NATIONAL RURAL HEALTH MISSION

FIRST COMMON REVIEW MISSION REPORT

November 2007

MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA
NIRMAN BHAWAN, NEW DELHI

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

NRHM

FIRST COMMON REVIEW MISSION

November 2007

National Rural Health Mission
Ministry of Health & Family Welfare
Government of India
Nirman Bhawan, New Delhi.

Contents

EXECUTIVE SUMMARY

The National Rural Health Mission is mandated to bring about an "architectural correction" of the public health system so as to make it "equitable, affordable and effective", with an enhanced capacity to absorb the increasing outlay on health. Such architectural correction is organised around five pillars, each of which is made up of a number of overlapping core strategies that are envisaged to eventually have impact on 14 critical areas of concern. These are considered the essential cornerstones of an effective health service system.

This Common Review Mission (CRM) was set up as a part of the Mission Steering Group's mandate of review and concurrent evaluation. It conducted its appraisal in November 2007, 16 months after NRHM got final cabinet approval in July 2006 and the actual processes started up. The terms of reference set out the task of the NRHM CRM as, assessing the progress of the NRHM on 24 parameters, which relate to the core strategies and the central areas of concern. Based on these, the CRM was mandated to identify the constraints being faced and to make recommendations on the areas that need strengthening and course correction. The Review Mission was made up of 52 members – central and state health government officials and public health experts. After a one-day orientation briefing by the various divisions at the ministry in Delhi, the team divided into 13 groups and left for the selected states: Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal.

At the state level, there was an initial one-day briefing, after which the team divided into two groups and each went to visit one or two districts. The district visits lasted two to three days and the appraisal was done using a protocol that indicated the minimum number of each type of facility (and villages) that should be visited and the thematic areas that must be covered in the enquiry. Upon returning to the state headquarters, there was an interaction with civil society groups, after which the reports were finalised. Finally, the Common Review Mission teams presented their observations and findings to the host state department heads and NRHM facilitation teams for their feedback.

Key Findings

General Patterns

a. An increased access to the public health sector and improvements in its quality has led to the general trend of strengthening these services, reflected in increasing utilisation of these facilities. This increased utilisation can be attributed to the overall increased attention and investment that the public health system is getting, the increase in institutional deliveries consequent to the *Janani Suraksha Yojana*, the filling up of vacancies, the untied funds being used to fill gaps in infrastructure and maintenance, and the improved availability of diagnostic services and drugs. However, there is still much to be done to call them 'fully functional' as per the Indian Public Health Standards(IPHS), and even these improvements are varied, with peripheral facilities showing less changes while the district hospitals have developed relatively more.
b. The performance of NRHM is varied across the states. Different programme components have taken off at different rates. States that had better baselines and had similar programmes in place have been quick to take off.
c. A major contribution of the NRHM framework is the increased attention on the functionality of the public health systems and their bottlenecks in the states. A number of innovative strategies and measures are emerging locally, as a result of the efforts made by the state personnel to meet the overall objectives of NRHM.
d. An increase in public investment by the center has helped in many ways. However, the system continues to lag behind in fund utilisation and there are challenges in both programme management and governance to be overcome before the capacities to absorb more funds and deliver better services are in place.
e. As a rule, the directions in which NRHM is proceeding, as visible at the district level, seem appropriate and welcome – but the scale and rate of rollout seem inadequate. Part of this is due to administrative constraints and perhaps issues of governance. Part of this is due to the time it takes to overcome inadequacies in human resources for health that results from a lack of planned growth in this sector. And part of it is due to the poor

investment in public health services in the recent past. In many areas, therefore, the initiatives taken under NRHM would take time to manifest as improvements in service delivery and in health status.

f. Whilst the impact of the NRHM strategies could be observed and commented upon by the CRM in terms of the structural and functional aspects of the health care facilities and the management processes, it was not possible in such a review process to assess outcomes in terms of MMR, IMR, fertility rates or health status indicators. At any rate, on theoretical grounds, it is too early to expect changes on these parameters.

Performance of NRHM Strategies

a. The Accredited Social Health Activist (ASHA) programme is one major component on the ground. By allowing a space for communities to actively participate and by creating awareness and facilitating people's access to services, the ASHA programme has received a wide welcome from communities. However, for this programme to be sustainable, considerable facilitation and much more attention to the strengthening of key processes is required.

b. The *Janani Suraksha Yojana* (JSY) is another visible and welcome component, but is challenged by the slow rate of growth in infrastructure and personnel to meet the demand generated by the shift to institutional deliveries.

c. Untied funds have been another successful component at all levels, from the sub-centre to district hospital, empowering local health care providers and closing many critical gaps in service delivery. As more guidelines evolve and confidence to spend increases, rate of utilisation of these funds would increase with more visible outcomes.

d. Hospital Development Societies (*Rogi Kalyan Samitis* – RKS) have been formed in most states and, with the provision of untied funds to them, are acting as enablers of facility development. However, their role has been limited by the perception of RKS as an alternative financing device and the consequent emphasis on user fees as cost recovery. Composition of the

RKS and processes of functioning are also not always conducive to community participation.

e. In most states, *Panchayat* standing committee members are involved in the District Health and Family Welfare Societies, *Rogi Kalyan Samiti*, the Village Health and Sanitation Committee (VHSC), and selection of ASHAs (as well as certification of SC/ST/BPL families for JSY). Actual devolution of facilities to *Panchayats* is a feature only in West Bengal, Kerala and Nagaland. In states like Tripura and Tamil Nadu, the *Panchayat's* role was found to be proactive and very valuable. Progress on VHSCs becoming functional has been slow, due to the states taking time to set up the enabling framework.

f. Most NGOs, while being appreciative of the NRHM, maintained that the scope for NGO participation was very limited. In particular, there was keenness on coordinating with the ASHA programme and other community processes, on assistance in ANM and *dai* training, and in BCC work. Meanwhile, there was widespread dissatisfaction in government divisions with the NGOs' performance.

g. The IPHS standards have been widely circulated and are acting as a valuable benchmark for facilitating states to reach desirable levels of both infrastructure and human resource provision. One immediate benefit has been the attention given to improving the quality and quantity of nursing personnel deployed, and in states where this has actually been achievable, the outcomes are immediately visible. However, often IPHS has been read only as a prescription of inputs and not as a prescription of outputs or as a service delivery guarantee. A focus on ensuring appropriate quantity and quality of service delivery outcomes to match any given level of inputs is not in place. In some states, notably Tripura, there is a conscious effort to reach the service guarantees specified, and to convey this to the public.

h. NRHM strategies and the IPHS have led to filling up of existing posts and creation of new posts. However, shortages continue due to a lack of availability of sufficient nursing personnel and specialists. One priority is,

therefore, the expansion of nursing and medical education in areas where human resource is scarce. In parallel, multi-skilling of nurses as practitioners and medical officers for specialist tasks is an additional strategy that some states have put in their PIPs but is yet to be operationalised. Poor performance due to lack of accountability was also noted.

i. Emergency ambulance services as public-private/public-NGO partnerships are doing well in many states. With a toll free telephone number and a central control room, they have had remarkable success in Andhra Pradesh, Tamil Nadu and Gujarat.

j. Setting up of integrated State and District Health Societies with representation of all relevant departments is a step forward towards integration, and one that is found in all states. However, complete integration between different divisions of the health department on financial management, monitoring and use of human resources is slow.

k. One major development of the NRHM is district level planning, which is complete or near complete in almost all states. Despite a mixed picture in terms of quality, it has brought various data together and made a basic skeleton of a plan which can be subsequently revised and built upon. However, the plans are yet to become documents that can provide information on local health service development, programme implementation or community monitoring. Preparation of village plans based on household health data and with involvement of PRIs is still an exception.

l. Progress has been good in the setting up of district and state Programme Management Units. The PMU has brought management skills on contractual terms into the health team, but the integration of PMU staff with the rest of the system still remains a challenge. This effort needs to be examined against and coordinated with the techno-managerial role played by the district programme officers. Coordination between the directorates and the programme management unit in the state level also remains a challenge.

Financial Management procedures have been improved in most states with the use of e-transfer for funds up to the districts and a large induction of personnel with financial management skills to attend to this aspect.

m. The Mission notes that the Integrated MIS Format for flow of physical performance data were found at all levels, including the lowest (ANM). However, multiple reporting is still in vogue, earlier forms are not yet abolished and there are many other constraints in data collection and flow. Copies of reports sent above are not being maintained at that level. HMIS is not used adequately to inform planning and responsive corrective action. In Gujarat, Andhra Pradesh and Tamil Nadu, systems of monitoring of general facility functioning are in place and grades are used to rate facilities into four categories, with pressures to improve performance of poorer facilities.

n. While the various components of NRHM are oriented to increase access and outreach to the underserved, most CRM teams found it difficult to assess the impact on equity within this review's framework. Some CRM teams have reported a high utilisation of JSY by the SC and BPL groups.

o. The review mission also points to a number of important governance issues that are acting as programme constraints.

Some Key Recommendations

The remaining 5½ year timeframe of the NRHM gives us ample opportunity to strengthen its positive elements and make mid-course corrections.

At the Central Level

- Ensure timely release of funds to the states for various components of NRHM, especially *Janani Suraksha Yojana*.
- Work with states to evolve a common nomenclature for the facilities, such as PHC and CHC, as this influences much of the planning process and budgetary allocations.

- Build systems for actively promoting cross-learning from the varied experiences of different states, and accelerate changes and innovations in poor performing states through appropriate facilitation, capacity building and technical assistance.
- Develop a monitoring and support system that not only identifies lack of progress, but is able to respond and reach out to assist in areas and states showing limited progress.
- Develop guidelines for integration of the activities of various programmes and the general health services. To integrate all the disease control programmes, the way forward is to build in the preventive, promotive and curative care for communicable, chronic diseases and non-communicable diseases into the definition of fully functional health facilities and the provision of promotive and preventive services. Thus, one needs to develop their standard treatment guidelines, their essential drug lists, their referral systems, their support systems for capacity building, logistics, and monitoring, and their Behaviour Change Communication (BCC) work.
- Develop guidelines for a more integrated approach within programmes - for instance, integration of assistance at deliveries with neonatal care and with post partum sterilisation - by building the natural links between these dimensions, found to be low in the states.
- Develop guidelines for more integrated management structures at various levels: directorates and mission programme offices at the state level or sub-center facility committee, and the ASHA programme with the Village Health and Sanitation Committee (VHSC) at the village level.
- The institutional framework proposed for the state level health systems management has evolved differently in different states and it would be useful for more active cross-learning of experiences. Further, to ensure effective programme management at the state level, support is needed for the creation of minimum institutional arrangements and their proper functioning.

At State and District Levels

In programme management:

- The institutional framework at the state level to strengthen health systems management is the urgent priority. The directorates, the programme

management unit of the NRHM, the SIHFW, the state health systems resource centers, the community leadership support units, the infrastructure development support units and the drugs and supplies procurement and logistics management units are all essential and must have the appropriate professional teams and enabling structures to manage a vast and growing public health system. Clear role definitions and coordination mechanisms, along with team building efforts, should ensure that the conflicts between different structures of management are overcome.

In attaining fully functional health facilities:

- Rational restructuring of the health services, with the IPHS service guarantees and guidelines for infrastructure and human resources as the organising principle, needs to be pursued more vigorously. Though these benchmarks may not be possible for each state to reach immediately, given their vastly differing baselines, each state should develop a clear roadmap showing how this would be attained in a phased manner. Such plans should guide the allocation of resources and the measurement of outcomes.

In Improving Workforce performance*:*

- Building a network of district, regional and state level training institutions - led by the SIHFWs that ensures that the level of skills needed for service delivery at every facility and in every health programme are in place - is one of the most important areas of health sector reform that is urgently needed. Putting this in place at every level, along with teams/centers for providing assistance and the institutional memory for district planning, is another priority.
- Pre-service training institutions for generating multipurpose workers, both male and female, and their supervisory staff, which have become dysfunctional in the last decade, need to be revived, expanded and strengthened.
- There needs to be a systematic examination of the compensation packages and incentives being provided to the various health service cadres, and the opportunities for advancement in their careers along with a fair transfer and posting policy. These are some of the most sensitive

indicators of good governance and a system of measuring and rewarding these needs to be built up.

- Multi-skilling of doctors, nurses and para-medicals is needed as a general strategy to provide the skill mix for reaching service guarantees under current human resource constraints.
- Also required is making available the graded standard treatment guidelines and essential drug lists and formularies to the wide range of health care providers. This will provide valuable guidance to these personnel involved in providing health care.

In HMIS and Decentralised Data-based Planning

- The HMIS must be rationalised to make it user-friendly and ensure quality data while reducing the workload of the peripheral health workers and eliminating redundant formats.
- Village level planning under *Panchayat* leadership remains a goal that we must develop as a core activity of planning. This requires active facilitation of the village health and sanitation committee.

District health planning must be taken to its next level - where the district has sufficient capacities to make its own plans, where budgetary resources flow according to the plan, and where the plan is widely disseminated and is used as the measure against which outcomes are socially audited. States and Districts need the time to learn and improve. However, to achieve this, an agency or team is required to act as an institutional memory of the plans and pro-actively pursue their implementation. Like the role envisaged for the SHSRC at the state level, there is a need to infuse new methods of problem analysis and solution search appropriate to local needs. In this connection, greater non-official involvement - especially of local professional from NGOs and research institutions with expertise in development and public health who are also capable of planning - should be sought.

Common Review Mission Report

Background:

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. Such a shift is important for improving the health 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% only. 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. Also 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.

As in our federal polity, health is a state subject; the NRHM requires states to submit sector wide well integrated state plans which it then jointly with the states, appraises for consistency with the NRHM framework for implementation – a common framework that the centre and the states have agreed to and around which a national consensus has been built. Based on this appraisal, the state plans are approved and the NRHM then provides the financial resources and technical support needed to implement these plans.

The NRHM framework represents a conscious decision to strengthen public health systems and the role of the state as health care provider. The NRHM recognises the need to make optimal use of the private sector to strengthen public health systems and increase access to medical care for the poor. But given the uneven growth of the private sector, its current situation in regulation

and the issues of access to the poor, the public health care provider remains the mainstay of public health policy. 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 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.

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. 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 80:20 to at least a 60:40 ratio in this plan period. Another important corollary is that the state health sector develops the capacities to absorb such fund flows. There are currently many constraints, especially in the EAG states to absorbing these funds, and the poorest performing states which require the largest infusion of resources have some of the greatest problems in being able to expend the funds already with them. This is one of the main reasons why a process of reforming and strengthening the state health systems needs to go hand in hand with the increase of fund flows.

The NRHM is thus also about health sector reform – or in its language – an "architectural correction" of the public health system so as to make it "equitable, affordable and effective". Such architectural correction is organised around five pillars, each of which is made up of a number of overlapping core strategies.

a) **Increasing Participation and Ownership by the Community** (what is often 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, through increased public participation in hospital development committees and district health societies and in the district and village health planning efforts and by a special community monitoring initiative, and through a greater space for NGO participation.

b) **Improved Management Capacity:** The core of this is 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 units and 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.

c) **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 *Janini 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.

d) **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 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 downs 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. Contractual appointment route to immediately fill gaps as well as ensure local residency, incentives and innovation to find staff to work in hitherto underserved areas, and the use of multi-skilling and multi-tasking options are examples of other 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.

e) **Setting of standards and norms with monitoring**: The prescription of the IPHS norms marks one of the most important core strategies of the mission. This has been followed up by a facility survey to identify gaps and funding, directed at closing the gaps so identified. Gaps in equipment are relatively easily addressed. Gaps in drug supplies need an adequate drug procurement and distribution policy. Gaps in infrastructure require an efficient mechanism of completing civil works in time with quality. Gaps in human resource require expansion of education plus workforce reforms and innovations. And 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, the NRHM aims to provide adequate technical facilitation and monitoring support.

Each of these five pillars and the many core strategies that they are composed of must eventually have an impact on the 24 critical areas of concern which the NRHM framework for implementation identifies. These 14 areas of critical concern are essential cornerstones of an effective health system. The first and most important of these is the responsibility of creating, what the framework calls, "fully functional health facilities". 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 the outcome most expected from the Mission is that each facility is able to fulfill this guarantee. The entire list of the 24 critical areas is as given below:

1. Fully functional facilities – from sub-centre to district hospital
2. Increasing and improving human resources in rural areas
3. Accountable health delivery
4. Effective decentralisation
5. Reduced MMR, IMR and TFR
6. Action for preventive and promotive health
7. Disease surveillance
8. Hamlet-to-hospital referral linkage
9. Health information systems
10. Planning and monitoring with community ownership
11. Equity issues: women empowerment; securing entitlements for SCs/STs/OBCs and minorities
12. Convergence – with HIV/AIDS; AYUSH; chronic diseases, malnutrition, safe drinking water – with community support
13. Chronic disease burden
14. Social security to poor – for reducing impoverishment and bankruptcy related to ill health

Timeframes of achievement:

The NRHM was inaugurated in 2005; however, it took quite some time to finalise the Mission content, and final cabinet approval was in July 2006, with funds starting to flow to the states thereafter. Thus, though the Mission is now two and half years old, in terms of actual processes starting up it is now 16 months old. The timeframe of the Mission is up to March 2012 – there is another five and half years' time remaining to complete the Mission.

The Common Review Mission

The Mission Steering Group, which leads this programme, has called upon the NRHM to have adequate mechanisms of review and concurrent evaluation so as to steer the programme effectively. The Common Review Mission was set up as a part of this mandate.

The terms of reference of the Common Review Mission set out the task as assessing the progress on the mission on each of the core strategies and its impact on the central areas of concern and the constraints that were being faced. Based on these, the CRM team is to make recommendations on the areas of the Mission that need strengthening and course corrections.

The Review Mission and Its Methodology

The Mission was made up of 52 members who, between them, visited 13 states selected for the review. Of the 52 members, 30 were officials from the department of health and family welfare, 4 were from the states and the rest were from the different divisions of the ministry. Of the 20 non-official members, three were former union health secretaries, and the others were public health experts from leading public health institutions that have been working with the National Rural Health Mission.

On 14 November, the entire group assembled in the committee room at Nirman Bhavan, chaired by the health secretary Shri Naresh Dayal. After a briefing by the various divisions, the team divided into 13 groups and left for the states. The states chosen were Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal.

On 15 November, there was a similar one-day briefing at the states, after which the team divided into two groups again, with each group visiting one or two districts. One of these two districts had been purposively chosen for the state to explain what it had been trying, and the other district was chosen by the CRM team. 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 thematic areas that must be covered in the inquiry.

On 19 November, the teams returned to the headquarters. Following further interactions with the state team and the civil society, the teams finalised their reports. On 21 November, the Common Review Mission teams presented their observations and findings to the host state before bringing this part of the Mission to a close.

It was decided that as soon as all these mission teams submit their final reports, the draft of the findings would be presented before the entire mission team at a national consultation.

FINDINGS OF THE MISSION

The findings of the Mission are discussed as two main sections - the national overview report and the state specific reports. The first section, which is the national overview report, is made up of four parts.

First, a brief summary of some general patterns seen across the states; Second, an assessment of the core strategies that characterise the NRHM thrust most evident in the field. Thirdly, progress along the areas identified as critical areas of concern. This is largely made up of a discussion on fully functional health facilities and human resource management. And fourth and finally, a section listing the main recommendations and follow up action that the CRM calls for.

SECTION I – NATIONAL OVERVIEW

1.0 General Patterns

a. There seems to be a general trend towards strengthening the share of services provided by the public health sector and increasing their access and quality.
b. There is a varied performance across states. In each state, different programme components have taken off at different rates. States that have better baselines and similar programmes in place have been quick to take off. States with health systems development programmes under bilateral donors have various fund overlaps.
c. An increase in attention to the functioning of public health systems, the fact that the systems functionality in states and their bottlenecks are now receiving attention and critique, is perhaps the major contributor at one state. The fact that it is a systems approach lined 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.
d. An increase in public investment, the very fact that lack of funds can no longer be the reason, has helped in many ways. However, actual increases in terms of funds absorbed by the system still continue to lag behind and there are challenges in both programme management and governance to be overcome before the capacities to absorb more funds, and thus deliver better services, are put in place.

1.1 Increasing performance of health systems:

Of the 13 states visited, almost all have reported increased performance in terms of absolute attendance and, to a lesser extent, in terms of quality of care. This is most obvious for institutional deliveries where the JSY has put pressures on the public health system and to a large extent of outpatient attendance in general – but it is more mixed with in patient attendance or surgeries or diagnostics, etc. However, even in these though rate or improvement may not be commensurate, the trend is still upwards.

Thus of Bihar, one of the weakest performers in terms of public health services, the CRM report states that there is an "Increase in Block PHC OPDs from 39 per month 2 years ago to over 2500 per month now for many months, and from 7000 institutional deliveries in government institutions in October 2006 to over one lakh such deliveries in October 2007… Given the low utilisation of public services in Bihar, as reported by NSSO 60th Round 2004-05 (5 per cent out patient and 11 per cent in patient treatment in Government institutions), this is indeed outstanding. There is a confidence that the public system shall deliver quality health care services and people are flocking to the public system to utilise services even on holidays and over weekends. There is still scope for improvement in the supply side and quality of services, which, hopefully, will receive priority attention in the months to come".

It is important to start with this quotation, for not only was the baseline one of the poorest for this state, even the unfolding of the NRHM programme has been very poor, and most of the core strategies described in the next section are not yet in place.

At the other extreme, even for a state with a known record of very good performance like Tamil Nadu the CRM reports that "after the start of the NRHM, the number of cases in public health facilities have increased considerably in

PHCs, and there is diversion of a number of cases from private institutions to public facilities. The team was informed that as a result of this, some of the private medical colleges have even started to offer incentives for delivery in their hospitals.

