed and bank accounts opened. • Untied fund for better health facilities is observed • Two FMGs are created: one for NRHM, NPCB, IDSP and the other for RCH, RNTCP, NLEP, and NVBDCP. • NGO based sickle cell disease control program, MMUs providing services to underserved areas 	<ul style="list-style-type: none"> • Sub district hospitals need to be improved for better support for patients • JSY incentive distribution need to be improved • Newborn care at institute need to be strengthened. • Initiatives to be taken for more BPMUs to be made functional • Data is not made available on national website under HMIS. • Rational utilization of Civil works funds as per guidelines • Rationalization of posting of anesthetists needed • Maintain a Woman Friendly atmosphere at institutional level

MIZORAM

THE REVIEW TEAM:

1. Shri Rajesh Bhatia, MoHFW, Govt. Of India;
2. Dr. Ashoke Roy, RRC NE, Guwahati
3. Dr. Vijay Aruldas, Christian Medical Association of India (CMAI), New Delhi;
4. Shri M. K. Talukdar, NHSRC, new Delhi
5. Dr. Sharad Iyengar, Action Research and Training for Health (ARTH), Udaipur.

THE DISTRICTS/INSTITUTIONS VISITED:

District Kolasib: District Hospital, **CHC:** Vairengte **PHC:** Bilkhawthlir, Kanpui, Lungdai **SC:** Bilkhawthlir, Diakkaun, Thingdawal, Bualpui, Zanlawn
District Serchhip: District Hospital **CHC:** Thenzawl **PHC:** Thingsuliah **SC:** Chinchhip, Buangpui, Thenzawl

Progress under NRHM	Areas for improvements
<ul style="list-style-type: none"> • Presence of Regular MO has made positive impact on IPD / OPD at PHCs and instt deliveries • Ssignificant number of home deliveries being conducted by ANMs • Facility survey has been conducted in all the health institutions • Well maintained facilities with proper cleanliness, disposal pits (using RKS funds) and at District Hospital • Central procurement of medicines, Engineering cell for construction activities set up • Upgradation of DH and CHC are already initiated • ANM, Nurse, MPW (M) in fair numbers • Active involvement of the Village Council Members in RKS • District Health Society meetings not regular • Financial recording at various facilities are in place • VHSC are operational with a high degree of involvement Pilot project on health insurance with Reliance, • NGO participation in MMU are initiated • Training for DPM staff regarding District Action Plan formulation done 	<ul style="list-style-type: none"> • Cash disbursement of untied fund, annual maintenance grant and non deposition of user fees in RKS • New born care corner, Blood storage unit, functional OT at CHC, supply of RD kits & EC pills, emergency drugs to be ensured • Role differentiation among ASHA & ANM not well understood by community hence need to be clarified • Usage of HMIS data for feedback • Coordinated intersectoral thrust should be developed with NVBDCP • health workers of SC should be made aware of TB patients as they are not DOTS provider • Ensuring home visits by health workers • Need to invest in improve quality of primary healthcare services beyond the clinical care by doctors • In service training for SN, • Timely payment of JSY should be initiated • Training in IMNCI & a maternal component might be considered as a pilot exercise • district mentoring groups, and district and block facilitators for ASHA are suggested • Integrated compensation package for ASHA need to be put in place • Involvement of SPMU & DPMU in JSY monitoring suggested • More involvement of VHSC • oral health interventions might be considered by the state. • male health workers should be given an active role in condom promotion and their performance need to be monitored.

MADHYA PRADESH

THE REVIEW TEAM:

1. Shri Javed Chowdhury - Former Secy. FW, MOHFW, GOI
2. Dr. Kiran Ambwani --DC (FP) MOHFW, GOI
3. Dr. L. M. Nath --Former Director, AIIMS, New Delhi
4. Dr. Manoj Kar --Advisor, NHSRC, NIHF, New Delhi

THE DISTRICTS/INSTITUTIONS VISITED:

District Kahargone: CMHO Office, Distt. Hospital **PHC:** Padalia, Karhi, Pipalyabujurg, Bamnala, Segaoon, Unn **SC:** Dodwa, Bablai, Kavadiya, Lalkheda, Thibgaon, DPMU, District ICTC Services Centre, AWC, Village gogariakhedi MMU – Mobile Medical Unit
District Dhar: **CHC** CEMOC, Sardarpur, **PHC** BEMOC PHC Nalchha, Amjhera, ANM Training Centre, MMU at Sardarpur