In states like Assam, Tripura and Madhya Pradesh, the trend is not as clear – where, after exclusion of institutional delivery, some facilities are seen to be stagnant, with some even witnessing decreasing attendance due to a shift of manpower, etc. However, the same states also report sharp increases from many other facilities. The methodology of the review does not help us to reach precise estimates of the actual increases in caseloads being handled in the system as a whole – and, therefore, this observed trend is something of a tentative observation – encouraging but requiring a much better HMIS to confirm.

It would be useful to conclude the observations on increase with this cautionary quotation from the Gujarat report as Gujarat has perhaps the best monitoring system in place for tracking patient loads: "There has been an impressive increase in OP/IP for the state as a whole. In both districts visited, the trend was visible. Often the increase is related to the competence and commitment of the doctor posted at PHC which sets off a virtual cycle of all round PHC improvement and patient satisfaction. The team would like to note that the overall increase in a district often hides much variation among PHCs. This is also an evidence of exclusion which may arise out of many reasons such as left out, drop outs, pushed out, denied, etc. - each type of exclusion demanding a different response. Monitoring that tracks variance and underserved areas is the only basis for ending exclusion and for consolidating the ASHA programme".

1.2. Varied performance between states:

Though there is a general trend for increasing performance, the increase in performance varies across states and much more so when seen for each core strategy and central concern of the NRHM. The variation seems to depend on baselines – states with better health systems taking better advantage of the

provisions of NRHM. Further, states that are already familiar with a specific NRHM core strategy, having introduced it already in their respective areas, are able to do much better in implementing it. Though all states show forward movement, the areas they show differs. In those cases where the state was already set in that direction, it accelerates easily; for instance, RKS and ASHA in Rajasthan, and ASHA and village committees in CG. (CHC in Kishangarh as contrast to CHC Thana Gaji – the contrast is not permissible). In case it is a new strategy being introduced in the state, its implementation takes time.

We also note that no state has been able to rollout all the core strategies that it has chosen to include in its PIP. Change is difficult to initiate, and much more difficult to accelerate, and the state leaderships have been able to focus only on some of the changes they themselves want to carry out. It is also likely that other than monitoring, which has received a fair degree of attention, a much higher level of technical facilitation is required from the national centre to the states and from the state centres to the districts to improve performance. Human resource

development is another critical constraint that is very sensitive to baselines of human resource development capacities.

1.3. **Renewed attention on public health systems**:

Performance is attributable to core strategies and increasing investment – but often it is merely the renewed attention on functioning of public health systems that is the key.

There are many examples of the changes that took place, which required no policy change and no resources. They merely happened because after a fairly long period of neglect, basic issues of the public health system had once again caught administrative attention.

One example of this is the ANM and MPW training schools that, in almost every state, had fallen into complete disuse with no further ANMs being trained – despite a growing vacancy. In the years since, the Mission began one of the areas of considerable intervention: the reopening and expansion of ANM schools. Though expansion needed NRHM funds, the existing schools already had unutilised funds, which are being put to use for their functioning. Vacancies long unfilled are being filled again, especially for nurses, pharmacists and MPWs. Budgets for drug supplies have been increased. A large gap in infrastructure that had developed over the years is now receiving a flow of funds. As the Uttar Pradesh report observes: “We note that the NRHM has awakened a live debate at every level about… why did it take so long for the government to wake up to so many rather obvious and basic needs. In particular, untied funds given to facilities and the renewed attention to closing human resource gaps, the ASHA scheme with its thrust towards community participation and the pressure brought on public health systems to perform by the JSY scheme have been seen as the major harbingers and potential triggers of change”.

It is important to try and understand why there was such stagnation in investment in the public health system and a rapidly declining share of the budget during the

1990s. Some of it may be due to macro-economic trends. Some of it is attributed to a few chosen national schemes taking up increasing funds at the cost of health systems developments. Some of it was perhaps due to a loss of belief in the ability of the public health system to deliver despite investment. Perhaps, the most likely explanation rests in that health systems development was a state subject, the financial crunch felt in many state economies in this period was disproportionately passed on to the health system. Whatever the reasons, the most obvious and perhaps major contributor to change is the way the NRHM has brought back the attention to the development of health systems. It should have further gone beyond health systems to the maintenance of public health as a whole – but, as we shall see later, there is still some way to go about this.

1.4. Again, as a rule, the directions in which NRHM is proceeding – as visible in the district level – seem appropriate and welcome. However, the scale and rate of rollout seem inadequate, again mainly due to administrative constraints and perhaps issues of governance.

Section 2 – CORE STRATEGIES AT WORK

2.0 Communitisation:

There are seven core strategies that make up this key pillar or category of reform. These are the ASHA programme, the village health and sanitation committee, the enhanced role of PRIs and decentralisation, the role of NGOs, the role of public participation in hospital management committees, the role of public participation in the village and district planning process, and community monitoring. Of these, the last was not observed anywhere in the review and this component is at an early state of takeoff. Public participation in hospital development committees is discussed in the section on RKS, and public participation in planning in the section on district and village planning. So the discussion here below is confined to the first four of these – ASHAs, village health and sanitation committee, PRIs and role of NGOs.

2.1 ASHA

The rollout of the ASHA programme numerically is impressive. The ASHA programme is, by formal definition, confined to the special focus states, and to the tribal areas of all other states. However, states like Andhra Pradesh have already extended this programme to the entire state and most other states seem favourably inclined to such a proposal. It is thus very important to make an assessment of the ASHA strategy as it stands now and chart out its future directions.

a) Selection

Almost all the states visited have completed their ASHA selection. The quality of selection varies. In most states, the decision has been made by the ANM in consultation with the *Panchayat*, or vice versa. In states where the *Panchayat* system is more vibrant, like in Tripura, the participation of the *Panchayat*s has been more. The understanding of the importance of prior social mobilisation is poor. The *gram sabha* meeting as the site of selection has also largely not been adhered to.

However, despite these shortcomings, the observations from most states are that the resultant ASHAs are quite enthusiastic and capable and, though better

selection would have helped, the programme could still proceed. Three criteria are almost completely fulfilled. All are women, almost all of them are married or have been married, and all the ASHAs the CRM team met were residents of the habitation where they are appointed ASHAs. We heard of some violations of the last clause but this is clearly rare and easily remedied.

There is also a trend towards auto-correction since poorly selected ASHAs, who were expecting regular remuneration or a government job, tend to drop out and replacements could be done in a better manner. In places where selection is not complete, there is much to be gained from reiterating the selection process.

Important variations are Chhattisgarh and Rajasthan. In Chhattisgarh, the existing *Mitanins* are declared ASHA equivalents and they have been performing well in this slight modification of their role and support systems. In Rajasthan, the *Sahyoginis* of the *Anganwadi* centres were declared ASHAs – and renamed ASHA *Sahyoginis*. Of the targeted 42,000, some 37,000 have been selected and renamed thus.

b) Training

One of the best reports of training is from Andhra Pradesh. This good quality of training is attributable to an organisation at the state level that is specialised in this function and nodalising it, as it is to a provision of 21 days of residential training in the very first round. In Chhattisgarh, where the programme had begun two years earlier, the 10th round of training and some 25 days of training is nearing completion.

In other states, about two thirds or more of the ASHAs have received the first round of training, which varies from 5 to 7 days, but less than 10% have received any further training. This is really behind schedule and reflects the weakness in building up systems to manage such a massive programme effectively. Memory of key issues in the training curriculum was weak; but given the fact that one year has elapsed since the training, this need not by itself be a comment on the

quality of training. The lack of periodic training, however, is a serious setback to the programme.

It has been noticed that the programme is getting slowed down to sub-critical rates wherever staff loaded with many other responsibilities are also given the additional task of functioning as ASHAs, and where the programme leadership has insufficient autonomy and delegation to continue at a desirable pace of work.

In Bihar, the second training phase proposal developed by the Bihar State Water and Sanitation Mission (BSWSM) and approved by the SHS focuses on drinking water and sanitation. The training, to be conducted by BWSM and SIHFW, is scheduled to start in January 2008 at a cost of Rs. 38 crore. Training resource teams at State, district and block levels are planned, with 12 day training for the District Learning Team. The ASHA training is proposed to be done through a 12 day non-residential course in all 534 blocks over a six month period. The NGO network, through which the Total Sanitation Campaign was conducted, will play a role. The CRM suggested that the first district could act a pilot to assess this new strategy.

c) Drug Kits

Drug kits have been given to all *Mitanin*s in Chhattisgarh and about 50 per cent of ASHAs in Rajasthan and Assam. They are not yet distributed in Bihar and await the next round of training. In the state of Uttar Pradesh, procurement is not completed. This again is too slow and deprives the programme of much effectiveness. Organising procurement remains a bottleneck in most states.

d) Payments

Performance based payments are able to incentivise the ASHA and act as adequate encouragement for her to perform these tasks. However across the states payments to ASHAs are invariably delayed and on many occasions denied. The challenge seems to be to set up a system of payment that is accountable and reliable, yet swift and dignified.

There is one view that such a payment is not possible and it is worth considering a regular – though small – part payment. The Government of Rajasthan has done just this by combining this with their *Sahyaogini* scheme. To begin with, assistants in the *anganwadi* centres under the Department of Women and Child Development (originally called *sahayoginis*) have been renamed ASHA *Sahayoginis*. ASHA *Sahayoginis* are paid a monthly stipend of Rs. 500 (over and above which they receive incentives for different tasks); they are required to do 10 household visits daily; and they function out of the *Anganwadi* Centre. This has led to better integration of ICDS and health, greater accountability (as the ASHA *Sahayogini* is required to work half day), and greater coordination of ASHAs with *Anganwadi* workers. On an average, an ASHA earns around Rs. 2000 a month.

This innovation in paying ASHA *Sahayoginis* in turn still left some problems. ASHAs tended to concentrate only on those activities that offered them incentives and to earn more. As a result, many critical areas such as child care, counseling, etc., that were not tied to incentives remained neglected. There are also reports of several instances of conflicts between ASHAs and *Anganawadi* workers arising out of these incentives. This was particularly so in the case of

JSY where two workers would often fight over who gets the monetary incentive. We also heard of some families that do not want the ASHA to accompany the pregnant woman to the health facility so they can collect the transport charges themselves. In particular, there is an urgent need to separate the transport compensation from the ASHA incentive and make these non transferable. Similar conflicts can occur in other situations, notably the sterilisation incentive, which in practice few ASHAs are getting anywhere, as others can claim it first. Some states, notably Tripura, have issued an OM formalising the incentive structure for payments to ASHAs on all heads, but most are yet to do so and incentives remain limited to JSY incentive, the immunisation incentive and the DPT incentive.

e) Support

Support is needed to keep the ASHA enabled and empowered by creating a favourable environment and providing her with social recognition and helping her in her work. It is also needed as on the job training.

This has been addressed in different ways in different states but few have a systematic plan of action for this. On the whole, almost no state reports a regular schedule of meetings of ASHAs at the local or block level, or on the job support or training. There are some efforts at social mobilisation – but they are weak. The village health and sanitation committees could have helped, but in most states they are not yet functional. In some sectors, however, based on individual initiative of a medical officer or a LHV, regular meetings have started; and in these sites, both knowledge levels and functionality is much better. In Tripura, bright red coats and blue kitbags given to the ASHAs have given them a unique sense of pride and identity. This need is felt by the organisers for organising support, but there is little clarity on how exactly this can be initiated and achieved.

The JSY and immunisation incentive link ensures that there is some live contact with the health and *anganwadi* system, but in most states there is a need to enhance these contacts. Without underplaying the role of payments and financial incentives, there is a major need to enhance non financial incentives as well.

There is a provision for a full time structure of five block level facilitators and a full time district and state team, but this is not set up in any state. In Rajasthan, there is an ASHA Resource Centre which is not very functional and an ASHA Mentoring Group. But in all other states, the ASHA state mentoring groups have not really come up, reflecting the sharp limitations in understanding community processes. Participation of NGOs experienced in community health work would enhance the quality of ASHA capabilities. The logistics of the programme are fairly complex and a strong state level team with high motivation would help to see the ASHAs make a significant difference to the health care sector. The provision and replenishment of ASHA drug kits, the monitoring of payments, and, above all, keeping the periodicity and pace of training in a timely manner needs such a command unit to manage the programme.

Involvement of PRIs was seen at the selection stage but this has not been maintained after that stage. Training of PRI members about the ASHA role would help in the support process.

f) Role clarity and Monitoring

As a general rule, ASHAs are active – their main work being linked to JSY and immunisation. This is largely attributed to the influence of the incentive. While this is true, the Mission also notes considerable lack of role clarity and thus monitoring and direction. Though most department functionaries are clear about these two functions and the role of ASHA as a DOTS provider, they are unable to name other roles – much less describe other roles in such a way that it can be supported and monitored. Systematic use of this ASHA workforce for health education and, where relevant, essential newborn care, as well as for first contact care for the sick child or for malaria control needs to be clarified in a district specific manner – for these are known to be lifesaving interventions that CHWs can achieve and these could lead to measurable outcomes for the programme.

Despite these constraints, the ASHAs we met were enthusiastic and looking forward to more training, being more useful, and going beyond JSY and immunisation. The focus on empowering the most socially excluded groups in the society and reducing inequalities should be given priority, and though there were expectations from the ASHA in this regard, there has not been much discussion on this as the programme unfolds. Once role clarity is achieved, a monitoring plan based on what outcomes and processes are expected could be put in place.

ASHAs are easily one of the most vibrant dimensions of the NRHM rollout. That this could be so, despite all the limitations, just points to the great potentials of community involvement. Providing ASHAs with a more effective support and leadership – as well as incentives – and deepening all the community processes of ASHA is one of the most urgent requirements. Despite the fact that the states have seriously grasped this programme, there is a need to bring in more technical support and civil society partnership at the district and state levels to enable community building processes for the ASHA programme and through the programme itself.

A catalyst in the form of an active mentoring group or activists drawn from NGOs working in partnership with the district administrations could make a big difference.

2.2. Village health and sanitation committees

- The village health and sanitation committees are another key strategy of communitisation. The village committee is being given a small fund of Rs 10,000 which forces the states to plan out institutional mechanisms. These mechanisms involve an order constituting the committee, a bank account with signatories, an accounting and decision making process, a finalisation of the relationship between this committee and the *Panchayat* health committee, guidelines for expenditure of the money,

and finally mechanisms for capacity building and for supporting village level planning. Simple though the idea is, it still requires considerable decision making and facilitation. This may be one reason why despite widespread welcome of this strategy, progress has been slow. It is likely that in the next round, once these hurdles are crossed, the progress will be much faster, with only the village level health planning remaining to be done. The sub-centre facility committee and the ASHA programme also needs to be integrated with this structure.

- West Bengal has constituted 16,770 VHSCs out of its target of 44,175 and 12,000 would be finalised this year. In Tamil Nadu, 12,169 VHSCs are functional and they have used the fund of Rs. 10,000 mostly for 'cleanliness purposes'. Some PHCs have provided free food for mothers who came to the centre for delivery, with self help groups paid to do this provisioning.
- No village health and sanitation committees have yet been formed in Tripura, CG, etc., but the process is ongoing and nearing completion in most states.

2.3 Involvement of PRIs

The involvement of *Panchayat*s takes a number of forms. Actual devolution of power to *Panchayat*s to extend their level of involvement is a feature seen only in West Bengal – in primary health centre and sub-centre levels – and in Kerala and Nagaland.

In most states, *Panchayat* standing committee members are involved in RKS and District H&FW Society. Even within this, there are varied levels of involvement, and in a state like Tripura where the *panchayat's* role is proactive, this has been very valuable. This level of involvement has been at times very helpful.

In Tripura, the CRM reports an instance where the *Panchayat* had invested Rs. 62 lakhs in Kathailia PHC for renovations, construction of a meeting hall, and purchase of surgical instruments. The PRIs themselves are demanding extensive training on their role in various management structures under NRHM. Involvement of PRIs at PHC level is hampered (as in Bamutia PHC) as Block *Panchayat* Chairman has to head these RKS, which are spread across in the block. As a result, PRIs are not always available for signing and approving vouchers/ expenditures for RKS of PHCs that are located far from the Block HQ.

In Bihar, the elected representatives of the PRI are members of the RKS and PHC Committees. The name, designation and contact telephone / mobile numbers of all the members of various committees are displayed at respective health facilities. The initiatives for inter-sectoral convergence for public health activities, including involvement of PRIs and VHSC, are yet to be taken up.

In Tamil Nadu, the *Gram Panchayat's* involvement has been maximal at the sub-centre and PHC level, with *Panchayat*s raising funds, providing meals and actively managing VHSCs. However, PRI involvement at higher levels is reported to be much less.

In all the states, they are involved in the selection of ASHAs and in forming village health and sanitation committees.

Another major role of the *Panchayat*s is certifying the BPL/SC/ST status of JSY beneficiaries. The expenditure incurred under JSY is discussed in the RKS meetings in the presence of PRI and other members. JSY grants for home deliveries are paid by the BDO who receives funds from the District H&FW Society.

However, as of now, *Panchayats* from only a few states are conducting household surveys to ascertain local health indicators and disease burden, or doing any form of village planning. In Tripura, PRIs were sensitised during a micro health planning exercise undertaken during early 2007. However, since they did not receive formal training in NRHM, their role in planning, implementation and monitoring of various components is limited.

2.4. NGOs and their role

The CRM team invited the NGOs for discussions in a number of states, especially in Bihar, Uttar Pradesh, Rajasthan, and Madhya Pradesh. Some groups like Janani are involved as service providers who are reimbursed by the government. They have carried out 4,035 tubectomies and 1,200 non-surgical vasectomies, working through franchised clinics. They mentioned lack of coordination and delays in payments as problems. However, as a rule, the CRM came across only a few NGOs carrying out this role.

Most NGOs, while being appreciative of the NRHM, maintained that the scope for NGO participation was very limited. NGOs felt rebuffed and their services not sought adequately. In particular, there was keenness on coordinating with the ASHA programme and other community processes, assisting in ANM and dai training, and in BCC work.

One specific experience discussed was the PPP arrangements with NGOs for service provision at the PHC level. There was widespread dissatisfaction from both NGOs and government and the programme had literally broken down. An NGO that had taken up ten APHCs under a PPP arrangement for three years said that it was difficult to work with insufficient funds. He said a payment of almost Rs. 60 lakh from the district health society was still pending for want of counter signature by the CS. They have discontinued the contract since March 2007. Overall, outstanding payments of about Rs. 1 crore are yet to be released to the 36 PHCs that were earlier outsourced. Even in the MNGO programme,

there were major complaints of non-payments of funds since the last three years. After formation of the SHS, funds have not been released to old MNGOs. Another NGO working in Sheikhpura and Begusarai also has 7 months' payments due to it.

The CRM team visiting Bihar suggested "introduction of conditionalities" to ensure Government responsibility and accountability in partnerships, a nodal person responsible for management of NGO partnerships preferably at state level, and payments made electronically within the stipulated number of days, third party appraisal and community monitoring as correctives.

3. The *Rogi Kalyan Samiti* and the flexible funding options

The NRHM provides a major part of its funding through untied funds available at the level of utilisation. Thus, Rs. 10,000 is given to every sub-centre as an untied fund, plus another Rs. 10,000 available as maintenance grant. For every PHC, a fund of Rs. 25,000 is available as untied grant, plus another Rs. 25,000 available for maintenance grant and possible funds available for upgrading it into a 24X7 hour service. An untied grant of Rs. 1 lakh is available for every CHC, plus maintenance grant and funds up to Rs. 40 lakhs for upgradation to IPHS standards.

There is also an understanding that in future, districts would be given a resource envelope within which they would be free to make their plans. States have already been notified of their annual resource envelope.

In addition, the NRHM looks at other ways of financing health care – and this excludes direct expenditure incurred for provision of public health services. One such set of options is known as 'demand side financing' where the funds follow the patient. Of the various demand side financing options, the one known best and the most widely utilised is undoubtedly the *Janini Suraksha Yojana* programme. The fund for sterilisation compensation is similar.

The NRHM also provides space for flexible funding in terms of supporting a number of public-private partnership options. The progress on many of these lines is discussed below.

3.1. Rogi Kalyan Samiti:

3.1.1. The *Rogi Kalyan Samiti* can be equally discussed under three heads: as a form of communitisation/ public participation (this includes its role in increasing accountability), as part of a strategy to improve the quality of management and therefore facility outcomes, and as a form of providing flexible funds for facility improvement. The *Rogi Kalyan Samiti* under the NRHM is not seen as a vehicle of cost recovery though states are free to decide their policy in this score.

3.1.2. The results of the *Rogi Kalyan Samiti* programme, as proposed under the NRHM and for which untied funds are made available, has been broadly very positive. In the context of untied funds, the RKS is a vehicle that ensures its proper utilisation and forms a framework of both accountability and its outcomes. The outcome of RKS - in relation with NRHM's understanding of this *Samiti's* role as a hospital management committee that improves quality and accountability and facilitates flexible state funding, ensuring equity in care – is varied across the states:

- In Bihar, *Rogi Kalyan Samatis* have been established in all hospitals and health centres and their impact is clearly visible in outsourcing of ambulance services, uninterrupted electricity through generators, dietary services, provision of linen supplies, cleanliness services and environment. Services are generally of good quality. The untied funds were available at Medical College hospitals, district hospitals and 24x7 PHCs and have been used effectively for the above activities.
- In Tripura, RKS have been established in all hospitals and have received the untied funds. The spending of untied funds, which is in the range of 50

to 70 per cent, is mainly on facility renovation and purchase of required instruments, furniture, etc.

- Rajasthan has done particularly well in this area. Rajasthan Medical Relief Societies (the RKS equivalent) existed up to CHC level prior to the rollout of NRHM. However, these societies were extended up to PHC after the launch of NRHM. Set up in the late 1990s, they now cover all 45 district and sub-district hospitals, 352 out of 354 CHCs, and 1,489 out of 1,503 PHCs. These three sets of institutions have started receiving Rs. 5 lakhs, Rs. 1 lakh, and Rs. 25,000 respectively every year as untied funds. A well-thought out set of guidelines govern the functioning of the RMRS. For instance, free medical care is provided to everyone below poverty line, pensioners and senior citizens. The rest are required to pay a modest amount for services ranging from Rs. 5 for registration to Rs. 30 for ECG and blood tests, and Rs. 60 for X-rays. The guidelines also prescribe how the money collected ought to be spent – 25 per cent on purchase of medicines and so on. These inflows, combined with the direct transfer of untied funds from NRHM, have led to the accumulation of reasonable sums of discretionary funds at each level.
- In Tamil Nadu, the Patients Welfare Society and their untied fund has been welcomed and are reported by the Mission as achieving marked improvements in the appearance, in the patient amenities provided and the overall environment of the facility. The funds for sub-divisional hospitals are considered inadequate.
- In Madhya Pradesh, the *Rogi Kalyan Samiti* in one district hospital, which was analysed by the team, showed a heavy reliance on user fees as a source of income, and a major chunk of RKS untied fund was expended on routine heads like salaries and medicines, which should be largely met through departmental funds. A state level analysis of RKS data showed large financial fluctuations and significant divergences between income and expenditure in the past several years; large scale non-reporting or inadequate reporting from RKS institutions to state level, with RKS from

one-third of districts not reporting at all; an unacceptably large 'others' category in reporting both total incomes and expenditures; and over one-third of RKS income coming from user fees, which is regarded as a regressive form of financing. These findings suggest the need to move towards a different model of RKS in the state, given the availability of untied funds under NRHM. The report also notes that "Only 2.47 per cent of the patients were exempted charges for services on basis of BPL, although Madhya Pradesh has 37 per cent BPL population". There is also a concern that the untied fund given to the state's RKS is not visibly reflected in the accounts and the reasons for these needs to be ascertained.

- In Chhattisgarh, *Rogi Kalyan Samiti*s have been re-named *Jeevandeep samitis* and have developed a charter of improving the quality of services in a measurable manner. The level of achievement is certified after external verification and stars of recognition and incentives are awarded to the best performing facilities.
- In Jammu and Kashmir alone, this is yet to be operationalised- symptomatic of the relatively poor take off of the NRHM in this state.

3.1.3. However, the RKS approach is not without its problems. One of the most persistent problems with the RKS is the apparent reluctance towards utilisation of funds, lack of awareness or of delegation of powers. Even where there is a long tradition of working with such societies, officials are still not comfortable about spending the money. Part of the reason for this lies in mindset of vertical programme management and poor delegation of powers; part of it lies in the lack of clear enabling orders and guidelines. And, in certain cases, confusing and contradictory statements that place arbitrary ceilings on what can be spent is to be blamed. Many states have now overcome these problems; however, there are states which are yet to follow suit.

3.1.4. The other issue relating to RKS is the equity dimension. All RKS provide for fees exemption for those with a BPL card and pensioners. Yet, there exists a very ambivalent and ill-defined strategy for dealing with other categories of the poor. Equity of access is not a part of monitoring at any level, and the old perception of RKS as an alternative financing device and the consequent emphasis on user fees as cost recovery may not have completely gone. It should be mentioned here that in the state which gave the programme this name, equity exists between facilities and the linkage of untied funds. This, however, is not the case with all the states. West Bengal has mechanisms of moving money to facilities with fewer collections, but almost all states are allowing each facility to retain its fee collection, besides giving the same amount of NRHM grant to each facility irrespective of the amount they have collected.

3.1.5. If equity linkage is one challenge, performance linkage to both quality of care and volume of care provided is another issue. The flexibilities of funding have not yet been called upon to play such a role and thus better performing hospitals may not be getting the assistance they deserve even as funds get locked up with relatively poor performers.

3.1.6. The component of communitisation/ public participation is also limited. For instance in Uttar Pradesh, the only non-medical member of the RKS is the PRI representative, and there is no other form of community involvement in the decision-making or running of the institution.

3.2. The Untied fund for the sub-center

3.2.1. This is one strategy of the NRHM that has widespread appreciation from all levels of the system – and a very high level of utilisation. In all states, these bank accounts have been opened, the funds have been received and largely (60 to 70 per cent) spent. ANMs at the sub-

centre have been particularly benefited by inflow of united funds every year. They have used this money to improve the condition of the sub-centre and to equip themselves better.

3.2.2. There are a number of small long standing gaps – either in infrastructure maintenance, or in small conveniences like curtains or furniture that is essential for quality of care or in minor equipment like BP apparatus. Across the states, the untied funds have been used to close these gaps. It has also given a sense of responsibility, recognition and confidence to the ANM. In most places, there is a joint account operated between the ANM and the *pradhan* of the local *Gram Panchayat*. Though the team heard of complaints, no team actually met anyone who had such a conflict to relate. More often than not, there is a committee in place to administer these funds. Where there is such a committee and some broad guidelines in place, pressures from vested interests on these funds are minimal. Gujarat is an exception where the second signatory is the school teacher and not the *pradhan.*

3.2.3. There is some reason for concern that when the second tranche of money is received, there is insufficient clarity and ideas about how to expend it, now that the obvious immediate needs have been met. At this stage, having a village plan or village plans and a sub-centre development plan would be helpful. However, some degree of skill building is required if the ANM and MPW is to be able to make these plans or even to participate in its making. In its absence, the expenditure of the second round of Rs. 10,000 would be slower and perhaps with less relevance to access and quality of care issues.

3.3. Janini Suraksha Yojana

3.3.1. This is easily one of the most visible developments of the NRHM and, therefore, requires careful consideration. Every one of the 13 review teams tried to make their assessment of this programme.

Reading across their findings, there are many areas of commonality and some divergence.

3.3.2. One common finding across the board is a sharp rise in institutional deliveries. For example, the Bihar team reports that institutional deliveries in government facilities have risen dramatically to 4,25,253 between April-September 2007 – a jump of 62 per cent over the corresponding period in 2006. Almost all of this can be attributed to the monetary incentives offered under the JSY.[1] We found, for instance, that between 1995 and 2003, the CHC in Kishangarh conducted 33 deliveries a year on an average. This rose to 75 during 2004-05 and to 275 in 2006. Between January and mid November 2007, the CHC had already conducted 919 deliveries.

3.3.3. The second common feature across states is that the increase is largely on the public health system and this has in turn has put

[1] In rural areas, Government of Rajasthan pays Rs. 1400 to every woman who delivers in a government facility; and an additional Rs. 300 to cover transportation costs. The health worker accompanying the woman gets Rs. 500 (Rs. 400 paid at the time of delivery and the remaining Rs. 100 at the end of completing DPT 3)

tremendous pressure on the public health system to improve its performance. This represents a reversal of privatisation of the earlier period, which has been always described as not occurring by conscious choice but as imposed on the poor due to lack of services of any quality whatsoever in the public sector. This phenomenon of de-privatisation is best seen in a state like Tamil Nadu where near 100 per cent institutional delivery had already been achieved, and, as an impact of JSY, a shift of patients from the private sector to the public sector has been witnessed. In terms of impact on the poor, in a situation where there is no reimbursement for private care fees and where fees in the private sector are soaring, this de-privatisation is a step forward. A more detailed assessment from the Andhra Pradesh by the Mission team compares two districts to show that the percentage of total deliveries that happens in public institutions remains the same across districts and seems to be capped by the capacity of the public health system. Further increases in institutional delivery are achieved by spilling over into the private sector and in a poorer district no such movement occurs despite JSY. In Chhattisgarh, the failure of the public system to respond to absorb the increasing flow of referrals for delivery is being felt by the referring community health workers and not adequately by the health system. But in all states, the pressure is invariably on the public system and not on the private.

3.3.4. The third major cross-state finding is that the ability of the system to deliver quality of care has been limited and, at its current levels of efficacy, may not be as yet adequate to make a dent on the issue of maternal mortality. To some extent, the provision of labour rooms and basic equipment has kept pace because of the availability of untied

funds. But the rate of skilled birth assistance training is not at pace with the expansion of institutional delivery, and in the absence of the expanded set of skills that SBA training provides, the impact on maternal mortality would be low. Across the states, there is also a marked reluctance to book them as inpatients, and institutional deliveries may paradoxically not be reflected in IP statistics. The main reason is that post-delivery, 2 to 6 hours stay is the dominant practice when what is required is following the norm of at least 24 to 48 hours of post-delivery stay. Integration with neonatal care, post partum sterilisation and other aspects of RCH are also low. Quality assurance protocols and their monitoring, especially in terms of cleanliness, disposal of wastes, etc., would also help improve quality of institutional delivery.

3.3.5. The fourth major finding across states is that though human resource requirements have expanded consequently and though the NRHM provides for more nurses and ANMs in the system, recruitment is slow and limited because of absolute scarcity of potential recruits in the open market. The opening of more institutions for ANM and nursing schools is far behind schedules in those very states and areas where this is needed the most.

3.3.6. There is some concern that in the absence of increased skills or increased staff, what the JSY represents is a shift from ANM assisted delivery provided at home to ANM assisted delivery provided at the sub-centres, with a much less increase in institutional delivery in the true sense of the term. However, the ability to reach the desired level of care is now much enhanced as many sub-systems are in place. And with more skills imparted, better quality protocols, and with linkages to other components of RCH as well as referral transport

systems, a substantial improvement in care at pregnancy and early childhood is at hand.

3.3.7. Issue of timely payments to the pregnant women and of payments not reaching ASHAs due to a number of inessential clauses (e.g. ASHA should stay for 48 hours in the facility for getting a fund, or her name should be entered at the time of pregnancy registration) or due to plain carelessness are also common across the states. Most state governments are, however, more aware of this problem (as compared to the predecessors) and many states like Rajasthan have simplified the system. Women who deliver in institutions are given a bearer cheque that can be cashed the same day, irrespective of whether they have a bank account or not. Transparency in maintaining accounts and constraints in flow of funds and their timely accounting are other problems some of the states are facing.

3.3.8. Many health officials and workers expressed concern over the future of the JSY, especially since the coverage extends to all women and the fund flow does not seem to be matching with the growing demand. There is also very little likelihood that such a demand side approach can be extended to any other medical condition, given the costs.

3.3.9. An even more controversial issue is the increase in compensation for lost wages paid to men and women under sterilisation. In the case of women, the demand for sterilisation was high; and the real constraint was in terms of ensuring safe good quality service. With men, most health workers felt that money – and that too Rs. 1100 – could not be the determining factor. They also felt that introduction of money often corrupts the system and, given the huge demand and the failure of the system to be able to meet this demand, such

monetary incentive was quite unnecessary. We noticed that in most states, a small portion of the sterilisation "motivator" incentive flows to ASHAs and many states have liberalised rules for this scheme such that a wide variety of persons can be eligible for this. Given the fact that amongst contenders for the motivation incentive (*Anganwadi* worker, ANM, *pradhan*, male worker, etc.), the ASHA has the least bargaining power, which is not surprising. And read along with the fact that motivation in most districts is no longer necessary, the system may just be handing out a record compensation package to its own employees and the local elite. This needs to be studied immediately.

3.3.10. There is a good public awareness on the JSY programme in all the states, except in J&K, and in an entirely different context, Tamil Nadu (the JSY-like Dr. Muthhulakshmi Reddy scheme). The programme publicity as well as details of its rules are widely available in most of the states visited.

3.4. *Other PPP or risk pooling initiatives*:

The Mission focus did not lead to any significant examination of these options. However, it did encounter some form of PPPs in most states.

3.4.1. The NGO partnerships, especially the MNGO programme, did come up in many state reviews and these have been discussed earlier.

3.4.2. In West Bengal, there have been a number of initiatives in establishing PPPs that strengthen the public system. This includes establishment of a number of ANM training schools, outsourcing of 3 mechanised laundry units to service 30 government hospitals in Kolkata, construction of night shelters and toilet complexes, outsourcing of diagnostic units for 87 government hospitals and

similar plans for another 74 block PHCs, and procurement of 334 ambulances. In Tamil Nadu and Andhra Pradesh, PPPs are most prominent and almost exclusively in the domain of providing ambulance services. Tamil Nadu, in some of its schemes, is limiting the emergency ambulance service to neo-nates or to emergency obstetric care, in which case its viability would need to be examined. Gujarat, Chhattisgarh, Madhya Pradesh, Orissa, and West Bengal have all gone for contracting out mobile medical units to NGOs. In Bhopal, the CMES (Center for Emergency Maternal Services), which is run in a public-private partnership with a local NGO, has software that compiles data on pregnant women with mechanism for reminders on their EDDs and other health relevant dates. Accordingly, the NGO makes phone calls and keeps track of the actions to be taken at their end during the entire pregnancy till childbirth. The same NGO also provides emergency transport service to nearest accredited private institutions for deliveries when they receive phone calls requesting for the transport. In Gujarat, the *Chiranjeevi* scheme has been able to build a workable model of PPPs for provision of comprehensive emergency obstetric care and institutional delivery, which has been widely appreciated. Institutional deliveries have shot up and the rate of emergency obstetric care provision approaches the desired norms – being neither too high nor too low. However, the report has raised some larger issues for discussion. In Bihar, a major effort at contracting out PHCs to NGOs has come to a standstill and been reversed due to serious problems of both design and implementation.

3.4.3. The overall picture from most states is clearly of a limited and carefully chosen use of public-private partnerships, most of which are being used as supplements to strengthen public health care provision. The most important and universal of these PPP innovations, and also the only one which represents a general trend, is the emergency referral transport system and the mobile medical

unit. On the latter, the Andhra Pradesh report is overwhelming in its praise – *"If our founding fathers were drafting the Constitution today, they would have included this facility as one of the fundamental rights".*

3.4.4. There is also considerable innovation in terms of taking advantage of the flexibility provided and using state funds. The results are mixed with some being promising and some not doing well.

4. Improved Programme management

One of the central pillars of the corrected architecture of the health sector that the NRHM intends to achieve is improved health sector management. The NRHM has five core strategies that address this dimension. One is the creation of integrated district and state health societies as measures of horizontal integration and convergence, better governance and participatory decision making. The second is the induction of a number of contractual staff with management skills, i.e. programme management, data management and financial management. The third is the building up of state level institutions. The directorates of health services, the state programme management units of the registered societies, the SIHFW or equivalent, the state health systems resource centre and a autonomous body or empowered cell for management of procurement and another for civil works are some of the institutions that need to be created or strengthened. These many bodies are not necessarily duplications. Rather they are institutional forms of specific skills and a body of domain specific experience for which an experienced team and an institutional memory needs to be built up. With a clear demarcation of roles and deliverables for each of these institutions, programme management could be made much more effective than it is today. Though potentially all of them could be telescoped into one or two institutions, the leadership competencies required are such that separate structures have in practice been more viable than bringing them all under one roof.

4.1. State health societies and district health societies have been created in all states. The level of integration, however, varies. In most states, district health societies of the TB, malaria, blindness and leprosy control programmes have separate accounts and may also be retaining their separate registration. In most states, the state health societies have brought all these programmes under the common health society, except for the AIDS control society. However, each has a sub-account and makes their state plans independently, integrating them only at the level of the final document. This could be seen as a failure of integration, or alternatively it could be seen as the level of integration that programme managers and different stakeholders are comfortable with. For purposes of operationalising the NRHM objectives, such integration should be adequate. Further integration could be achieved as and when the vertical programmes perceive the need for more systemic coordination and for improvement of health systems that have an impact on the performance of their programmes.

4.2. There is, however, much more to be done to ensure that these societies are able to provide better governance, better transparency and participation. Key officials of these bodies as of the department itself are changed far too often to get adequate experience. Where there is some continuity, like in Gujarat or Tamil Nadu or in West Bengal, the difference is positive and visible. But in the EAG states like Bihar and Uttar Pradesh, where the problems are most, the changes are also most frequent. Meetings need to be more frequent and they need to become major sites of decision making. The composition of these bodies and the efficiency with which they function and deliver needs further studies to draw lessons for optimising this strategy. Based on such studies, indicators of good governance could be developed so as to be able to estimate what contribution this element makes to poor performance.

4.3. Progress has been good in the inculcation of management skills into the contractual staff at the district and state levels. District and state PMUs, as per NRHM norms, have been established at state and district levels in Tripura, Rajasthan, Assam, Orissa, Madhya Pradesh, and Chhattisgarh. District and block level managers have added new energy to the system of health care delivery. There is a 15 to 30 per cent vacancy situation in most of these states, but that is not unexpected. Processes are on for establishing block level PMUs. This course of action has been found useful enough to call for its replication at the block level, and most states are planning to include block level programme managers and accountants. We, however, noticed that the states of Uttar Pradesh, Tamil Nadu and Andhra Pradesh have not yet exercised this option. Uttar Pradesh has a number of posts at the administrative level in the district, and West Bengal, Tamil Nadu and Andhra Pradesh have different forms of administrative cadre. It is worth considering whether this has a correlation. However, even these states are opting for these posts after noticing its positive impact in other states. We also noted that there are a number of unresolved workforce issues with this cadre, such as no increments, no regular appraisals, no clear extension period or security of contractual tenure and no career graphs. These need to be resolved on a priority basis.

4.4. The institutional framework proposed for the state level health systems management has evolved differently in different states and it would be useful for more active cross-learning of experiences. Gujarat has set the prototype and benchmark for a state level institution to manage infrastructure development. Tamil Nadu has created the benchmark of state level institution to manage drug and supplies procurement. Andhra Pradesh has a similar institutional arrangement to Tamil Nadu which also manages infrastructure. Bihar is planning a construction corporation. Chhattisgarh currently represents the benchmark for an institution to

manage community processes. Rajasthan has started an ASHA resource centre. Other states are considering similar structures but none have started any work on this front as of now. State Health Systems Resource Centres have not started functioning as envisaged in any other state and there are no special efforts to strengthen SIHFWs. Hence, the institutional framework at the state level to strengthen health systems management is an urgent priority.

4.5. Nine District Child Health Coordinators out of 18 have been hired for implementation of IMNCI in Rajasthan. There are suggestions to consider more district programme managers for different functions. Before we consider these, one needs to look at the techno-managerial role played by the programme officers of the district. There is a need to consider the technical staff available at each district who are playing managerial roles. Most states have four of five programme officers under different vertical programmes, but this is not the same as having a cadre of deputy chief medical officers allotted different programmes as in the case of Uttar Pradesh. Tamil Nadu has created a cadre of deputy directors of public health who are interchangeable with the assistant professors of preventive and social medicine in the state medical colleges, and these younger officers committed to a career in public health management are in charge of primary health care in the districts. It is worth noting that these two states have not opted for the district PMU staff.

4.6. The integration of PMU staff with the rest of the system still remains a challenge. As of now, they are seen as agents of a new programme, NRHM, whose sole function is to ensure that funds coming from NRHM are properly accounted for, as there is not enough trust in the existing system to do so. This has created some dissatisfaction among the regular staff, which has been attributed to the difference in remunerations paid to them and the PMU staff. There is also a sub-optimal use of the skills of

the PMU staff, most of them being relegated to secretarial support functions rather than management and planning. The trend of having separate trainings and arrangements for them, exclusive of the other administrative staff, is not helping. Workforce management principles for contractual staff have also not stabilised. Integration rests not only on taking care of these concerns of both the PMU and regular staff, but also on working out ways to build a team by giving them equal training and support.

4.7. Financial Management procedures are being improved. One major step forward is the use of e-transfer of funds up to the districts. This has occurred in most states but is yet to happen in Bihar and Jammu & Kashmir. The other important step is the increase in accounting staff under contractual appointment at the state, district and block levels. West Bengal has appointed one regular government accounts officer at the district level from its accounts and audit cadre and is planning to raise the number to two. It has hired contractual block accounts managers for all the blocks at Rs. 8000 per month. The Finance Manager and other supportive staff at the state level are in position. The financial powers were delegated adequately to the districts, MOs in-charge and various committees. The system of concurrent audit is unique to Madhya Pradesh and is very effective in ensuring timely reports, and is worth replicating by other states.

5. *Functioning against the norms*

5.1. The establishment of standards and norms is another key pillar of the NRHM framework. The IPHS taskforce laid out the standards for sub-centres, PHCs, CHCs, sub-divisional hospitals and district hospitals. Each of these standards specifies the population norms it should fulfil, the human resources it should deploy, and the services packages expected of it. The IPHS mainly specifies the norms regarding infrastructure,

equipment, drugs and supplies. In addition, the NRHM framework for implementation specifies the service guarantees for each level of services.

5.2. One observation with respect to assessing progress against norms is the variable nature of nomenclature. PHCs could mean at a one per 30,000 norms or at one per 1 lakh norm. It could mean no beds, or six beds or 30 beds. It could mean one doctor or two doctors or four specialists plus two medical officers depending on the context of usage. The term CHC could be reserved for a 30 bed, 6 doctor hospital or it could be used loosely for a PHC, so designated on paper with no accompanying changes. There is a need to agree to some standard usages at least within states, and work out their correspondence with IPHS terms to help the process further.

5.3. The IPHS standards have been widely circulated, but, more often than not, they have been read as a prescription of inputs and not as a prescription of outputs or as a service delivery guarantee. Thus, there is almost no effort to increase service delivery outcomes for a given level of inputs. This is most evident in a state like Jammu & Kashmir where inputs are adequate but there is no corresponding output. But even in other states, this picture was often obtained. For example, the District Hospital in Alwar, the CHC in Kishengarh, and the sub-centre at Dhani were fairly well-equipped in terms of facilities, staff, and delivering services. However, conditions were not as good in the CHC at Thana Gaji and the PHC at Harore, nor were they delivering even the services that they were capable of. In the absence of such outputs that match the current level of inputs, it is not useful to pay attention only to expanding inputs. In some states, notably Tripura, there is a conscious effort to reach the service guarantees specified and even to convey this to the public. In most states, the public is unaware of the service guarantees of the IPHS and there are no efforts to display this.