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • Significant increase in IPD and instt delivery at SC, PHC • Newborn corners are in place in the labor rooms in most of the FRUs • <i>Swastha Gram Swastha Panchayat</i>- MCH services being provided at CHC, PHC and Sub Health Centers through specialists from Private Sector • Janani Express vehicles for referral, Mobile health unit (DINDAYAL CHALIT ASPATAL) in tribal blocks • NABH Accreditation project in Bhopal & Jabalpur initiated • Sub-Center untied fund utilization has been high but without the consent of Sarpanch • ASHAs have a Identity card with drug kit, AYUSH specific incentives for ASHA are planned • VHSC formation under progress • Outreach activities through Mobile Medical Units • Insurance schemes for BPL families, Nutrition Rehabilitation Centers, <i>Janani Sahyogi Scheme</i> (Accreditation of Private Institutions) & <i>Matra Shakti Yojana</i> through PPP for MCH services initiated • Strong community monitoring pilot • Infrastructure development a wing, Constitution of a separate AYUSH cell, developed drug policy, procurement through TNMC, Warehouses are initiated, Privatisation of waste disposal, • SPMU, DPMU, RKS are functional, Block PMU is proposed, District Community Mobilisers recruitment in Progress. • Monthly audit of district accounts 	<ul style="list-style-type: none"> • Strengthening of PHCs • Quality assurance committee at various health facilities to be formed • Training of PMU staff and District Programme Officers for District Health Action Plan (DHAP) • State funded construction should not be replaced by NRHM funded constructions • HR policy, upgradation of medical practice skills of MO & SN are required, additional incentives may be planned for persons posted in difficult areas • VHSC should be operational with formal orientation • Fund utilisation, PPP need to be streamlined • Timely availability of compensation, replenishment of drug kits are critical and need immediate attention • State budget should flow into the Health Society account • HMIS needs improvement in reporting & analysis • MMUs should be made available on a more frequent and regular basis. • Additional incentives may be planned for personnel posted in difficult areas • Functional merger of Disease control programmes with DHS, Nodal officer for M&E is designated at the BEMOC and CEMOC facilities need to be strengthened • Development of District Health Action Plan involving multiple stakeholders

ORISSA

THE REVIEW TEAM:

1. Dr K.R. Antony, Director, SHRC, Chhattisgarh
2. Dr Prabha Arora, Deputy Director, NVBDCP, GOI
3. Dr. Ritu Priya, Advisor (Public Health Planning), NHSRC, New Delhi
4. Ms. Deepika Shrivastava, Specialist (Child Development & Nutrition), UNICEF
5. Dr Rajmohan Panda, Public Health Specialist, Public Health Foundation of India
6. Dr.H.Sudarshan AGCA, Hon Secretary, Bangalore

THE DISTRICTS/INSTITUTIONS VISITED:

District Dhenkanal Dhenkanal District Hospital, Kamakhyanager SDH, **CHC** Anliberani, Parajang , Sriramchandrapur **PHC** Guneibili, Khankira , Deogan, **SC** Mahulpal Sarang Parjang, Sriramchandrapur, Sadangi Village Gundrapasi, Badapokharia

District Subarnapur: Subarnapur DH, **CHC:** Tarva, Ullunda **PHC:** Charbhata, Naikenpal **SC:** Kamsara , Charbhata, Kotsamalai, Khaliapali, Kotsamalai AWC

Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • Increased patient load and institutional deliveries in CHCs, Sub-divisional & District Hospitals • Effective use of untied fund at facilities • 'Yashodas' in the hospitals as companions & counselling women during delivery. • PHC (N) and Mobile health units being managed by AYUSH doctors • NGO participation in NRHM activities for management of Janani Express and a few PHC (N) • VHSCs formed; PRIs, women's SHGs and ICDS actively involved with the health system. • VHNDs being conducted as effective forums for increasing community ownership and convergence • Excellent GIS mapping for all districts • NRHM financial guidelines are being followed very effectively by the state • The State and district IDSP operational. • The State PMU has strong leadership and very good working ethos. District PMUs are active, professional and vibrant • Bilateral donors such as NIPi and DFID providing technical assistance in the State 	<ul style="list-style-type: none"> • Strengthen PHC and Sub center services; including staff quarters • All vacancies for the NVBDCP from District Malaria Officers to Lab. Technicians and MPW (M) to be filled up. • Integrated vector control, with engineering works and use of biological control needs to be strengthened; IT bednets supply to be improved in high endemic zones • An integrated Mother & Child Health, FRU operationalisation, IMNCI roll out needs to be given high priority. • Linking of TBAs with ANMs for underserved areas/ population groups. • New born care equipments, Childhood illness care at primary level needs strengthening; • Scaling up of telemedicine facilities for "hard to reach" areas. • Transparency and need based procurement and distribution of drugs, infrastructure development mechanisms • Creation of a public health cadre in the state