5.4. The major strategy form in which IPHS standards are to be implemented are in the form of facility surveys that have been completed or are nearing completion in almost all of the states visited. This is being used to close the gaps between what is required and what is present. While conducting the facility surveys for the health facilities, the Medical Officer should be a part of team so that he will also be aware of the gaps in the health facility. Though this stratagem is enough to close gaps in hardware, it is inadequate to close gaps in human resources, its motivation and its skills. The programme has reached the stage where the states are well aware of the hardware gaps.

5.5. In a number of states like Rajasthan, Tamil Nadu, West Bengal, Andhra Pradesh, and Orissa, there are state partnership plans with bilateral or multilateral funding agencies that seek to improve health systems. NRHM inputs have further supplemented the efforts and they have been quick to build on this.

5.6. Innovations in Human Resource Management: This is another core strategy of the NRHM. The NRHM is committed to finding solutions to some of the key constraints that the public health sector has been facing in terms of recruitment and deployment to rural areas, workforce skills and workforce performance This is discussed in detail later in section 6.0.

Section 4 - IMPACT ON CRITICAL AREAS OF CONCERN

1. **Fully Functional Facilities**: Fully functional sub-centres, PHCs, CHCs, and division district hospitals:

1.1. This is assessed under the heads of sub-centres, PHCs, CHCs, sub-divisional hospitals and district hospitals, laboratory and diagnostic

services, infrastructure and maintenance gaps, drugs and logistics issues, and waste disposal systems.

1.2. **Sub-centres**

1.2.1. Most states report an improvement of services due to filling up of vacancies and improved monitoring, and also due to the untied funds that has overcome many small constraints and given confidence. The main services available in the sub-centre are immunisations, ANC services and DOTS. In most states, the sub-centres were not the main site of delivery and often they were conducting none – mostly referring delivery cases to health facilities and not actually conducting deliveries. Sub-centres in Andhra Pradesh or in Tripura and West Bengal do not perform delivery. Similarly, IUD insertions were not a feature of sub-centres and this was attributed to poor demand for these services. There was an insistence in these states that ANMs could not be persuaded to do these services though in fact they are done by ANMs in many states. The sub-center records and registers were found to be up-to-date and properly filled up. They also had records of JSY beneficiaries in their area. The untied funds had made a big difference to the sub-centres. The second ANM could make a difference but at no place visited had this happened and, therefore, it is difficult to judge. It would be important to break the belief that activities like deliveries cannot be carried out by ANMs in those states where this is a problem before appointing the second ANM. In some states, there is a clear roadmap evident as to how the second ANM could be put in place. In most states, there is a decision to do so but not much of a roadmap.

1.2.2. To call it a fully functional sub-centre, the roles of the male worker in disease control, and the role of both male and female workers in first contact curative care needs to be enhanced. The core RCH activities depend on the vaccine delivery system, and the efficiency

and quality and regularity with which outreach services are organised and the community processes that support her. The improvement in vaccine delivery and the improved quality and regularity of the immunisation session expanded into the health and nutrition day are recorded in most states visited – though in quality of care per se there is no evidence either way. Infrastructure, drugs and supplies continue to be major constraints and these are discussed further below.

1.3. PHCs

1.3.1. The situation in PHCs varies very widely across the states. The problem of assessment is also confounded by issues of nomenclature. Most states still refer to the facility of one per block or per 1.2 lakh population as the PHC, and the facility of one per 30,000 as additional PHC. (The area being catered to by one such additional PHC is referred to as a sector). In such cases, the CHC is a subset of the block PHCs which have been re-designated thus. In some states, such re-designation implies that administrative sanction for posts in conformity with the CHC has been sanctioned. Sometime such sanction is only intended. Others like the Mohanpur CHC has 20 beds and there is a fully functional lab (all routine tests, sputum and slide examinations), X-ray (60mA), etc., but it is not a FRU as OT is not functional and there are no anaesthetists. And nor is there a plan of moving it to IPHS norms. Thus, the definition of a CHC and what people understand by this is variable.

1.3.2. Ideally for a block of population of 1.2 lakhs, there should be at least four sector PHCs catering to 30,000 each and one CHC. There is some need for clarity whether one of the sector PHCs should be incorporated into the CHC or should be over and above it. (4 PHCs plus one CHC in a block of 1.2 lakh population of 3 PHCs plus one CHC). If it is incorporated into it, the staff of the PHC should be

additionally available in the CHC. In practice, of course, the number of PHCs per block is often less than three and this is one area where the gap between the norms and the situation on the ground is maximal. For example, the Mission reports from Tripura that the coverage of the PHCs varied from 5000 to 1.2 lakhs.

1.3.3. Out patient attendance is varied but most states, except Jammu & Kashmir, report sizeable increases. In Tripura, the OPD attendance was around 100 per day for all the PHCs. Functional bed strength varied from six to ten beds, with bed occupancy being more than 100 per cent in summer and monsoon seasons. Cases admitted at present were mostly fever cases. On an average, the PHCs were conducting 20-50 deliveries per month. By any form of measurement, this is a 24X7 PHC – and though the full package of services, as specified in the IPHS, is not yet in place, it is well on the way to achieving this. In other states, the increase is less dramatic and less uniform. Orissa and Rajasthan report general increases. Increases in Chhattisgarh and Madhya Pradesh are more varied. In Jammu & Kashmir, there is no definite evidence of increase. In Bihar,

the increase is in block PHCs – the situation in sector PHCs being less clear.

1.3.4. The factors that have helped most, other than a general seriousness to revive them, are the contractual appointment of staff in PHCs, especially of nurses. Thus Tripura, which has implemented it, has performed much better than say Uttar Pradesh, where there is no special effort seen to increase nurse strength in the PHCs. Tamil Nadu has made 780 of its 1421 PHCs into three nurses PHCs and the rest would be made so in the coming two years. On the other hand, it is clear that it is not going for the two ANM option. Planned, phased and well thought out, Tamil Nadu remains a leader in most reforms that it chooses to act on.

1.3.5. Many states have put special effort into filling doctor's vacancy in PHCs, which is an old problem. Uttar Pradesh has had a policy of using AYUSH doctors as one of two doctors posted at the PHC was from the AYUSH stream. In Chhattisgarh, AYUSH doctors had been recruited to close medical officers' gap and the existing vacancies were much limited. In Orissa and in a number of other states, pre-PG compulsory rural posting in the public service has helped fill substantial gaps. In Tripura, there were two or more doctors per PHC as required under the IPHS norms. We note, however, that Andhra Pradesh still reports low caseloads even of institutional delivery in 24X7 PHCs due to lack of manpower. This, despite having one of the largest number of medical colleges, all of which is in the private sector.

1.3.6. Hardware gaps continued to trouble despite facility surveys and untied funds. For example, in Bihar, no PHC had a generator, causing problems in maintaining cold-chain in case of power cut for

more than 24 hours. However, the funds are in place, the gaps are clearly delineated, and there is every reason for confidence that with some enabling support these gaps can be bridged within this year.

1.4. CHCs

1.4.1. In CHCs, the criteria of "fully functional" is to achieve a level of good quality in patient care as well as basic surgical and emergency services. This is in respect to the RCH programme equivalent to the creation of a FRU or Cemonc centre – but as most of the inputs required for these two are the same for any basic surgery and referral care, other than the skills – creating a CHC as per IPHS standards and a FRU or a comprehensive emergency obstetric care centre are not that different a task – except for the skilled human resource component.

1.4.2. With this understanding, there is a need to synchronise the FRU and CEmONC creation goals with the health facility development goals. The overlaps must also be clearly stated so as to prevent duplication of efforts. Thus, if a block has a rural hospital or a sub-divisional hospital or a district hospital, does it need a separate CHC or FRU or just adequate staff in the district/sub-divisional hospital? (Similarly if a sector has a CHC or block PHC in it, does it plan for a 24 hour or for that matter any PHC? If a section has a PHC in it, does it need a sub-centre?) These seem to have obvious answers but in practice there seems to be duplication occurring due to a complex of reasons (for instance, often PHCs/CHCs are under a different directorate from the sub-divisional hospital, etc.,) that leaves both institutions short of human resource.

1.4.3. There has been a marked increase in the functioning of CHCs, both in terms of the quantity and range of care they offer. Bed occupancy

at the CHC in Alwar, for instance, is 70 per cent now; and during summers, it rises to 100 per cent. This improvement is not uniform across the states but the graph is upwards. However, many state reports give a more varied picture.

1.4.4. Of more concern is that most CHCs visited are still functioning at the level of PHCs, unable to make the transition to regular full occupancy in patient care and a wide range of specialist services. The critical gaps are in specialists and nurses though there are sufficient examples of facilities where these were in place but services had not reached the benchmark. There is obviously a need to address all three aspects of workforce – recruitment, adequate skills, and performance though better accountability and support to get to the levels of service delivery required. Of both PHCs and CHCs, the observation has been made from many states that even RCH is often translating into antenatal care and care at delivery and immunisation. The other components, fixed sterilisation day per week, safe abortion services, adolescent clinics, RTI/STI clinics, infertility services, newborn care, institutional care for the sick child, care for the sick malnourished child, all lag behind. This is not an unavailability of human resource problem. It is a skill and workforce organisation issue. In short, turning every block PHC into a CHC is still a long way ahead and many states seem to have settled for making the district and sub-divisional hospitals functional rather than trying for a goal that they have little confidence in reaching.

1.4.5. One other interesting observation of a CHC in Gujarat is worth recording. “In the current year, a total of 133 medico-legal cases were dealt with by the CHC. In the current year, a total of 15 post-mortems are conducted by the CHC”. The legal obligations of the district health system and even of district hospitals and CHCs are less discussed on

literature and not the object of studies. Yet this is an important role that the public health system delivers for which there is no substitute. The level of assistance and capacity building this needs has to be estimated and this function also needs to be brought within the planning horizon.

1.5. Sub-divisional hospitals and district hospitals

1.5.1. In contrast to the observations reported by the Mission on CHCs, there is not only a marked increase in the load that district hospitals and sub-divisional hospitals are undertaking, all the changes expected of the CHC are taking place in almost all the states visited. The criteria of a good district seems to be largely influenced by a well functioning district hospital. For instance, at the District Hospital in Alwar, we found that apart from institutional deliveries, there was a noticeable increase in inpatient treatment, out-door care, surgical operations, and laboratory investigations.

1.5.2. This is probably because with human resource constraints being less restrictive, the system responds to the rest of the NRHM inputs promptly and positively. With the untied funds regularised, *Rogi Kalyan Samiti* functioning, and improvements in bed occupancy, the closure of diagnostic gaps are all much faster. Much of this is perhaps responsive to the general increase in interest in strengthening public health systems, and part of it is responsive to the increased referrals from the *Janini Suraksha Yojana* programme and the increased referrals consequent on improvements of functioning of the peripheral facilities and of the ASHA programme.

1.6. Laboratory and diagnostic services

1.6.1. This has improved at the district hospital level. Though some improvements have been made in the CHC level, it tapers off to even

lesser levels of improvement in the PHC and sub-centre level. There is little focus on reaching IPHS standards as such, except for the visible diagnostic of ultrasound and X-ray machines at the district hospital and CHC.

1.6.2. There has been a NRHM focus on sharing of laboratory infrastructure, equipment and the technician between various vertical programmes as one of the most recognised issues of horizontal integration between programmes. But, as the Mission showed, this recognition of the need to do this has not yet translated into action in the field. There is a need to reiterate this goal and keep up the pressure to achieving it.

1.6.3. In Bihar, in view of the gross shortfall in laboratory technicians, the state opted for private sector participation in provision of laboratory services. These services have been outsourced and the timings of sample collection are well displayed at the health facilities. The available X-ray machines are provided to the outsourced agency. The outsourcing has been effective in ensuring the services at 24x7 PHCs. These services are in the process of being extended to all other PHCs and other health facilities, including medical colleges.

1.6.4. Court cases impede laboratory technician recruitment in West Bengal and Orissa.

Sivasagar DC examining a TB microscope in the Health Mela

1.7. Logistics and supplies

1.7.1. In most of the states visited, the Mission team recorded absolute improvement in the availability of drugs and supplies and none of the states reported poor quality or access to health care due to lack of these. Nor were there complaints of lack of funds for drugs and supplies.

1.7.2. However, regularity in drug supply was poor in most sub-centres visited. This situation was more varied in PHCs and CHCs visited and reasonably acceptable at the district hospitals visited.

1.7.3. The central problem seems to be that in most states, except Tamil Nadu, the distribution is still supply driven and not automatically responsive to changing patterns of consumption. Thus, a fixed set of

supplies reach every facility in the form of kits or quotas with a varying periodicity. There would be a quick stock out of high turnover drugs and wastage of low turnover drugs. In one instance, large amount of baby face masks to be used in OTs were lying in the store. This is clearly a waste because such a large number cannot be used at any facility in the jurisdiction. There are many such examples of what we call supply driven logistics.

1.7.4. The problem is worst at the sub-centre level where, by definition, drugs are supplied in the kit mode. As we go higher, there is more space for indenting and responsive supplies to indents, which decreases the problem. Considerable facilitation is needed to put the logistics system in place in other states, similar to what Tamil Nadu has done.

1.7.5. Good distribution and logistics needs a sound procurement policy, the benchmark of which is the Tamil Nadu system. Most states are committed to moving towards this – and many states like Andhra Pradesh, Gujarat and West Bengal have made some strides in this regard – but nowhere has it reached the benchmark levels. In west Bengal, the budgets are communicated to district CMHOs and the rate contract for each drug is fixed at the state level. The state is also considering the establishment of a WB warehouse corporation for procurement of drugs and equipment. As an issue of good governance, this needs to be monitored.

1.8. Infrastructure and maintenance issues

1.8.1. Lack of adequate buildings of their own remains a problem. This problem is maximal for sub-centres where rented space is often not adequate. (For example, four of the six SCs visited were running from donated/ rented buildings but had adequate space, except one in Bhabanipur). More often than not, PHCs and CHCs were running

from government buildings but with sizes less than those specified under the IPHS norms.

1.8.2. Most state visits report considerable activity in the civil works area – some going as far as to state they found it everywhere they visited. Since in many states this represents a catching up after years of stagnation, this is not unexpected. Also in many states, much of the funds is locked up in civil works, which is slowing down rates of expenditure.

Logistics and drugs and supplies: Stock register showed frequent stock-out problems in all the SCs, especially for PCM. DOTS and malaria drugs were available in sufficient quantity. It was observed that stock of any particular medicine was allowed to fall below average monthly consumption and reach zero balance before new indenting.

1.8.3. It seems that while PHC constructions could be matched by human resource and equipment to reach the desired outputs, the same cannot be said of the construction of CHCs where the human resource gaps and skill gaps remain far behind. However, in district hospitals and sub-divisional hospitals – since manpower is less of a constraint – inputs of infrastructure are matched by expected outputs in terms of increase in services.

1.8.4. Cleanliness and maintenance is an issue and the situation is varied across the states. Most states have used their untied funds and the special maintenance grant towards this end. Many states have added considerable investment of their own. Thus, except for three states – Bihar, Jammu & Kashmir and Madhya Pradesh, the reports speak of a high level of cleanliness in all the facilities visited. This was particularly so in Uttar Pradesh where cleanliness was receiving the highest political priority as well.

1.9. Waste Disposal Systems

In most states, sub-centres were using disposable syringes. In contrast, hub cutters were often rusted and unused. Syringes and needles were not decontaminated and proper mechanisms for needle disposal in pits are not in place. Similarly, the segregation of waste at source in PHCs, CHCs and district hospitals were not observed in most of the states visited. Though instructions are known, there is much more facilitation and training needed to achieve this. Even where PCB has certified the facility, the minimum requirements of waste disposal were not being met.

1.10. Summarising

Increased confidence in government facilities: We found a general increase in the use of government health facilities that signals a positive

change in people's perceptions regarding government health facilities. Observing the improved facilities at the time of deliveries has made people regain their confidence in government services. The better position in drugs and supplies, increase in manpower, and use of untied funds is reflected in the increased use of government facilities.

2. Human Resources for Health

2.1. This is discussed in terms of numerical adequacy and the requisite skill mix. Then we discuss issues of workforce management and then issues of capacity building and finally to issues related to workforce performance.

2.2. Numeric Adequacy and the skill mix

2.2.1. One major step undertaken by the NRHM has been to increase the total number of posts by firming up norms (under IPHS) of how many posts are needed at each level and offering to fund them for contractual appointment. There was a condition attached that funding for contractual appointments would flow only if there are corresponding efforts to fill up regular posts by the state government.

2.2.2. These measures together led to a considerable filling up of existing vacancies. Madhya Pradesh, for example, has filled up all male worker vacancies and many other states are following in this. ANM vacancies in most states are less than ten per cent – and this is a precondition for the second post. Similarly, medical officer posts in PHCs have received attention and a variety of means of recruitment have lowered the vacancy position considerably. Thus, even without actually expending NRHM funds, most vacancies – except that of the specialist posts and to some extent of nursing – have received a push to fill up vacancies.

2.2.3. The IPHS has raised the nursing posts in the system considerably. Instead of one, the NRHM is now willing to fund two ANMs per sub-centre. Instead of none or one nurse at best that current PHCs are deploying, the NRHM is recommending and funding up to three nurses per primary health centre and nine per CHC. Most states that had not utilised this option earlier are struggling to find ways of filling these posts up – for that many nurses or ANMs are simply not available for hire. West Bengal leads in the rollout of this component. The government has taken the decision to appoint married women residents of the local area, as chosen by the *Panchayat*, to this second post. The revised sub-centre building design can house two ANMs and costs Rs 8.5 lakhs to build, of which a Rs. 3.6 lakh share is being picked up by the state government. The state has established 49 ANM training schools, including an existing 18, and 3527 ANMs are under pre-service training and certification programmes. Most of these new ANM schools are under PPP arrangements and once this sudden increase has been met, the state can cut back to a regular smaller number of schools for annual replenishment.

Tamil Nadu has chosen another route, more appropriate to its stage of development. It has no ANM training school and does not intend to start any. Instead it is able to produce 6000 staff nurses every year from its 21 government and 53 private nursing schools. ANM (called VHN cadre) exists in the state but under its present rules, it is a cadre promotion of *anganwadi* worker who after ten years' service qualifies through the 18 month training programme leading to a much older entry point. The state has chosen to focus on increasing nurses in the PHC and not go for the second ANM option in the sub-centre.

Rajasthan is actively recruiting nurses and, to a large extent, has been successful in dong so. Bihar reports the posting of 2nd ANM in 40 per cent of sub-centres. Chhattisgarh, on the other hand, has not yet started though it is stated in its PIP. Uttar Pradesh has opened the posts but states that its inablity to find qualified nurses – partly because they have defined their qualifications in an improper manner, leading to an artificial scarcity. Tripura and most other states have started the process but have found only a small part of the workforce needed. This, in turn, has brought pressures on a rapid revival of existing ANM schools and a rapid increase in new ANM schools and nursing schools in all these states. However, the ground reality remains that except in a few states, it is going to take a few years before the positive impact of these changes are felt. Gujarat efforts in expanding the nursing/ANM force is also limited reflecting, perhaps, a poor confidence in this cadre being able to make a dent. Their focus on the PPP approach is seen as filling the gap, and vacancies at government institutions remain one of the highest (43 per cent – without the expanded post sanctions under NRHM).

2.2.4. The IPHS has raised the norm for medical officers in PHCs to two per PHC (additional PHC or sector PHC). Tamil Nadu already has this in place. Few states like Chhattisgarh have created that many posts in the state sector itself. But Chhattisgarh has not yet started filling up these posts even two years after its creation. Others are considering filling it with contractual staff under NRHM, but no state has started doing this as yet for the second MO. However, states have filled up the first medical officer post with either a compulsory pre-PG rural posting of a fresh graduate, or an AYUSH doctor. Both of these are without specific induction training and that would limit their utility. Meanwhile, there is also a sharp improvement in medical officer vacancy situation in a number of states. Uttar Pradesh has sanctioned a post of an allopathic medical officer (MOIC) and one of

an AYUSH medical officer (MOCH) for each PHC. This is a step forward if they implement it uniformly and provide the drugs and other support to the AYUSH practitioner. At present, its implementation is patchy. West Bengal has given powers to *Gram Panchayats* for recruiting medical officers in underserved areas for outreach services for 3 days a week. On the other hand, some states like Gujarat, a good performer by many scores, is not doing well in this and is still facing problems of doctors and nurses shifted away from places they are posted in on deputation orders.

2.2.5. For the CHC, instead of 11 specialists as recommended by IPHS, most states have sanctioned a more manageable earlier norm of 4 or 5 specialists and 2 or 3 medical officers. The IPHS recommendation for specialists appears to be set too high to act as a reference point.

2.2.6. Specialist shortages cripple the system. Some of it can be improved by rationalisation – like gynaecologists and anaesthetists not being posted in the same place. But such improvements, though important to show the government's resolve, would still not be adequate to make up for the gap. It is also worth noting that the usual approaches to posting and transfers of staff based on seniority and cadre, when applied mechanically to specialists, leads to considerable problems in service delivery. The need to build up a specialist cadre and a postings policy for them around the "service guarantees", which each facility has to ensure, remains a challenge.

2.2.7. New recruitment of specialists has been given priority in many states. But the turn out is limited. Joining rate against advertised posts is 15 to 20 per cent in West Bengal and there are similar reports in most states which have tried the regular route.

2.2.8. The route of contracting in specialists from the private sector is unanimously accepted at the policy level, but in practice, either due to lack of private sector where it is needed most, or due to the nature of relationships between professional practitioners, very few states have been able to make a big difference by such contracting in.

2.2.9. Lack of satisfactory remuneration is another major constraint. The current payments are far too low to attract or retain specialists. In many states, regular employment still starts at Rs. 8000 per month and contractual at Rs. 10,000 or 15,000 per month. Again manpower recruitments at the specialist level could be augmented if we are able to pay market rates, which the Andhra Pradesh report points out, is an option available under GFR 2005 rules. However, this rule has not yet been evoked in the context of finding specialists for rural service, and this may be one option that needs to be considered further. Madhya Pradesh, meanwhile, has been able to make some headway in finding specialists by offering a larger initial package with a good performance based incentive thrown in.

2.3. Increasing professional and technical education

2.3.1. The gaps between the generation of skilled human resources and their requirements are large and growing, and only a massive expansion of nursing education can meet the demand. Of 400 posts of nurses advertised in Tripura, only around 70 joined; and similar reports came in from most of the states. Every state had gone through the experience of letting their ANM schools wind down and were now in the process of reviving them as well as opening new schools. A state-wide assessment of the situation reads thus:

- ***Tripura:*** There are only two ANM training centres in the state, with one in south district. Both put together are producing 50 ANMs

every 1.5 years. One MPW (Male) training centre functional in Agartala is expanding to 100 seats. Nursing college started functioning under PPP for GNM courses.

- ***Rajasthan:*** Five new ANM training centres are being established. MPW (M) training centres are non-functional in the state. State expressed that GNM may be allowed to function against the post of MPW(M).
- ***Bihar:*** The state is reviving 12 ANM schools.
- ***Orissa:*** There has been a 33 per cent increase in seats in the existing ANM schools and new nursing schools are being established.
- ***Uttar Pradesh:*** Has 49 ANM schools of which 27 can be made immediately functional. However, only one batch has been turned out between the mid-1990s and now. The next batch is yet to join, though a decision on this has already been taken up. Male MPW schools are limited and not functional.
- ***Tamil Nadu:*** There are no new ANM schools and all earlier schools have been converted to nursing schools. At present, there exists 21 government run and 53 private nursing schools. Male MPW schools are also not considered.
- ***West Bengal:*** Has established 49 ANM training schools besides reviving an existing 18. There are 3527 ANMs under pre-service training and certification programmes. Male MPW schools are not functional.
- ***Madhya Pradesh:*** At present, 29 existing ANM schools run by the government have been revived and proposals from 19 districts for setting up private ANM schools are in pipeline to augment the creation of ANMs. Sponsored development of faculty and select technical cadre in private schools is being used to accelerate progress.

- ***Chhattisgarh:*** Has 6 ANM training and 3 MPW training schools. These have been revived. Their plans include expansion to 16 ANM schools and as many nursing schools with ANM schools being prioritised for distant blocks. However, despite the fact that plans have been on for two years now, operationalisation has not begun.

2.3.2. The situation is similar to nurses but relatively less acute for MBBS doctors. This too is partly because most states are not aspiring to meet the IPHS recommendations. Regional variation is also high. Bihar is finding doctors though it has a shortfall of medical colleges, as many have graduated in colleges outside. In contrast, Tripura is not. Following an advertisement for 300 posts vacant for doctors, only 67 turned up. There is no local "production" of doctors, as state medical college will pass out the 1st batch only in the next 3-4 years. There are two medical colleges running in the state with 100 seats each, with one under PPP. MBBS is the only course offered by these colleges, apart from DNBE at the government medical colleges. When they are in full production, Tripura should have a big excess – one year's output being equal to the needs of the entire public health system. But currently they remain in deficit.

2.3.3. Quality of professional education is a problem and this is exacerbated by the rapid expansion of the courses. On one hand, there is a set of restrictive rules that do not necessarily guarantee quality but which seriously impede the expansion of professional education. On the other hand, there are no faculty development programmes or inbuilt systems of quality control or any effort to match the skills being provided with the skill requirements of the public health system and no formal ways by which this can be enforced either.

2.3.4. There is a similar situation as regards paramedical technical education. Though schools for technicians are expanding, the systems of regulation, faculty development and quality control and skill match with public service requirements are all very poorly addressed.

2.4. Multi-skilling

2.4.1. Multi-skilling is one major option for getting the skill mix required within the available human resource of the department. There are three areas where such multi-skilling has been encouraged under the NRHM. One is in paramedicals, especially for laboratory technicians, and for curative clinical skills and first aid skills in pharmacists and other paramedicals posted in remote areas. This has been taken up in two states, Tripura and Chhattisgarh, and in the latter the progress is slow. In Tripura, all supervisors had received multi-skill training. In other states, this measure has not attracted attention.

2.4.2. **Multi-skilling of nurses:** The specific proposal in this regard has been for the creation of nurse practitioners, in a context where there are no women doctors and often no doctors at all. Some functions like RTI management need women doctors and indeed in all functions this is welcome. Counselling, adolescent clinics, and regular follow up in non communicable disease are other functions that nurses can perform. This is in the PIP of a number of states but only Andhra Pradesh, and to a limited extent West Bengal, has begun work on this.

2.4.3. **Multi-skilling medical officers for specialist's tasks:** Multi-skilling for specialist skills needed for emergency obstetric care is the area where the most visible advance has been made. The systems for this have been put in place and the legal challenges have been

engaged with. Paradoxically, the programme proceeds fastest and best where it is least essential as the potential availability of specialists is highest – Gujarat and Tamil Nadu, and slowest in the states where it is most needed. The success in the first two states points out the universal validity of this approach, and in a much more modest way Chhattisgarh too has shown that it can be done. Most other states have started up these courses but again it would be a year at least before the results starts showing in terms of increased service delivery. One aspect worth noting is that in many states, a fair number of medical officers are providing surgical and anaesthetist skills and they are under pressures to stop doing so. However, given the fact that as recently as 20 years back this was the main form of surgical skill availability in the public health system, it would make more sense to prioritise such officers for certification through short term courses so that the start up times are much reduced.

2.5. Improving Workforce performance

2.5.1. Pooling of resources at block level as a way of getting the right skill mix both at the PHC and at the CHC has been proposed – but there are few instances of it being practiced. *Mandal* level pooling of resources – by which we prioritise making one facility at the *mandal* headquarters highly functional – was seen by the Mission as an option suited to the Andhra Pradesh situation. A *mandal* being approximately one thirds the size of the block, this approach offers much greater advantages than even the usual block pooling. The presence of an excellent referral system makes it even more attractive and effective. However, one has to understand the constraints and why this suggestion has not taken off in most states.

2.5.2. The issue of government specialists doing private practice was another major issue that was raised. Andhra Pradesh report in

particular quotes a case from Nalgonda where this "has become a vested interest in the public health provider not to operationalise emergency obstetric care. To make the matter worse, the ANMs and ASHAs under the MO in-charge may become agents for taking the C-section cases to the private clinics being run by them and earn some extra bucks". This report has called for better monitoring of hired specialists as an immediate measure of improving workforce performance. The Mission group visiting Rajasthan saw the need for a comprehensive policy on compensation within which the private practice issue should be addressed.

2.5.3. Incentives have been proposed widely and are in place in Madhya Pradesh and a number of states. However, except for hardship allowance in most states, few incentives have actually been paid out. Again, it is probably early days in this strategy and also a lot of caution in embarking upon this route for improved workforce performance.

2.5.4. The issue of a lack of a transfer and posting policy impeding workforce management and workforce morale has been reported from many states. Again, it is worth noting a clear alternative observation made in Tamil Nadu. The review mission to this state notes that the state "follows a very sound system of transfer of doctors and paramedical staff, as transfers are affected only on requests and that too against clearly available vacancies. This year, only 10 per cent of the total numbers of posts were transferred. Transfer procedure involves counselling and transparency wherein the list of vacancies is put in the public domain and doctors can put in their requests for their posting to the place of their choice".

2.6. Improving workforce skills for service delivery

2.6.1. Improving workforce skills in-house requires a systematic programme of in-service training. Current training programmes are almost completely linked to the national health programmes and even within these divided into IMNCI, SBA, adolescent and reproductive health, training in IUD insertion, training for different types of sterilization surgery and for safe abortion, etc., each of which is proceeding independently of the other. There is no way of even measuring how many facilities now have all these skills in place and are using it and the training institutions are not charged with ensuring that each facility has the requisite skills in place. There have been efforts to set up district and regional training centres and state institutes of health and family welfare. However, they are limited to transmitting, as unchanged as possible, these packages to a fixed number of persons every year with little certainty of what becomes of it after they have left the training hall. Beyond these fixed RCH and RNTCP type training packages, no other dimension of the IPHS specified service package is currently being addressed. A national stewardship role for in-service skill development consistent with the NRHM mandate, which builds the SIHFWs into effective state level leadership roles, is an urgent priority.

2.6.2. Even with available human resources and skills, more could have been done; and if the district had a training node /centre which addressed skill gaps, facility by facility, then far more could be done. Putting this in place along with a team/centre for providing assistance and the institutional memory for district planning is another priority.

2.6.3. Another area that needs attention is making available graded standard treatment guidelines and essential drug lists and formularies that could guide a wide range of health care providers. There are AYUSH doctors providing modern medicine care without as much as

a book to refer to. Both MBBS doctors and AYUSH doctors have to fall back on MIMS, which is far more appropriate than their text books in the context of their use. However, MIMS is hardly a desirable standard for the health system and the earlier the state circulates standard treatment guidelines the better. Both Maharashtra and Chhattisgarh and the Armed Forces medical division have graded guidelines that could be easily borrowed from and built upon. This is essential to reach the NRHM objective of comprehensive care.

2.6.4. A considerable effort is being put into public health management training. One set of trainings relate to the three-month professional development course where different state institutions have been accredited to deliver the training package. Another is the training programmes being organised for PMU contractual staff. An effort to start a diploma in public health in a number of institutions is also underway under the leadership of the NIHFW.

2.7. Integration with AYUSH system

2.7.1. Regular doctors for Ayurveda and Homeopathy exist under state cadre. This is excluding the AYUSH doctors recruited under NRHM and co-located at PHC/CHC/ SDH levels to provide AYUSH services so as to mainstream AYUSH, make it more accessible to the public, and make the public health facility more functional. Most states have now started undertaking this. AYUSH health care facilities are being provided under the programme *EK HI CHAT KE NICHE* (Under one Roof) in selected institutions of Rajasthan

2.7.2. AYUSH doctors and staff are playing supportive or trainer roles in ASHA programme and in RMP regularized to start for referral of TB cases in west district in December 07, it has not started yet.

AYUSH doctors and staff are playing supportive or trainer roles in ASHA programme and in RMP which – though regularised to start for referral of TB cases in west district in December 2007 – is yet to begin.

2.7.3. Another distinct feature is the appointment of AYUSH doctors in PHCs as medical officers against the regular medical officer of the modern medicine stream, because of the failure to fill it up with the regular doctors. The understanding is that curative care would be provided as per AYUSH but he would see all other public health programmes. However, neither any logistical support for the former curative task nor any necessary training inputs to make him capable of doing the latter seems to be in place. Further, there are no inputs available for the curative role that he could play at least at the paramedical level. However, in most remote areas, these doctors are now closing the service gaps and providing a good degree of patient care.

2.8. Summary

2.8.1. Where there are recruits available in the market, the larger pool of posts created are being filled up rapidly. There has also been a lot of pressure to fill up regular vacancies under the state budget. However, in most critical areas, even where states have charted a roadmap, it will take a few years before the impact will start showing. And what is a matter of concern in the EAG states is that much more facilitation is required before they are able to chart out and start moving on such a roadmap. In the area of human resources for health, it has taken this long just to break from a cynicism of “nothing can be done” to the central questions of getting manpower to serve in rural areas and provide quality service in an accountable manner. This cynicism underlies the complete closure of ANM training schools and the lack

of expansion of professional and technical education in the public sector and the failure to address many longstanding and festering issues of workforce management. The NRHM has opened up a wide number of possibilities for action. It has brought some of the key areas of human resources for health into the actionable zone. However, there is much that remains to be done and a very high degree of facilitation and change management is needed before the poor performing states are able to get going and even longer before the impact of these changes are reflected in health statistics.

3. Accountability

3.1. Measures of accountability envisaged under the NRHM are the process of review against norms and programme objectives clearly set by the programme for each state and district. At the community level, the *Panchayat*s, the community monitoring process and the participatory management committees of the village and district, as well as those constituted for each facility have the main role to play. Other than these, committee structures, a formal process of evaluation and reviews are also being put in place.

3.2. Though in most places the issues of gaps in provisions and human resource are the main problems, there are other places where all the investments are in place but there is very poor performance for no reason other than poor accountability. In particular, the Mission team to Jammu & Kashmir notes that there is adequate medical staff and perhaps an excess of paramedical staff and "major investments have been made in infrastructure, equipments, supplies and even availability of human resource is good – but there is very poor performance and outputs due to rampant private practice, unnecessary referrals. Even where skills are in place, surgeries are not being conducted".

3.3. The recent revealing of large scale unaccounted funds with senior health department official in Madhya Pradesh leading to his suspension, and such other complaints are a matter of concern, especially given the increasing flow of programmatic and untied funds under NRHM. These need to be addressed by greater delegation and decentralisation of financial powers along with more effective financial monitoring, and full transparency subjecting major financial transactions to public scrutiny. If these combine with partnerships with the private sector, such problems would only increase given the lack of regulation of the private sector and its unofficial links with the government sector.

3.4. Some of these are no doubt governance issues and there is a need to develop indicators for good governance and to be able to measure what part of a lack of service delivery is due to constraints of human resource, skills or infrastructure and what is due to poor governance and the lack of accountability.

4. Decentralisation

4.1. This has been discussed along with communitisation. In brief, though there has been a considerable, even dramatic, increase in space for involvement of *Panchayat*s, decentralisation in the devolution of ownership over health facilities has almost not occurred except in Nagaland and in part in West Bengal and Kerala**.**

4.2. In terms of transfer of funds, West Bengal has specified that funds for the VHSC will flow to village committees from the Zilla Parishad and be reported back through them. Further annual maintenance grants of sub-centres, PHCs and CHCs would flow via the Zilla Parishad to the

corresponding *Panchayat* tier (sub-centres to *Gram Panchayat*, and PHCs and to block *Panchayat*s) and be reported back through it.

4.3. Areas where *Panchayat* involvement has increased and made a difference in almost all states is the *panchyat pradhan* signatory in the untied fund for the sub-centre, the *Panchayat* involvement in the village health and sanitation committee, the *Panchayat* involvement in the *Rogi Kalyan Samiti* and the district health society. These are tentative steps forward in the road to effective decentralisation, but they seem to be, despite some misgivings, creating a right atmosphere for further changes. In Gujarat, the reports of forward movement even in these limited steps are negative.

4.4. As the processes of village planning and district and block planning improve, and as *Panchayat* involvement in these processes increase, the capacities of these structures to govern health improve. In states like West Bengal, *Panchayat* level cadre are being developed and paid for through *Panchayat*s making for considerable local accountability.

5. Reducing maternal and child deaths and population stabilisation

5.1. The major change in this period is undoubtedly in Institutional deliveries – this has been discussed earlier.

5.2. A number of states have proposed and continued with TBA training, anticipating that SBA training would take time and the shift to full institutional delivery would take longer. TBA training are being undertaken in tribal (ADC) villages under various schemes under DM. Home deliveries are still preferred in tribal pockets with difficult access to health facilities.

5.3. The other major thrust has been in immunisation. The immunisation programme has been strengthened by many measures – approval of an alternative vaccine delivery mechanism, a computerised immunisation management system, careful closure of cold chain gaps and a general transition to a 'fixed day fixed time' schedule for every village – when the children and women to be immunised are gathered in. This last programme has taken the form of a village health and nutrition day. Most state visits report the positive impact of many of these developments. It is technically difficult to measure increase in immunisation in a short appraisal visit, but both vaccine delivery systems and health and nutrition days were seen to have become major features of the district health programme. Taken along with the support from ASHAs and the strengthening of sub-centres with an untied fund and better community support, a favourable impact can be expected.

5.4. The IMNCI rollout, however, was not as visible in the states visited. And other aspects of child care intervention, especially institutional care for sick newborns, were also limited on the ground at all levels. In Bihar, even at the medical college level, it was inadequate. This is probably because the process is at an intermediate stage and has not yet reached the service delivery level; but it is worth examining further, whether we are on the roadmap. In West Bengal, a pioneer in institutional new born care, five district hospital level units with corresponding stabilisation units at the block level have been established on the Purulia model. Each district unit has 4 medical officers and 6 nurses trained to manage the unit. This is the best progress report in this front, but even this is too slow a rate of expansion.

Mobile Medical Unit

5.5. Contraceptives are available at all levels but the rate of utilisation is difficult to estimate. There seems to be an adequate demand for services but the ability of the systems to deliver needs to keep pace. In some states, it was reported that IUD is not popular, but it was also observed that IUD insertions were done only by MOs at RH/SDH level and the ANMs were unable to do this. NSVs are improving but still low and some states show decline in sterilisations. There is a need to re-examine a comprehensive way in which service delivery in these areas can be improved now that demand is no longer the problem and that lack of sterilisation providers is a growing issue. Once a week sterilisation services in all PHCs and CHCs seems a distant and perhaps even receding goal, unless urgent action is taken.

5.6. RCH programmes have suffered from the lack of human resource planning in the past and should gain the most from such planning under the NRHM. However, this would take time and till then there would be a need to persist. Similarly, in-house skill development is critical and, given the slow progress of training in so many states, one needs to examine

whether a more active national facilitation and strengthening of institutional mechanisms to play this role is called for.

6. Preventive and Promotive Health

6.1. The Disease Control Programmes, nutrition related programmes, school health programmes and de-worming and anaemia management programmes, oral hygiene and dental health programmes, the role of village health and nutrition day as a health promotion programme, and behaviour change programmes all have an impact on preventive and promotive health. The NRHM *per se* facilitates all these strategies to the extent that it provides a forum for appropriate district level planning and for integration with the rest of the health sector work.

6.2. Integration across programmes has been a key theme. Sharing of laboratory technicians and laboratory facilities has been noted as a priority. Some states report achieving this – others, that it has not yet been achieved.

6.3. The control of malaria and *Kala-azar* received priority in areas where these diseases are prevalent. It is difficult to estimate changes but the systems in place for their control have been strengthened by the introduction of ASHA, by the filling up of MPW vacancies and medical officer vacancies, and by the improvement of laboratories.

6.4. Work on the elimination of *kala-azar* has accelerated. The Bihar report states "*Kala-azar* is present in 31 districts and its control has regained priority since the last 2 years. Spraying with DDT, which was not done for 16 years, has been restarted. The state government ensured their primary thrust on control of *Kala-azar* through provision of free transport, free testing, free supply of drugs, and free diet to patient attendants and payment of Rs. 50 per day for the loss of wages. All the PHCs visited

have admitted *Kala-azar* patients, tested the patients and treated the confirmed cases as per the protocols. The procedures for payment of Rs.50 per day are yet to be streamlined as lump sum payments are made instead of daily payment for loss of wages. The teams visited the MSF *Kala-azar* unit established in the District Hospital, Vaishali, where the patients were fully satisfied with the facilities provided. Adequate arrangement has been made for treatment, assured drug supply and financial support for patients and one attendant. Partnerships have been established with MSF (Doctors without Borders). The RMRI (ICMR Research Institute) does a variety of good research, including basic laboratory, entomological, sociological and operational field research".

6.5. From various states, school health programmes, de-worming and paediatric anaemia control campaigns, BCC activities, and oral hygiene campaigns have been reported. Other missions have not examined these activities and, to the extent that they were reported, they seem to be exceptions, the programmes remaining confined to RCH and disease control areas.

6.6. One issue reported from Bihar and Uttar Pradesh particularly has been the problems of managing many rounds of pulse polio campaigns. This draws away a bulk of the human resources. The Bihar report states: "Of the 3 polio cases in the state, about 24 had received 4-5 doses of OPV. Many children receive around 10 doses of OPV. The Government of India was requested to take this up as a policy issue. While so many resources are focussed on this problem, the much more widespread and serious problem of anaemia and malnutrition are relatively neglected".

7. Disease Surveillance

7.1. IDSP programmes report a variable take off. In some states, they are yet to be established whereas in other states centres are operating at all levels. Registers are being maintained and training has been received by

supervisors and MPW/ ANMs. ACMOs or other suitable officers of the districts have been declared District Surveillance Officers and sites for Data Collection Centres were identified. In other states where progress to this level has not been made, these efforts have to be prioritised for early implementation. In some states, computer hardware has been received but software is not yet installed. In others, facilities are ready but data-entry operators are yet to be placed.

7.2. Tamil Nadu is one state where the entire processes of IDSP are in place and functional.

7.3. Hospital-based data is an important source of information that the system must use. No hospitals are recording diagnosis in inpatient registers and case records are weak or absent. This hampers assessment of local disease burden, preventing preparation of epidemiological profile of the area.

8. Hamlet to Hospital Linkage - The Hamlet

8.1. There are two aspects that can be discussed under this head. One relates to the structures at the hamlet level. The main development in this regard is the ASHA programme. Some states have also experimented with training RMPs in a limited way for this role. *Anganwadi* workers also provide a first contact curative care.

8.2. The second aspect is related to the referral transport system. In the past, main effort has been in making the fund available in the *Panchayat* or in the peripheral health facility that can be used for hiring and paying for transport when there is an emergency. In most states, this is still the dominant form and its use is largely limited to transport for emergency obstetric care.