RAJASTHAN

THE REVIEW TEAM:

1. Dr. Gian Chand, Ex-Director Health Services, Government of Himachal Pradesh
2. Mr. Gautam Chakraborty, Senior Consultant, Financing of Health Care, National Health Systems Resource Centre, New Delhi
3. Dr. Rajib Dasgupta -- Associate Professor, Centre for Social Medicine & Community Health, Jawaharlal Nehru University (JNU), New Delhi
4. Mr. Sanjay Saxena, Senior Advisor, Finance, Operations & Administration, NIPI-UNOPS, New Delhi
5. Dr. Ute Schumann -- European Commission, 16, Golf Links, New Delhi

THE DISTRICTS/INSTITUTIONS VISITED:

District- Jaipur, Dungarpur: SIHFW, Jaipur Medical College, Udaipur EMRI Centre- SIHFW Campus, Jaipur, JK Lone Hospital Static Centre- Adarsh nagar, Janana Hospital **CHC-** Sagwada, Simalwada, Bichhiwada, Govindgarh, Chomu, Bassi, **PHC-** Kaladera, Vatika, Tunga, Kanba, Bhiluda, Dudhiabara Vidyadharnagar Urban RCH Centre **Sub centre-** Mohanpura, Bagrana, Meghtalab, Bedsa, Narniya, Malikheda, Karauli VHSC Meeting- Vijayapura, Bedsa, Ramratanpura, Meghtalab District ANM Training Centre- Dungarpur

Achievements	Areas of Improvement
<ul style="list-style-type: none"> •Marked increase in case load at all levels. •Human resource shortages minimised. •All PHCs with MBBS doctors. •ANMs under TSP contractual; drawing hardship allowance under NRHM in tribal/desert areas •Approval of district PIP and release of funds using flexi pool mechanism has been initiated from 2008-2009. reducing the no. of transactions and flexibility at the district level. •Pregnancy Tracking System (PTS)-- individual record of identified pregnant mother at Block level. Extending PTS to PCTS (Pregnancy and Child Tracking System 	<ul style="list-style-type: none"> •Strengthening Community Health Centre services. •District Health Missions, on the other hand, are non-existent/non-functional. •ANMs and doctors not residing in the facilities located in difficult areas or located outside habitations. •ANMs to be trained; were not confident of application of Rapid diagnostic kits for malaria and haemoglobin assessment available with them • •Clear guidelines for fixing of salary of DPMs and BPMs •Institutional synergy between the Regional Institutes at Jaipur and Ajmer, the Directorate, the SIHFW, the schools for LHV and ANM training. •Need to streamline Social protection schemes that include use of RMRS funds for the BPL, <i>Rajasthan Swasthya Bima Yojana</i>, to BPL card holders & <i>Bhamashah</i> scheme. •Coordinated teamwork between the AWW, ASHA and ANM •Underweight / malnourished neonate identified by ASHAs •Follow up of PNC visits and monitoring by ANM / supervisor to be strengthened •Design pneumonia control programme - with referral for sepsis management. •The register kept at the institution does not record a) Weight of the newborn b) condition at the time of discharge – difficult to track pre mature / mal nourished neonate.

TAMILNADU

THE REVIEW TEAM:

1. Prof A.T. Kannan Prof & Head of Department of Community Medicine, UCMS, New Delhi
2. Dr S. K. Sikdar Assistant Commissioner (Family Planning), Nirman Bhawan, GOI
3. Dr. D. Thamma Rao, Advisor – Public Health (HRD), NHSRC, New Delhi
4. Mr. Sushil Pal, Financial Management Group, Nirman Bhawan, New Delhi
5. Ms. Sheena Chabra, Chief, Health Systems Division , USAID, American Embassy New Delhi

THE DISTRICTS/INSTITUTIONS VISITED:

<u>Villupuram District</u> Kallaikurchi Hospital Kallaikurchi town District Hq. Hospital PHC: Saram, Kiliyanur, Iruvelpattu, Elavanasur Kottai, Nainarpalayam, Chinna, Thirunavallu SHC: Kandhalavadi, Killapalayam, Sempai <u>Salem District, Krishnagiri, District, Vellore District</u>	
Progress under NRHM	Areas for improvement
<ul style="list-style-type: none"> • High per capita financial allocation, low out of pocket expenditure, good Infrastructure, laboratory services, logistics situation are the trend in Tamilnadu • Facility survey, AYUSH collocation are in progress • Fair number of instt is providing 24x7, FRU facilities. diet for ANC cases, 2 nd day stay for Post natal care, functional OT at PHC are seen • Maternity picnics, bangle & birth companion programmes for pregnant women, Additional SN in PHC, gestational DM screening & preventive measures are observed • VHSC exists in town <i>panchayats</i> • Filling up over 99% of specialist positions at FRUs, rationalisation of posting & transfer policy, promotional avenues, Relocation of Specialists from periphery to bigger instt. Are good initiatives. • Smooth disbursement of Untied fund, Annual Maintenance Grant, RKS fund in most of the facilities • Functional MMU with contractual staffs • 'Short stay home' for 10 days for the expectant tribal mothers near the health facilities is a good initiatives • computer and internet connectivity in PHC 	<ul style="list-style-type: none"> • Promotion of nutritional improvement, early diagnosis & treatment of Anaemia and health education of obesity in children, adolescents and women, male participation for Family Planning are required • Strengthening of SC, remuneration for staffs of hilly areas, • Reassess blanket JSY coverage, Streamline district society meeting, provide rural and hard area allowance for all categories of health workers, consider 2nd ANM, implementation of double ledger accounting systems should be strengthened • Reorientation trainings for ANMs to facilitate decentralized preparation of Village and SHC level health action plans • Skill up-gradation of laboratory Technicians and Radiographers • Enhance intra-sectoral coordination (Directorates of Public Health, Rural Health, Medical Education etc) for strengthening of linkages • up-gradation of SDHs as per IPHS • Electronic transfer of funds to sub-district levels • Establishing Infrastructure Development division at State level and units at district level for high quality infrastructure • streamlining of the TNMSC procurement and distribution systems to eliminate short expiry drugs • Capacity building of the six regional training institutes for Continued Medical/ Nursing/ Paramedical Education • Plan definite program for all non communicable diseases • VHND need to be augmented

UTTAR PRADESH

THE REVIEW TEAM:

1. Dr. N. C. Saxena, Consultant, UNICEF India Country Office, UNICEF House, New Delhi
2. Dr. Sunil D. Khaparde Dy. Commissioner (Immu. & ID) MOHFW, New Delhi
3. Dr. Arun Kumar Sharma, Professor in Community Medicine, UCMS, New Delhi
4. Dr. P Padmanabhan, Advisor (Public Health Administration) NHSRC, New Delhi
5. Mr. Gopi Gopalakrishnan, President World Health Partners, New Delhi

THE DISTRICTS/INSTITUTIONS VISITED

District Unnao and Bharaich: District Hospital for Women & Men- Unnao, **CHC**-Nawabgunj, **Block PHC**- Safipur, Fatehpur Chauras, Achalgunj, Asoha, Kalukhera, Hiloli, **Addl. PHC**- Roop Pur Chandel, **SHC**- Jamalpur, Kardhaha, Kalukhera **Village**- Dhannapur, Pichauda, Sarai, Katha

Progress under NRHM	Areas of Improvement
<ul style="list-style-type: none"> •Upsurge in institutional deliveries and increasing OPD attendance •Excellent improvement in infrastructure of facilities, Very spacious HSC buildings. •Those in position work hard to deliver health care •ANMs and ASHAs are well accepted and respected in the community •RKS formed up to Block PHC level •Steps taken to activate VHSCs – 2nd October •Clear Guidelines for the use of funds 	<ul style="list-style-type: none"> •Second ANM and MPW (M) needed at Sub-centres •Active screening for communicable diseases (Malaria) needs more attention •FRU and Mobile medical Units not operationalised •Mapping of human resource and redistribution for rationalization of services at different levels following IPH standards is recommended. •Creation of a public health cadre •Mass media campaigns to inform community about facilities created and their benefits •Transparent policy and procedures for recruitment and transfer of workers, protection of erring workers. •Funds for new PHCs •PRIs not uniformly involved for VHSC •Monitoring and supportive supervision of programs should be ensured •Rapid grievance redress for staff and beneficiaries. •Community participation and social audit to be encouraged •Nutrition supplementation, nutrition rehabilitation and provision of food for mothers after delivery and after tubectomy •HMIS and data utilization for planning and monitoring Expansion of nursing education and post graduation in specializations where there are inadequate specialists.



PH-110
11657 P08