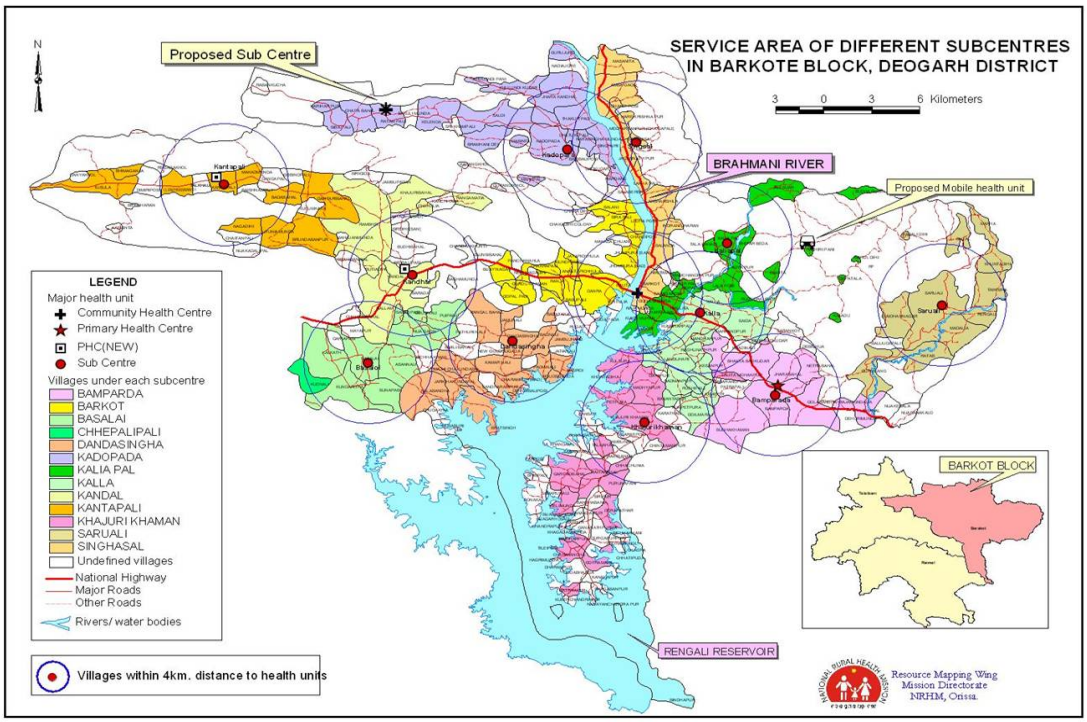
8.3. The new and rapidly emerging form of referral transport, which is increasingly becoming synonymous with emergency ambulance services, is the outsourced ambulance service. Tamil Nadu has such a system which is outsourced in each block to an NGO and coordinated by a district level control room. Both ANMs and control room and the ambulance drivers have been provided with mobile phones, and recently there has been a move to allot a single emergency number.

8.4. The benchmark for emergency ambulance services has, meanwhile, been established by Andhra Pradesh which has, with private partnership, evolved a remarkable system which, within Indian circumstances, is actually able to reach patients and deliver them in increasingly short time cycle of 30 to 60 minutes in most circumstances. A simple call to a toll free number 108 leads to an ambulance access in as low as 20 minutes in the villages visited. Moreover, the ambulance has trained attendant and adequate emergency care equipment for stabilising the patient in a wide variety of circumstances.

8.5. In Tripura, serious efforts are on to use the tele-medicine facility – linked with the state medical college in Agartala – to forge a PHC to tertiary care referral linkage. This enables specialist consultation for required cases. This is being financed from the state's own funds. Almost all states are experimenting with tele-medicine, but a benchmark programme with clear patient care or health systems benefits that can be replicated is still not established.

9. Health Information System (HIS)

9.1. NRHM aims to strengthen monitoring and, as part of improved management and better monitoring, it needs a functional health management information system. The NRHM emphasis is also on integration of monitoring across the different programmes and with the Integrated Disease Surveillance Programme.



9.2. The Mission notes that the Integrated MIS Format for flow of physical performance data were found at all levels, including the lowest (ANM). Nonetheless, multiple reporting is still in vogue under different programmes, and earlier forms are not yet abolished. Copies of reports sent above are not being maintained at SC level. Reporting under NRHM is being undertaken by the contractual staff and often differs from the record-based reports or programme performance reports.

9.3. The reports required are bulky and the periodicity of data flow is irregular. There are many data elements that are difficult to source. Systems of validation are not yet in place. One important observation is that the use of HMIS data as a regular tool of data management is not the rule.

9.4. In Bihar, the State Health Society data collection centre was visited and the Mission appraised the daily collection of data from the Health Centres,

including number of deliveries, utilisation of ambulance services, telephone, 24 hours electric supply, working condition of generators, etc. The Data Centre has been very useful in improving the feedback on programme performance and also in reducing absenteeism at health facilities.

9.5. In Gujarat, Andhra Pradesh and Tamil Nadu, systems of monitoring of general facility functioning are in place and they use grades to rate facilities into four categories, with pressures to improve performance of poorer facilities.

9.6. There is a need to publish/ disseminate district and facility profiles/ reports that are prepared to the subordinate facilities; they should also be available for scrutiny by the general public. It was observed that district health reports were not being prepared, and facility survey reports were not found in the facilities. It is suggested that copies of these reports should be retained at facility level too.

9.7. Lastly, quoting from the Gujarat report, “it must be recognised that unless the remote area problem is integrated into the district health mission plans, progress will not be quick or easy. It would be useful to devise special indices for such remote areas; it will bring out the true disparities often hidden in averages for the districts. Our field visit indicated the urgent need for such data collection”.

10. Planning and Monitoring with community ownership

10.1. One major development of the NRHM that has already occurred is district level planning. This process is complete or near complete in almost all states. In Rajasthan, 26 districts out of 32 have prepared district health plans with the technical support of identified 6 non-government agencies. Twenty-three district plans out of 26 have been appraised. In Chhattisgarh, all districts prepared the plan in 2005-06, but since have not updated or revised it. In Bihar, the District Health Plans have been prepared for two districts and is in process of preparation for the remaining districts with the UNICEF assisting the state in this regard. In the rest of the districts, work had been assigned to a consulting agency, where there has been a discord and the matter went to courts and has now gone in for arbitration. In Jammu & Kashmir, district plans were outsourced and this did not have the desired results with outcomes still not available. In Uttar Pradesh, district planning was outsourced to SIFPSA and was completed in all districts with reasonable quality. Awareness about the district plans was, however, low amongst senior district health administrators. In Orissa, all districts have completed their plans. In Tamil Nadu and Andhra Pradesh, the district planning is still more of a dis-aggregation of state data and allocations and does not meet the process requirements of the exercise.

10.2. Despite this mixed picture, the overall view is that district planning to the level that it has happened is a step forward. It has brought various

data together and made a basic skeleton of a plan which can be subsequently revised and built upon. Planning improved over the years and districts need time to learn and improve. Nevertheless, there needs to be an agency or team within the district which acts as an institutional memory of the plans and for nurturing/ pro-actively pursuing their implementation processes.

10.3. At the district level too, like the role envisaged for the SHSRC at the state level, there is a need to infuse new methods of problem analysis and solution search appropriate to local needs. In this connection, involvement of greater non-officials should be sought, especially of local professional and development and public health experts resident in NGOs and research institutions who are capable of planning, to understand the dynamics of power relations in rural areas.

10.4. Village plans prepared based on household health data and with involvement of PRIs are still an exception. In this regard, the *Swasthya Panchayat* experience flowing from Chhattisgarh is worth learning from. A joint exercise of PRI members and *Mitanin*s and their support organisations have measured the status of health and health service delivery on a number of parameters and used it to calculate a health index and rank *Panchayat*s according to this.

10.5. The plans have not become documents that inform social audit or community monitoring. One of the challenges of the coming period is to improve the quality of community participation.

11. Equity

11.1. The NRHM addresses equity concerns in a number of forms. Firstly, it seeks to gather data with dis-aggregation for gender and for SC and ST. In this, the strategy of gathering such data needs revision from

being part of routine data to becoming part of sample surveys for operational reasons. Disaggregated data by population groups do not exist. There is an obvious need to develop workable methods of tracking equity concerns at the programme management level.

11.2. All schemes of community participation, especially ASHA, serve the cause of equity by empowering weaker sections and local communities. ASHA being women, it is access to health care for women and children that gets facilitated the most.

11.3. All NRHM efforts to get all peripheral health facilities to become functional is one of the most basic of ways in which social protection for the poor is provided and the health sector reaches out to hitherto under-served areas.

11.4. For outreach to even more remote areas, the mobile medical units and the outreach sessions are specific vehicles that the NRHM promotes. It has been difficult to assess the impact of these vehicles. It is also too early. In most states visited, these units have become recently functional or are still in the stage of procurement. In Tripura, a helicopter service to reach a particularly remote set of tribal hamlets has been sanctioned and is functional. In Andhra Pradesh, free bus passes to pregnant women for three visits for antenatal care has been attempted. In Tamil Nadu, in remote hilly and forested areas of Dharmapuri and Krishnagiri, a concept of birth resorts is introduced under the state plan, which provides for pregnant women, in the last month of their pregnancy, to move to a temporary home near a site that can offer institutional delivery. But there are some remote areas where even the bus service does not reach.

12. Convergence of programme for combating/preventing HIV/AIDS, chronic diseases, malnutrition, providing safe drinking water, etc., with community support

12.1. Representation of all departments in District H&FW Society is one first step forward in this direction. Integration of all these dimensions into the district plan is another step forward. Specific circulars and meetings have been held at national and state levels to facilitate this.

12.2. Though not observed during the review mission visit, Family Health Awareness Campaigns are an important interface of the National AIDS Control Programme with the rural health services. However, there is need for a greater information base with health personnel at all levels so that they can manage HIV positive cases with ease. Experiences of the evolving systems of ARV therapy through the public hospitals linked to social support by NGOs and CBOs need to be drawn upon for health services as a whole.

12.3. Where there are some tentative efforts made into entering health related sectors, the relationship and overlap with other departments needs clarification. West Bengal, for instance, reports a pilot scheme for additional nutrition package for malnourished children. But the review mission notes that this is very similar to the existing ICDS and may indeed be duplication.

12.4. One successful home grown model of convergence is the Madhya Pradesh *Bal Shakthi Yojana* scheme. Of this, the Madhya Pradesh report states: "*Bal Shakti Yojana* is a fairly successful scheme aimed at addressing severely malnourished children, i.e., children who come under grade 3 and 4 of malnourishment, who have been identified in the villages and who are now being taken in rotation to Nutritional Rehabilitation Centres (NRCs) in district hospitals, along with their mothers/ guardians,

for training and counselling and other necessary supports, including intensive observation and medical treatment in nutrition, hygiene and health care under the guidance of paediatricians and nutritionists. Noticeably, apart from the stay arrangements, the transport cost for travel to the centre and the loss of wage earnings for the mother/ guardian accompanying the child are also covered by the government to encourage access to this scheme. A follow up card is made through which the ANMs and AWWs carry out 6 months follow up to ensure sustainability. At present, 40 NRCs are operational and it is planned to increase the number to 100 by the end of 2008. A visit to an NRC at the Elgin Hospital in Jabalpur showed a very positive picture of success of this scheme".

Balshakti Yoina

12.5. However, despite these first steps, much more needs to be done before the objectives of convergence are realised. Village sanitation committees have not yet merged to form health and sanitation committee

and, at the district level, many societies function autonomously within the health sector and for each sector. .Linkage with the PRIs or a lead role for PRIs helps, but by itself it does not ensure convergence. Benchmark plans that demonstrate convergence and that when implemented yield measurable outcomes are still to be evolved. This would be a focus in the coming days.

12.6. The Gujarat report notes that "the role of the collector as the head of the district health mission can be crucial. By placing health in a wider social context within DHS, he can create natural linkages between the health and sanitation and water supply, girl's education, nutrition, forests, and housing sectors. There is a clear necessity for the district health society to address not only health care determinants but social determinants of health status. And this can happen only with greater association of PRIs and will need informed support of professional analytic resources. And accordingly, it should be made a specific task of the State Health Resource Agency.

13. Chronic Diseases: *Addressing burden of chronic diseases*

13.1. This is another area where work has to begin as part of the NRHM. Here, the overall approach that is going to be followed is not clear. Some states have made some tentative plans for cancer control or for geriatric care in their state PIPs but expanding these into full fledged and adequate strategies is some distance away. New vertical programmes for a number of non communicable diseases is mooted at the national level, but its relationship to the current processes of the NRHM is unclear.

The real way forward is to build in the preventive, promotive and curative care for chronic diseases and non communicable diseases into the definition of fully functional health facilities and the provision of promotive and preventive services. Thus, one needs to check their standard treatment guidelines, their essential

drug lists, their referral systems, their BCC work to see whether the main concerns of chronic disease as appropriate to that region and its disease burden have been incorporated. There was no clear evidence of these concerns having been fully taken on board.

14. Social Security: ***Social security to poor to cover for ill health linked impoverishment and bankruptcy***

14.1. No community health financing/ demand side financing initiatives being undertaken at community level were observed, except for the JSY scheme.

14.2. Risk pooling options are being proposed, but no such programme could be witnessed by any of the teams.

15. Overarching issues:

15.1. One of the key issues is that the overall budgetary outlay increases – and this is taking states and central budgets together. The picture on what is happening to the state budget rests on statements made, and independent data based assessments are not available for review. These statements are made in good faith but, in addition to the state's statements, it would be useful to institutional mechanisms in place for annual detailed budgetary analysis for every state and for the centre, which is tabled and reviewed, and is available for NRHM's decision making on compliance to this central objective.

15.2. Andhra reports a steady increase in budget – 15.83% in the previous year and a further 29% increase in the current year. The report for each state is being compiled.

15.3. One of the issues of concern is that we do not quite know enough about what is happening to budgetary allocation between different heads. In West Bengal, for example, the mission observed that in one BPHC, the

state budgetary support for salary, travel and routine expenses had declined though the State has communicated to the GoI the 10% increase in health outlay and 15% contribution of state finances to NRHM. The Madhya Pradesh report also points out that though total revenues raised by user fees for the state may be a modest Rs. 10 crores, less than 1%, at the facility level a large proportion of financing may actually be coming from user fees, much of it paid by the poor. There is clearly a need to assess what is happening to facility level expenditures as related to state level budgetary projections and how budgetary allocations are moving with the fresh infusion of funds. There is also no clear projection on how collections from user fees are moving. The institutional mechanisms to look at this, let alone monitor this on a real time basis, have not yet begun.

15.4. The other major issue is the failure of utilisation of funds disbursed to the states. The actual position in this would be presented in an annexure. The key question is to understand in each state's context the causes for poor utilisation. Seven sets of causes may be contributing.

15.4.1. Delays in disbursal at national level and at state levels itself often due to non submission of accounts and utilisation certificates.

15.4.2. Delays/ snags in the pipeline – (the transfer of funds at each level after the decision is made): a technical issue.

15.4.3. Inability to expend funds due to poor programme management arrangements, mainly due to lack of delegation of powers and lack of management personnel: largely a capacity issue but with some governance elements.

15.4.4. Lack of capacity to account for the expenditure and submit utilisation certificates, especially the problem of a minority of lagging performance units delaying the submission of the major part of the good performing units.

15.4.5. Inability to flex financing structures to be able to account for funds in the pipeline, especially in civil works without losing.

15.4.6. Delays in decision making, especially administrative, and technical decision-making bottlenecks as regards policy and strategy: a governance issue.

15.4.7. Other issues of governance – lack of leadership, often due to frequent changes and unfilled key posts or a failure to take decisions due to influence of vested interests, some of which presents as delays in accounting and in decision making.

15.4.8. Inability to expend funds due to structural constraints – the human resource is just not there or the systems are too poorly functional to be able to expend.

15.5. NRHM intervention helps take care of pipeline snags by e-banking, of programme management, arrangement and accounting delays by additional staff – often contractual – and their training. But it is really stymied by issues of governance and structural constraints.

Institutional mechanisms to track expenditure and fund flow and monitor issues of governance are also a challenge that the NRHM must address. To do so in a federal structure calls for administrative monitoring to be accompanied by suitable policy changes to facilitate such monitoring. It also needs the generation of a political will and political mechanisms of doing so.

15.6. Structural changes require time. For example, the review shows that more nurses could dramatically increase outputs, and therefore increase expenditure; but the states that need them the most are just beginning to decide on setting up nursing schools. Or more drugs need to be procured, but the institutions that can handle procurement as flawlessly as the TNMSC benchmark take time in the building. Or district planning could dramatically increase fund flows – but to build institutional

structures that can retain the memory of last year's plans and professionally learn and improve on it from time to time takes a few planning cycles to establish – after the will to do so has been generated. Does the NRHM have that much time? Will the political gains hold? What are the low hanging fruits in a tree where mostly fruits hang high!

15.7. Structural changes, and for that matter any pro-equity change, requires political, administrative and technical facilitation. There is welcome attention today on monitoring by the NRHM and this must be further strengthened. But the system now needs to actively engage in facilitating these changes. Facilitation involves constant dialogue with partners at every level. It requires constant hand holding and technical problem solving as applied at the level of every facility and every village and every district. It requires capacity building – both of individual capacities and of institutional capacities and of systemic capacities. It requires internal advocacy and negotiation to hold firm on many processes that may not give immediate visible benefits but which are essential for eventually generating the desired outcomes. It requires engaging with and empowering weaker stakeholders who have greater interest in successful outcomes. It requires champions for pro-equity solutions to engage in working with the government. Identifying and stating the problems and designing innovative schemes would not by themselves overcome the many structural constraints in our path. Building the necessary institutional capacity and mobilising the technical talent and administrative will and applying these to the task of facilitation is critical for a successful outcome for the NRHM.

15.8. Historically, the NRHM represents a return to the spirit of the Alma Ata declaration with a much better understanding gained from the intervening period of the costs of not doing so. But the challenge is to be able to convert this opportunity into an occasion for building partnerships

and forging a unity across different stakeholders and political sections that gives it the time and space and guidance to do so.

Section IV

RECOMMENDATIONS OF THE COMMON REVIEW MISSION

The following are the recommendations made by the Common Review Mission team to the National Rural Health Mission for early implementation.

1. **Awareness of NRHM**

A systematic effort is needed at disseminating NRHM guidelines and practices. There is currently insufficient understanding in the public and even amongst many sections charged with implementing various aspects of the programme.

2. **Governance Issues**

The poor state of utilisation of funds in many states must be seen in relationship to this aspect. The senior levels of programme management are often beset with the problems related to deciding the chain of command, a lack of transparent and participatory decision making, frequent changes of key senior officers, needless delays in disbursals and accounting, and also a reluctance to engage in some of the longer term structural changes that are required. A systematic effort must be undertaken to identify issues of "Governance of NRHM" which are critical and need immediate attention of the state authority to address. Once such problems are recognisd and admitted, some common plan of reform in health sector governance should be worked for. One key area of governance reform would be decentralisation and increasing the role of *panchayats.*

3. **Decentralisation and the role of *Panchayati Raj* Institutions**:

For effecting this, a set of measurable steps are described below with a gradation from the relatively simple measures with widespread consensus to the more difficult, more contentious issues of decentralisation.

i. Ensuring adequate representation for PRIs in the district health committees and the *Rogi Kalyan Samitis* or equivalent bodies.

ii. Ensuring necessary consultation with PRIs before submission and approval of district health plans.

iii. Information about district health plans in print given to all three tiers of *Panchayat*s.

iv. Fund transfers to village health and sanitation committees and untied funds in sub-centre where necessarily the *Panchayat* member is one of the signatories or key decision makers.

v. Transfer of powers of recruitment of contractual staff to block or district *Panchayat*s, especially for specialists, nurses, doctors, and some technical categories. This could be limited to areas which are facing "willing"-staff shortages or made a general rule. To perform this function effectively, the *Panchayat* would be enabled by a suitable agency/ NGO whose costs for successful recruitments and assistance in negotiating the contract could be paid for by the state from NRHM funds. This could be on a continuous basis

vi. Allow states to include in their PIPs a plan to provide funds to block or district *Panchayat*s for incentives to pay for difficulty allowance or to pay incentives to staff who are resident there and performing their duties well. The untied funds to each *Panchayat* would vary according to difficulty criteria. This, along with the earlier clause of recruitment, would help.

vii. Transfer of Ownership at least of sub-centres and PHCs by the *Panchayat*s along with adequate resources and administrative

support for village health planning. This may be phased over a few years.

4. **Decentralised Planning and Local Area Health Planning:**

This aspect of decentralisation relates to capacity building related to decentralisation and needs to proceed in parallel with the administrative and political changes described earlier.

i. Ensuring that resource envelope for the district plan is known well in advance for each year.
ii. Ensuring that the previous year's district plan is shared extensively during the year and is updated and resubmitted by the February of each year.
iii. Developing a team of five to seven persons, other than the CHMO, to run the district planning centre. This should include at least two or three officers of the deputy CMO seniority, and one or two public health specialists. This centre should act as the institutional memory of the planning process. If needed, agencies may be contracted in to assist, but the core planning team should be from the health department with the district. There is an important role for non official members/ public health experts to be included in this process.
iv. Developing criteria and institutional mechanisms of appraisal and technical support and facilitation to improve the quality of district plans at the state level.
v. Developing a national cell to facilitate and follow up throughout the year with states to ensure that the states are in schedule and all four above steps are in place.

5. **Strengthening the ASHA programme**

i. Ensure there is a state-specific conceptual and role clarity of the ASHA with respect to programme outcomes expected from her and with respect to the roles of other peripheral government functionaries. Also clarity that she should not evolve as a link worker, a last leg of the government functionaries' pyramid, but as a representative of the community, providing leadership and guidance to the community and partnership to the health system. This clarity should inform the process of monitoring and support.

ii. Strengthen the payments mechanisms so that the ASHA is paid promptly and with dignity and does not have to spend more than a few hours on one day every month to get her payments for all the incentives due. Revise payment guidelines from the centre and the states. The centre should maintain a constant observatory of the state level guidelines so that timely problem identification and corrections could be facilitated.

iii. Ensure that states have developed appropriate training modules and strategies to continue training after the first set of modules are completed and the mechanisms of training M&E though which quality of training is maintained. States that need materials more appropriate to less educated ASHAs would also need facilitation to develop the same. A minimum of 12 days per subsequent year should be mandatory with 20 days in the first year. Identify reasons for delay and organise active facilitation to see that delays due to capacity constraints or failure to develop appropriate state support systems are overcome.

iv. Ensure that the first ASHA drug kits are procured and distributed in every state within a six month target, and then ensure that every state has subsequently put in place a system of refilling the kits every two months.

v. Ensure that the ASHA is supported by on the job training and facilitation by facilitators and that the ASHA support mechanisms

envisaged are initiated. Also developing her role as community mobiliser and developing social mobilisation and recognition processes from the *Panchayat*s is essential. Support and recognition from the department staff in different forms would also need to be organised.

vi. The funds required for all these are in place and in most states disbursed to districts as well. But in the absence of developing programme management and support structures, much of this money remains unspent and there are pressures to divert these funds. The critical step, therefore, is to create the ASHA resource centre and with NHSRC support and the support of state and national ASHA mentoring groups, build up its capacity in such a way that the state can implement all these recommendations in the spirit intended.

6. On Village Health and Sanitation Committees

i. Developing systems in the states to enable the department to track and guide the content of activities transacted by these committees.

ii. Developing systems for the states that enable them to facilitate the making of village health plans as well as the utilisation and accounting of the funds made available to it. This mechanism of facilitation would most likely be the same as that for ASHA so as to avoid duplication and build synergy.

iii. Ensuring that both *Panchayat*s and ASHAs are fully involved and provide leadership and coordination to these committees.

iv. Centre to have a detailed knowledge of the guidelines as issued in every state and the experiences of different approaches. From this to draw lessons and share these between the states so as to maximise the outcomes of this strategy.

7. On Role of NGOs

i. Insist that all dealings with NGOs be carried out on the basis of MOUs so that there is accountability on both sides.
ii. Each state to develop a clear understanding of where it would seek NGO participation and share it with the NGO partners. Each state to develop a grant in aid committee or transparent process of NGO selection.
iii. In all processes that relate to community participation in any form, to try to ensure that NGO partnership in some form or other is secured. In the ASHA programme, in particular, not only should at least a percentage of block programmes be supported through NGOs, their role in training and social mobilidation and support must be taken advantage of.
iv. Review the reasons why the MNGO scheme has not taken off in many states and undertake correctives.
v. Accelerate the implementation of the community monitoring programme.

8. On the *Rogi Kalyan Samitis*

i. Reiteration of RKS under the NRHM for better public participation to ensure better accountability and also as a vehicle of flexible funding by the government to help raise the quality of care provided without any detriment to equity of access. There is no goal of cost recovery. Moreover, there is concern that RKS funding should not reduce/ substitute state government expenditure on regular essentials like drugs and human resource.
ii. Training of RKS functionaries and key officials to enable expenditure planning in such a way that improves quality of care and equity of access.
iii. Monitoring to ensure that equity in access is not being limited by user fees. It is adequate to monitor exemptions in different services in the hospital to correlate this.

iv. Ensuring minimum standards in decision making and accounting.

v. Ensuring that untied funds given by NRHM are linked not only to facility development plans, but also to performance based on measures of quality improvement and total consumption of different services. Further, untied fund allocation also needs to look at equity consideration, relatively more backward areas getting more funds.

vi. If user fees are charged, their main use may lie in optimisation of expenditure patterns and better allocation between facilities and within facilities.

9. On untied funds to sub-centres and PHCs and CHCs

i. Most of the issues are the same as discussed for RKS.

ii. In the sub-centre, there is no RKS but the village health and sanitation committee should play this role. Most states have preferred a local sub-centre support committee. This too is acceptable.

10. On *Janini Suraksha Yojana*

The increase in institutional deliveries potentially assists the reduction of maternal mortality and it also puts pressures on the public health facilities to be revived/ strengthened and to function with quality. However, there are concerns. One concern is the huge and growing financial implications. The other was the way on the field the JSY programme tends to marginalise all other elements of RCH and how it could narrow the focus of facility improvement. Yet another issue was the usually delayed and some times denied payments to ASHAs and the mothers. And finally there was the concern that without a corresponding increase in the skills and logistic support of the nurses and without at least 24 to 48 hour postpartum care, and without sufficient quality in delivery and access to referrals, even the impact on maternal mortality would be illusory. To

address these concerns without losing the advantages of the JSY, the need is to:

i. Build up and monitor quality assurance systems to ensure that the level of care provided leads to decreased maternal mortality.
ii. Build up adequate awareness of the NRHM and the entire IPHS package of services so that the pressures for institutional delivery lead to development of the facility as a whole, instead of a possible trend where all other programmes get compromised in the process of meeting JSY targets.
iii. Build up ASHA grievance redressal mechanisms and streamline payment systems with the use of external appraisals to identify leakages and glitches in the rules. One key rule that needs to change is to demarcate the ASHA motivation fee from the transport support – but there are many other similar glitches in the details of rules in each state that need to be examined and corrected.

11. On Compensation and Motivation Fee

A related area of concern is the increase in compensation for sterilisation and the motivation fee. We need to examine in sufficient detail whether, given the high demand for these services, such money given as compensation and motivation adds value to the programme outcomes or merely corrupts the system. Whereas there is consensus on the priority being ensuring quality and access to these services, the role that the compensation and motivation fee is paying would need to be studied further.

12. On PPPs

i. Viable PPP approaches have been established for the provision of emergency ambulance services, where such services are largely an extension of the public health system itself. These models have

already been picked up by many states for replication and there is a need to replicate this approach widely.

ii. In the contracting out of PHCs and CHCs and in many other options of PPP, the differences between public sector provision and private sector provisioning with public funding, there is no model that is generally replicable and cost effective. Some efforts have either not taken off or have done poorly or been difficult to replicate. There are others like *Chiranjeevi* scheme that are promising and appropriate to their contexts but whose replicability and longer term issues need to be understood further. These models are in the stage where an active and analytic observatory and learning from the ongoing work would be the main form of advance for now.

13. On Improving Programme management

i. There is a need to strengthen the state level institutional framework at the state level. Past programmes have tried to add consultants to the directorate to achieve the necessary capacity. But this has seldom worked. What is needed is an institutional framework that has the following institutional capacities:

   a. A functional strengthened directorate with at least some of the officers trained in health administration. The directorate has divisions that provide technical assistance for each of the national and state health programmes. One recommendation is to build guidelines for the minimum strengths and skills that such a directorate would need.

   b. A state programme management unit made up of a mix of contractual staff and regular staff that leads programme management. The SPMU has several sub-components of which two essential ones are the HMIS unit and also the financial management unit.

c. A state institute of health and family welfare or equivalent body, which works in partnership with regional and district training institutions. The institute's core competence is that every health facility (sub-centre, PHC, CHC, district hospital, etc.) in the state has the skills needed for its optimal functioning given the human resources that each facility has available.

d. A state level institution (the SHSRC or equivalent body) that acts as an autonomous additional technical capacity for planning and building district capacities for planning, evidence based strategy development, for programme appraisals and programme innovation and for guiding health sector reform. Also as single window for channelising technical assistance and creating an institutional memory of such reports and work.

e. A state level institution for guiding, building and strengthening community processes. (ASHA resource centres and equivalents, as part of SHSRC or separately).

f. A state level institution for supporting procurement and guiding logistics in the district.

g. A state level institution for guiding civil works in the districts and, where needed, undertaking larger projects itself.

ii. In large states, a separate institutional arrangement for each is probably essential due to sheer volume of work. But in all states, each of these seven tasks requires a different core competence, a different leadership, a different set of skills and, therefore, different recruitment and career prospects. There is a need for both good coordination amongst them, and, at the same time, some autonomy or at least delegation of powers for each of these institutional arrangements to develop their own capacities and deliver. Further,

each of them needs to be placed within an accountability and good governance framework. Given these principles, the state may decide whether the institution is achieved by contracting in an agency, or by creating a registered society or just creating a division with sufficient powers and autonomy. If a local situation allows, it may combine two or more of these functions into a single institution, provided that each year the expected deliverable is obtained.

iii. Active facilitation would be needed to create these. More importantly, once these seven teams are identified, each of these need to be supported and capacities need to be built up to deliver their outcomes. Each of these institutions would need annual reports and reviews to ensure that they are delivering as per their MOU and slack in performance is prevented.

iv. Within this context, the importance of proper recruitment, support and training, and coordination of the contractual staff of the programme management unit should be discussed. Often the discussion on the contractual staff of the PMU overshadows all other questions of state and district programme management; this is not useful as it places an unrealistic set of expectations on their shoulders. However, the PMU is a key additional programme implementation capacity and the current emphasis on their selection and training needs to continue along with longer term career plans for this workforce. There is also a need to integrate their functioning with the other structures outlined above and this could be done by joint training and team building efforts.

v. Adequate financial Management capacity and HMIS capacity needs to be built into the programme management unit.

vi. The system of concurrent audit, as put in place in Madhya Pradesh, is unique and very effective in ensuring timely reports, and should be replicated by other states.

14. Monitoring Against Norms & Fully Functional Facilities

i. The nomenclatures of CHCs and PHCs and their bed strengths do not follow a standard pattern, even within states. This is causing considerable confusions in understanding the plans, and sometimes even leading to wastage of resources. It confuses people regarding the level of expectations from a given centre, besides creating difficulties in monitoring/ comparing performance. State Governments should seriously consider reorganising nomenclature of all institutions in consultation with the NRHM so as to reach a consensus that can be used for calculating fund allocations and for designing roadmaps to achieve IPHS norms and the fully functional status.

ii. We also need a uniform decision on having a sub-centre embedded in every PHC and a PHC embedded in every CHC, and a CHC embedded in every DH to look after the services of that section, sector or block where the higher facility is situated. This would alter calculations of requirements and increase staff and fund available in the higher facility. (This also relates to the earlier nomenclature issue).

iii. The IPHS norms should be increasingly popularised as a set of service guarantees that each institution has to deliver. With all the IPHS specified inputs (infrastructure, manpower, equipment and drugs), the service would be of a certain quality level. But there is an understanding that even without that targeted level of inputs, an improvement in service delivery can be recorded. This would imply

a focus on those inputs that are critical to achieve the service guarantee, some system of grading achievement and a roadmap to achieving the desired level of services.

iv. Further performance of facilities should also be measured against the available staff and inputs. In addition to the question of how many facilities have reached IPHS standards, the other key question should become: "what is the optimum set and volume of services that can be delivered for the existing level of human resource and infrastructure and in how many facilities are we are obtaining that level of services with sufficient quality?" Or to put it differently: is failure to move towards a graded IPHS norm due to infrastructure and human resource gaps (which take considerable financial resources and structural changes to achieve) or are gaps in supplies or minor equipment or skills or motivation levels (which are relatively easily remediable within the same year) the main barriers? Measures of quality would help us measure performance in such terms and also give us a more dynamic understanding of the IPHS standards. Issues like improving cleanliness, improving biomedical waste management improved patient amenities would all respond to a system of monitoring where the key is a flexible notion of quality that is specific for each facility.

v. The increase in the number of outpatients and in-patients should be monitored. But we also need to ensure that this increase is not producing "distortions which militate against equitable utilisation of institutions and provision of quality of services". One example quoted is "the skewed use of institutions has clogged the available bed strength and services with simple delivery cases in FRUs, which otherwise would have accommodated patients with serious health problems". To an extent, the system is alert to the distortion

that allows these problems to creep in, and that these problems can be attended to, But first we need to build a system by which we know what is happening.

vi. For strengthening facilities to meet the IPHS norms, the critical inputs are of deploying the necessary human resource with the necessary skills. The main inputs from the NRHM for strengthening facilities are the increases in doctors and nursing staff, effective use of untied funds to close hardware gaps, community level support for the ASHAs, and the referral transport system put in place. There is also the insistence on seeing that the staffs in place are well trained with the core skills and many cadres existing with state support, such as the male MPW, are revived and equipped to play a role in many of the services that the sub-centre has to deliver.

vii. A state by state decision is needed on the use of sub-centre as an institutional delivery site. The state to state variation is too high to have a single policy across states. Some states report no delivery at the sub-centre at all, and there are other states, where currently delivery in the PHC is still difficult but a substantial number of deliveries is occurring at the sub-centre. The suggestion is that wherever possible, the single ANM sub-centre be kept as an optional site for delivery in case of sudden need or where there is no PHC nearby, but the effort is to reach the nearest PHC. Once there are two ANMs, both trained in SBA and provided with referral transport support, mandatory availability of delivery services at the sub-centre could be insisted upon. This decision has implications for the JSY programme where in accordance the institutional benefits would not be available for the sub-centre delivery if this is not declared as institutional.

viii. The understanding of IPHS norms, as linked to a service guarantee package, must be accompanied by the availability in every facility of graded standard treatment protocols, essential drug lists and drug formularies that match the services that are expected. This same service guarantee must inform the drugs procurement and logistics system, the laboratory support system and, above all, the skill development programme that every district health society would have to ensure.

ix. Technical assistance needs to be made available to each facility to plan for development of quality services, which is described under the RKS section earlier.

x. Drugs and supplies logistics and a matching system or procurement is crucial. The benchmark for this is the Tamil Nadu system. There is a need to develop a comparable system that extends up to sub-centres and to ASHAs. The current drug kit based approach and supply driven distribution has a lot of redundancies, wastages and stock-outs. Facilities can never be fully functional till a Tamil Nadu style logistics management system is put in place. Drugs budgets also need to be indexed to patients' attendance and inflationary indices and be revised on an annual norm based system, rather than as response to crisis.

15. Human Resource Management

i. The availability of health human resources for making facilities fully functional is the central bottleneck. Each state has to develop roadmaps or five year plans to show how this can be achieved in the shortest possible time with annual targets for monitoring progress in place. Future funding commitments could also be based on such a projection, as current human resource availability

problems lead to a very poor current fund absorption position. These human resource development plans could be made a separate sub-component of a five year state PIP. Such a roadmap or five year plan would have to take into account the number of professional education institutions that are functional and those that are coming up.

ii. Dedicated ANM training schools – exclusively catering to candidates from areas where eligible ANMs are unwilling to be posted – should be considered. This is especially true for tribal areas. Necessary policy decision regarding entry qualification / procedures, selection of women from difficult areas, requisite representation of SC / ST candidates should be taken to facilitate it. Suitable ASHAs/ AWWs could also be sponsored for this training. The plan for vocational stream in higher secondary schools in remote areas could be explored in especially difficult areas.

iii. Similarly, initiatives to increase nursing schools and medical education and improve access of weaker sections to such education are also a priority.

iv. For other paramedics, suitable candidates from difficult areas facing deficiency of personnel should be selected and sponsored to training institutions. Necessary changes in rules of eligibility for entry to the courses may be made.

v. Cadre management of as much staff as possible may be decentralised by transferring the responsibility of recruitment, deployment, etc., at the district or even block level to appropriate PRI institutions or empowered committees. Appointment letter

should specifically carry the condition that the appointee shall have to work in a defined area.

vi. Task-shifting and multi-skilling – strategies of rationalisation of the workforce that refer to skilling one cadre of workers for tasks that normally other cadre would do – is one way of getting the right skill mix in place. Thus, training of MBBS doctors for specialist roles, training nurse practitioners or pharmacists for some curative roles where medical officers are not available, training male workers for laboratory roles and so on could be a general strategy and needs to be built on further.

vii. The AYUSH doctor as medical officer in lieu of an MBBS doctors must become part of an appropriate induction and support programme along with the necessary tools for being effective.

viii. The policy on promotions, transfers, postings, incentives taken together constitute one of the most critical indicators of good governance. An active process of engaging with the states to understand their problems and identify best practices in workforce management and support advocacy efforts for improved governance need to be developed. Appropriate non-monetary incentives, selective promotions for good workers, and favourable postings after a stint of ten or fifteen years, etc., should be provided to retain them posted in the area posted.

ix. Examine the issues of private practice of government staff and other conflict of interest situations. Push through an innovative package that engages with this issue. In this context, also examine the compensation package for doctors across the states, and

estimate the costs one needs to pay to get specialists where they are needed.

x. Building up the workforce skills level and skill mix is also a key responsibility of the district establishment. There is a huge requirement of training at all levels. The task is so enormous that ad-hoc arrangements would not be sufficient and require an institutional framework. The development of such a capacity in every large district or cluster of districts is a priority and the SIHFWs would have to give guidance in this regard.

16 Improved Maternal and Child Survival and Population Stabilisation Issues

Some of the concerns about whether we would be able to keep to the planning commission and MDG deadlines for improving maternal and child survival and for population stabilisation relate to the basic systemic issues of functional facilities and manpower availability. But some of them also relate to the design issues of the RCH programme, especially as regards the horizontal integration of different components and its integration into the district plan. The specific recommendation on issues of the RCH programmes in this regard are not gone into detail here, as there is also another process of review and recommendations for the RCH programme, that need not be duplicated.

Neonatal Corner

17 Preventive and Promotive Health

i. The main thrust of concern is the need for better integration of all the disease control measures into an effective district plan with measurable outcomes. One dimension of such integration is ensuring that the human resource and infrastructure deployed on each programme is fully utilised by rationalisation of task allocations between them. The other dimension is being able to address the social determinants and the common factors across such programmes through common strategies. And finally, it also includes a critical examination of each of these programmes and the use of the district planning approach to overcome the constraints they are currently facing.

ii. The other set of recommendations flow with regards to strengthening school health programmes, adolescent health programmes, oral hygiene and dental health programmes and the general lifestyle promotion activity as part of the district and state PIPs. In each of these, there are some preliminary programmes approaches evolving which would need to be built upon, evaluated and then, where appropriate, replicated.

iii. The effort on control and response to chronic diseases has also been slow. The effort to build a response should be integrated into the development of state and district health systems, without placing undue reliance on a further crop of vertical health programmes.

18. HMIS & Disease Surveillance

Both these programmes, despite several years of work that have gone into evolving them, are still evolving in design and very varied in implementation. This work needs to be prioritised so that there is an effective level of functionality across the states in a year. There is also a need to integrate both these aspects in such a way that the infrastructure, equipment and human resource of these two systems are shared even though there are many aspects which are distinct from each other.

19 Social Security Schemes and the Cost of Care

Many schemes for health insurance and risk pooling and for reducing the burden of the costs of care are in the pilot stages across different states. These need to be documented and learnt from so as to evolve a better approach to addressing the social security dimension.

Measures of equity in access, and considerations of gender equity and health equity with respect to programme design and programme implementation and health systems development need to be studied further to ensure that we are developing more equitable health systems.

20. Budgetary Outlays

An institution needs to be put in place or enabled in every state that can generate annual data on the health expenditure patterns, at least with respect to budgetary outlays and allocations within the health sector. This should be used for monitoring the overall pattern of increase in public expenditure in the health sector.

State-wise Performance on 24 Health Systems Development Parameters

ASSESSMENT OF CASELOAD BEING HANDLED BY PUBLIC SYSTEMS AT ALL LEVELS

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	Increase in out-patient cases and JSY deliveries; JSY deliveries in private clinics as well, even without formal accreditation.
2.	**ASSAM**	Increase in number of out-patient and in-patient cases due to JSY, better availability of doctors and medicines; higher increase where human resource gaps, especially Specialists, have been filled; not much change in caseload at sub-centre level as yet.
3.	**BIHAR**	Dramatic increase in caseload at all Block PHCs, Sub District and District Hospitals; 24X7 Block PHCs offering out-patient, emergency and institutional delivery services; substantial increase in institutional deliveries; doctors, drugs, diagnostics, uninterrupted power supply, infrastructure improvement, ambulance leading to improved public demand and expectation from public system.
4.	**CHHATTISGARH**	Improvement in outpatient cases at the sub-centre level. At PHC level, the number has also increased but less. At CHC, the picture was not very encouraging. Load at district hospitals is very heavy and *Jeevan Deep Samiti* has undertaken hospital improvement efforts. Shortage of specialist at CHC makes improvement of inpatient hospitalised care a little slow.
5.	**GUJARAT**	There has been an impressive increase in out-patient and in-patient cases for the State as a whole; often increase is related to the competence and commitment of the doctor posted at PHC which sets of a virtual cycle of all round PHC improvement and patient satisfaction; increase in a district often hides variation within.
6.	**JAMMU & KASHMIR**	Mixed reports of caseload could be seen in all the districts visited; in-patient load in CHC/DH/PHC is not commensurate with inputs of infrastructure and

	STATE	KEY FINDINGS
		manpower; weak thrust on improving quality and range of service delivery.
7.	**MADHYA PRADESH**	Significant increase in institutional deliveries; insufficient increase in general utilisation of services from health facilities; good gains in specially monitored and selected Dhanavantri Blocks.
8.	**ORISSA**	Overall increase in outpatient attendance; however, this increase is primarily in secondary care institutions and largely contributed to by institutional delivery increase; under utilisation of services at primary care level often due to non-availability of services at those levels.
9.	**RAJASTHAN**	General increase in the use of government health facilities – signals a positive change in people's perceptions; apart from institutional deliveries where increase is dramatic, there is increase in outpatient, inpatient, surgical procedures, diagnostics, lab investigations from public system; increasing trend in bed occupancy. National Health Programmes including RNTCP, blindness control, vector borne diseases and IMNCI are operated through the health facilities at all levels – Sub-Centres, PHC, CHC, and District Hospital; these facilities also offer the Indian System of Medicine, especially Ayurveda, to a limited scale.
10.	**TAMIL NADU**	Caseload of patients treated, in-patient and out-patient, has increased considerably during the last one year in all primary healthcare centres, particularly CEmOCs and PHCs; drop in referrals from PHCs to higher level institutions; possible due to improvement of facilities through Patient Welfare Societies and close monitoring; clear shift in the caseload towards public health facilities.
11.	**TRIPURA**	Most facilities showed an increasing trend in out-patient load; institutional deliveries showed a significant increase; in inpatient cases, the picture is mixed, varying from facility to facility.
12.	**UTTAR PRADESH**	Overall impression of a functional public health system which is delivering a considerable quality and quantity of services despite considerable constraints by which it is shackled; increase in institutional deliveries; high outpatients (not necessarily increase) due to improved availability of

	STATE	KEY FINDINGS
		drugs.
13.	**WEST BENGAL**	Sustained efforts at strengthening the public system is leading to higher caseload; sub-centres doing fixed day clinics and *Gram Panchayat*s authorised to hire doctors for a few days in a week, facilitates higher utilisation of services at the Sub-Centre level; drug availability is satisfactory; institutional deliveries have gone up. BPHC and Rural Hospitals' upgradation has also helped in meeting additional caseload.

PREPAREDNESS OF HEALTH FACILITIES FOR INPATIENT CARE AND UTILISATION OF BEDS FOR SUCH CARE

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	Lab facilities adequate at PHC/CHC levels; improvement in infrastructure; blood storage units coming up; need for adequate staffing at selected CHCs/PHCs; case for Mandal level pooling of inpatient services; private practice of doctors interferes with higher utilisation of hospitalised services from public facilities; government doctor is also the private practitioner.
2.	**ASSAM**	While bed occupancy and emergency care is steadily improving, availability of nurses and doctors is still a pressing issue; District Hospitals still catering to main inpatient load; deliveries are now happening at many more places as is surgical procedures; constraint of Specialists is the major issue.
3.	**BIHAR**	Human resources, especially nurses, is a constraint; physical infrastructure is improving steadily; Operation Labour Room to improve services at Block PHCs; Rs. 23 lakhs worth of repair and new buildings in all Block PHCs from Finance Commission funds is nearing completion; PPP for 24X7 power supply by generator and ambulance is working well; PPP for cleanliness needs to be decentralised to facility level from the district level.
4.	**CHHATTISGARH**	While physical infrastructure improvement has taken place, provision of adequate doctors and nurses need to be emphasised. Blood storage at CHC also needs to be prioritised. Upgradation of CHCs behind schedule.
5.	**GUJARAT**	Significant improvement in infrastructure; commensurate addition of Staff Nurses must be a priority for sustained improvement in utilisation of facilities; wherever qualified medical officers and related facilities exist, the bed occupancy seems to be better; availability of drugs was found to be uniformly satisfactory everywhere.
6.	**JAMMU & KASHMIR**	Infrastructure and manpower is adequate in many places; in spite of it, service guarantees are few, especially for hospitalised treatment and surgeries; need to provide more service guarantees; no CS in

	STATE	KEY FINDINGS
		many places despite appropriate specialists posted there.
7.	MADHYA PRADESH	The improvement in facilities for inpatient care is not commensurate with the increased load due to JSY; needs priority attention; need to streamline systems of diagnostics and availability of medicines.
8.	ORISSA	Nomenclature differences of PHC/CHC; there is progress in facilities though yet to reach Indian Public Health Standards; staff shortages and non-availability of staff during odd hours present a major constraint; diagnostic facilities and logistics of drugs and consumables need improvement.
9.	RAJASTHAN	Increasing utilisation of services putting pressures for better preparedness; infrastructure is much better at many places because of conjunctive use of NRHM and RHSDP funds; but still needs more inputs and a better hygiene and sanitation, upgraded institutions with human resources doing much better.
10.	TAMIL NADU	Available bed strength being utilised quite satisfactorily; facility improvement is under way.
11.	TRIPURA	Health functionaries are a very committed team, but shortages of trained professionals like specialists, doctors, para-medics, nurses and lab technicians; Improvement of physical infrastructure also needs to be on a faster track as PWD is not able to cope with the additional load; availability of drugs is satisfactory; TB and Malaria tests are in public facility; lot of other tests are from private providers.
12.	UTTAR PRADESH	Nursing staff is a major constraint; shortage of specialists also a constraint, good level of improvement in hospital cleanliness and demand for services; untied funds and RKS helping tide over problems.
13.	WEST BENGAL	128 PHCs and 93 Block PHCs have been upgraded; another 82 BPHCs being up graded; Doctors, Specialists and Nurses have been appointed; Lab Technician appointments are held up due to a court case; PPP for diagnostic services have been started in some BPHCs and Rural Hospitals; there is a demand for more such facilities.

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Institutional deliveries in public and private facilities; BPL paid on the basis of certificate; 26 per cent institutional deliveries in public sector in the districts visited.
2.	ASSAM	Mixed picture, depending on human resource availability; signs of improvement in CHCs/ FRUs in many places; need to improve cleanliness and waste disposal; community perceives improvement in services due to improved infrastructure and availability of drugs, doctors, nurses and para-medics at health facilities.
3.	BIHAR	Quality of services compromised due to large scale shortage of Nurses; State is recruiting 8000 ANMs/Nurses; need to focus on cleanliness, waste disposal, etc.
4.	CHHATTISGARH	While JSY coverage has increased, payments are not timely. More attention needs to be paid to quality of service.
5.	GUJARAT	Qualified medical officers for conducting deliveries was found in most of the institutions; in particular, district and sub district hospitals showed brisk activity and interest from doctors to patient needs; RKS filling gaps in infrastructure; problem of shortages of doctors and specialists and staff nurses remains everywhere and more glaringly so in un-served and underserved areas specially in the tribal tracts; there are no short term solutions for such shortage except to increase intake in Nursing Schools.
6.	JAMMU & KASHMIR	Very poor condition of labour rooms and lack of privacy in many places; inadequate new born care; improvement in institutional deliveries after JSY recorded in all institutions but quality of care needs to improve.
7.	MADHYA PRADESH	Quality of services needs improvement; RKS must have greater patient welfare focus; early discharge after deliveries is a problem; need to prepare facilities for inpatient care; cases of misuse of JSY as well.

8.	**ORISSA**	Quantum increase in institutional deliveries putting further load on secondary care institutions – Block PHC, CHC, Sub District and District Hospitals; very few deliveries at Sub-centre / Mini PHC level.
9.	**RAJASTHAN**	Sharp increase in institutional deliveries; 62 per cent jump over 2006; quality of care improving; hospital stay needs to be longer; need for more cleanliness in some institutions; improved performance and maintenance due to RMRS and untied funds in many institutions.
10.	**TAMIL NADU**	Availability of medical and para-medical and nursing personnel in the Block PHCs and other PHCs was found to be satisfactory; infection management and cleanliness found to be satisfactory; patients satisfied with the quality of services.
11.	**TRIPURA**	Increase in institutional deliveries is noticeable; still a large number of home deliveries due to distance factor from facilities; preparedness for complicated deliveries compromised with shortage of trained professionals; One New Medical College through PPP and Nursing College through PPP recently set up – may ease situation in a few years.
12.	**UTTAR PRADESH**	Gaps in quality of care at all levels; Sub-centre deliveries suffer in the absence of physical infrastructure and referral transport linkages; women returning after 3-4 hours post delivery from facilities is a problem; delivery cases have tripled at District Hospital level. Insistence on replacement donors even in case of life saving transfusion under JSY is a problem.
13.	**WEST BENGAL**	Institutional deliveries have increased; Many Sub-centres are far better equipped now with untied funds to carry out deliveries; Upgradation of PHCs and BPHCs along with the untied funds have also helped in improving the infrastructure; *Panchayat*s are fully involved in this process of improving quality of services.

IV SYSTEMS IN PLACE FOR IMMUNISATION AND CHANGES IN THE FIELD

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	Performance of the State is satisfactory.
2.	**ASSAM**	Impressive progress in immunisation coverage; increased awareness is palpably visible at all facilities; cold chain and vaccine availability well maintained; major role of ASHAs and ANMs in enhancing awareness and in organising immunisation rounds; improved monitoring of performance at State level.
3.	**BIHAR**	Cold chain well maintained; Facility improvement of Block PHCs and PPP for Generators at Block PHCs helps; alternate delivery of vaccines is working well; polio rounds taking too much time, adversely impacting on other health programmes.
4.	**CHHATTISGARH**	*Mitanin*s has completed list of hamlets where children were not immunised. List has been acted upon by district authority enhancing immunisation coverage.
5.	**GUJARAT**	Following measures for effective immunisation initiated – mapping of poor performing Blocks followed by area specific strategies; immunisation through mobile unit in difficult and remote areas; monitoring through RIMS; appointment of State Routine Immunisation Monitors; measles surveillance.
6.	**JAMMU & KASHMIR**	System of routine immunisation at facilities on fixed date and out reach in villages could be recorded; increase in coverage and usage of AD Syringes; regular immunisation sessions being held at village level and in Sub-centres as per records. System of waste disposal needs to be put in place.
7.	**MADHYA PRADESH**	Report has not commented on immunisation separately; more improvements in the selected Dhanavantri Blocks that are being monitored closely; some thrust on maternal and child health, including immunisation.

	STATE	KEY FINDINGS
8.	ORISSA	No confirmation of increase in immunisation coverage; even where institutional deliveries have significantly increased, there is no matching increase in immunisation coverage,
9.	RAJASTHAN	Very good progress in covering children below one year for full immunisation; strong monitoring; functional sub-centres improves outreach.
10.	TAMIL NADU	State has adopted 'fixed day fixed place' system for immunisation; every Wednesday; 8683 Village Health Nurses visit villages and around 1500 workers in urban areas to carry out immunisation activities; has ensured timely immunisation and quality coverage.
11.	TRIPURA	Immunisation coverage is high; Village Health Days are popular; system of following up on immunisation of children; helicopter used for health camps in remote areas.
12.	UTTAR PRADESH	Alternate vaccine delivery and untied funds to Sub Centres has helped in improving the sessions for immunisation.
13.	WEST BENGAL	Some stock outs for OPV and hepatitis B vaccine has been reported; otherwise immunisation levels in West Bengal continue to be satisfactory.

V DIAGNOSTIC FACILITIES AT HEALTH FACILITIES AND THEIR EFFECTIVENESS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory quality of diagnostic facilities available at all levels.
2.	ASSAM	Lab Technicians have been deployed PHC onwards; further vacancies being filled up; ANM providing basic services; need to multi-skill and break separate vertical systems for diagnostics; gaps in equipment and maintenance in some places; new equipment are with three year AMC.
3.	BIHAR	Diagnostic services up to Block PHCs through PPP working very well; basic services available at reasonable cost; X-rays in 136 institutions by outsourcing.
4.	CHHATTISGARH	Not commented upon.
5.	GUJARAT	Satisfactory availability of diagnostic facilities and their utilisation at all levels.
6.	JAMMU & KASHMIR	Diagnostic facilities of X-ray, ultra sound, ECG, lab , were available in all Sub Divisional Hospitals and one PHC visited; facilities being poorly utilised in many places.
7.	MADHYA PRADESH	Improvements in a few places; key Lab Technician shortages hamper diagnostic services;
8.	ORISSA	Diagnostic facilities weak; compartmentalised system of TB and Malaria needs to move towards multi-skilling; happening in a few places.
9.	RAJASTHAN	Basic diagnostic facility available everywhere; free for BPL, pensioner, and senior citizen; user charges for others through RMRSs (equivalent of RKS).
10.	TAMIL NADU	All PHCs are provided with lab providing basic facilities; special services like ECG, X-Ray in upgraded PHCs; semi-auto analysers in Block PHCs; District Hospitals have ECG, X-Ray, Ultra sound with CT Scan.

11.	**TRIPURA**	TB and Malaria diagnostic facilities in PHCs; other tests in private in many places; need for integration and multi-skilling of Lab Technicians and other para-medics to improve availability of diagnostic services.
12.	**UTTAR PRADESH**	Though under staffed, basic diagnostic facilities were available at most places; staff shortages are a key issue. Multi-skilling offers potential for closing gaps.
13.	**WEST BENGAL**	PPP for diagnostics seem to be working well in Bengal as well; Lab Technician for TB and Malaria are there but they do not seem to be doing TLC/DLC/ etc. The inability to fill up vacancies of Lab Technicians due to court cases is also posing problems; there is demand for PPP for diagnostics.

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	There are manpower mismatches; need to focus on a few institutions rather than all institutions at the same time, for inpatient, hospitalised treatment; satisfactory Lab Facilities; satisfactory position of Nurses; over 2500 2nd ANM already appointed.
2.	**ASSAM**	NRHM has increased/improved availability of MBBS Doctors, AYUSH Doctors, Nurses, ANMs; Lab Technicians and Pharmacists being recruited; ASHAs are very enthusiastic and are helping in putting community pressure on public facilities.
3.	**BIHAR**	Improving, but not fast enough; Sub-centres and Additional PHCs to be fully operational shortly; present focus on Block PHCs; Appointments of ANMs, Nurses, Lab Technicians, OT Assistants near completion; need to plan for additional manpower more effectively, especially nurses.
4.	**CHHATTISGARH**	There are shortages of staff at various levels. State needs to plan nursing and doctor needs more effectively. Quality of ANMs is reasonably good. *Mitanin* programme very strong, more than 60,000 *Mitanin*s creating an environment for state health institutions to provide services. *Mitanin*s very effective in the field. They have drug kits as well.
5.	**GUJARAT**	Major shortages in most cadres, AYUSH doctors being posted to fill vacancies of medical officers in PHCs; lack of specialists; urgent need for nursing staff to provide actual 24X7 services; ANM deputation reduces availability of ANMs where they are needed; Lab Technicians have been provided in most of the PHCs.
6.	**JAMMU & KASHMIR**	Good availability of Specialists and other professionals; Specialist services during day time; need to provide more quarters for staff to enable resident health workers; need for rationalisation and clear service guarantees from professionals.
7.	**MADHYA PRADESH**	Large scale shortages at all levels including specialists, PHC doctors, MPW (Male), Pharmacists and Lab technicians. Employment of doctors is only on contract basis since several years. Some

		manpower shortages being met in innovative ways; PPP training sponsorship for nurses from vulnerable social groups and remote areas; large scale shortages.
8.	**ORISSA**	Shortage of 700 Medical Officers; need for manpower needs assessment and long term planning; shortage of Nurses and ANMs; State has taken many steps – additional incentives for KBK area, appointment of contractual specialists, increase in MBBS seats, doubling Diploma in Lab Technology seats, 33% increase in intake of ANM Training schools, starting B.Sc. and M.Sc. Nursing courses, short-term course on Anaesthesia and Emergency Obstetric Care, and posting of 1500 additional staff nurses in the peripheral institutions.
9.	**RAJASTHAN**	Shortage of Specialists, especially Gynaecologists, Anaesthetists, and in public health; MPW(M) not filled up and training institution languishing; ASHA *Sahyogini* doing TB, Malaria, JSY and immunisation work, besides coordination with ICDS.
10.	**TAMIL NADU**	3 years compulsory rural service helps in filling vacancies; 740 VHN posts and 2400 Medical Officer posts filled up; 2258 Nurses recruited under NRHM to provide 24 hour service at PHCs. Second ANM not being considered as PHCs are able to close the gap.
11.	**TRIPURA**	Doctors' Association playing very important role in reducing absenteeism by promoting rotational posting for remote areas; there is a shortage of adequate number of trained and skilled doctors, nurses and para-medics. Need for more ANM Schools; two districts do not have any institution.
12.	**UTTAR PRADESH**	Human resource is the challenge in Uttar Pradesh; large unmet need for nurses, doctors and para-medics; need for more rational deployment as well; Key Specialist shortages alongside incidence of irrational deployment as well. AYUSH doctor being added at PHCs. 2nd ANM not in place. Large gap in male workers.
13.	**WEST BENGAL**	West Bengal has taken major steps to meet its need for ANMs; training capacity has been raised from 600 to 3500 by involving higher order Nursing Institutions in ANM Training and by involving Non Governmental organisations; difficulties in getting Specialists; strong Nursing cadre and Directorate is helpful in further strengthening the system.

VII UTILISATION OF *ROGI KALYAN SAMITI*S AND UNTIED FUNDS AT VARIOUS LEVELS

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	Large scale use of untied funds at all levels; VH&SC, Sub-centres, Hospital Development Societies have received funds and utilised it; Sub-centre needs not taken care of as resources are given village wise; sanitation and cleanliness is the focus; wider public health activity likely to be taken up
2.	**ASSAM**	RKS and untied funds have worked as enablers at all the places visited; used for improvement of amenities; elected representatives involved; funds being used for emergency referrals as well.
3.	**BIHAR**	Funds have reached and utilisation has just started up to Block PHCs; need to speed up utilisation to improve cleanliness and basic standards; need for stepping up of activity at Sub Centre and Additional PHC level; RKS guidelines prepared and disseminated; institutions need confidence to spend; electricity, ambulance, diet, and cleanliness through PPP.
4.	**CHHATTISGARH**	Untied funds utilised at all levels from sub-centre, PHC, CHC, etc. *Jeevan Deep* Societies playing positive role in hospital improvement need to give more confidence to these Societies for utilising untied funds.
5.	**GUJARAT**	RKS at the level of hospitals and sub hospitals are well set; RKS at CHC level is one year old and teething problems are over; RKS at PHC not registered as yet in many places; funds used for face lift of facilities; need to do more patient oriented services as well.
6.	**JAMMU & KASHMIR**	Hospital Development Boards from before charging user fees; RKS formed at PHCs and funds received; process being completed in CHCs and District Hospitals; few facilities were yet to receive funds.
7.	**MADHYA PRADESH**	RKS are fully functional; evidence of substitution of State Government resources by RKS resources; needs immediate rectification; user fee

		collections form large part of RKS Budget; infrastructure maintenance, salary and medicine purchase are few items of expenditure; need to provision medicines from general hospital budgets; need to ensure that poor are not denied health care because of user charge.
8.	**ORISSA**	RKS set up everywhere but not effective everywhere as yet; works taken up to improve facilities; needs to make RKS realise their role and function.
9.	**RAJASTHAN**	RMRSs established everywhere up to PHCs; raising revenues and also receiving untied grants; reasonable sums of discretionary funds are now available at institutions; while some have made good use, fear of incurring expenditure in others; Sub-centres have improved with untied funds; cashless hospitalisation of BPL – a focus in RMRSs.
10.	**TAMIL NADU**	Patient Welfare Society funds has led to marked improvement in the facility appearance and has considerably improved the look of the facility; development of gardens, gas stove connections, repair, RO system for drinking water, inverter in labour room, etc., done with untied funds.
11.	**TRIPURA**	RKS funds and untied funds very well utilised with complete involvement of *Panchayati Raj* Institutions.
12.	**UTTAR PRADESH**	Untied funds well utilised at Sub-centre level, improving the performance of the institution; RKS set up and beginning to use resources. Delayed utilisation of RKS/untied funds due to delays in guidelines. State already had system of user charges which has been modified; need to ensure that resources remain with the institution.
13.	**WEST BENGAL**	RKS formed in each and every institution up to PHC level; *Panchayat*s fully involved; untied funds used very effectively to improve the quality of services; physical infrastructure handed over to *Panchayat*s for maintenance; *Panchayat Samiti* involved in decision making.

VIII INVOLVEMENT OF *PANCHAYATI RAJ* INSTITUTIONS IN THE FUNCTIONING OF THE HEALTH SYSTEM

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	PRIs involved in VH&SC, Sub-centre level activities; as members of Hospital Development Societies.
2.	**ASSAM**	VH&SC not set up as yet as fresh PRI election is to be held; willingness to involve PRIs, village opinion leaders, local NGOs and *Mahila Samitis*; PRIs participating in RKSs and at Sub-centre level.
3.	**BIHAR**	VH&SC to be set up under the umbrella of PRI very soon; *Panchayat*s involved in RKS; need to orient PRIs for better management of health institutions and for inter-sectoral convergence.
4.	**CHHATTISGARH**	*Mitanin* programme works very closely with *Panchayati Raj* Institutions. Innovative *Swasthya Panchayat Yojana* in Chhattisgarh. Indicators have been developed for measuring health status and delivery of health services at the village level. *Panchayat* fully involved in this exercise. State is now setting up VH&SC under umbrella of PRI.
5.	**GUJARAT**	Need to involve PRIs more directly; DHS meets but the District Health Mission under the *Zila Parishad Adhyaksha* does not meet often; VH&SC accounts managed by ANM and teacher and not by PRI representative; need for capacity building in PRI members for better management of the health system.
6.	**JAMMU & KASHMIR**	No PRI in J&K; however, community members are fully involved.
7.	**MADHYA PRADESH**	Not commented upon separately; need to step up involvement of *Panchayati Raj* Institutions; joint accounts have been opened.
8.	**ORISSA**	PRI role limited to attending meetings and management of untied funds; VH&SC not in place as yet; ASHA has been positioned; Village Health Days are being conducted.
9.	**RAJASTHAN**	*Panchayat*s involved in the health system; partnership at Sub-centre level is working well; Village Health Committee meeting regular; Village Health Committee and water and sanitation

		committee to merge under the umbrella of *Panchayati Raj*.
10.	**TAMIL NADU**	12619 Village Health and Sanitation Committees are fully functional; untied grants used for cleanliness; has helped in community involvement; involvement of PRI at village and Sub-centre level is very good; *Panchayat*s providing free meals for patients in a few places.
11.	**TRIPURA**	Very high and effective involvement of *Panchayati Raj* Institutions in health institutions; very active in *Rogi Kalyan Samiti*s and Sub-centre Committees; Village Health Committees being constituted along with water and sanitation committees;
12.	**UTTAR PRADESH**	PRIs are involved in the Village Health and Sanitation Committees and the Sub-centre level Committee, as also the RKS; need to enhance their involvement in the management of the health system.
13.	**WEST BENGAL**	*Panchayat*s are actively involved in the management of the health system; RKS and united funds available with them; *Gram Unnayan Samitis* working as VH&SCs.

IX PROCESS OF PREPARATION OF DISTRICT HEALTH ACTION PLANS AND QUALITY OF DISTRICT HEALTH MISSION MEETINGS

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	District Plans prepared in 2007-08. District Teams are involved; involvement will increase with earmarked DPMUs and SPMU for the purpose, which is in the process of being set up.
2.	**ASSAM**	24 districts prepared plans in 07-08; regular district level review meetings; review by CM/Minister regularly improves performance; need to improve record keeping of District Health Mission meetings.
3.	**BIHAR**	District Plans by UNICEF in 2 districts; rest of the district through technical consultants; data collected but matter went into litigation; still being resolved; low local involvement.
4.	**CHHATTISGARH**	All districts have prepared their plans in the previous year. Need for more intensive discussion on the district plans. Need to link it up with *Swasthya Panchayat* programmes.
5.	**GUJARAT**	Plans prepared for all the districts; approved by the Executive Committee; need to seek approval of the District Health Mission.
6.	**JAMMU & KASHMIR**	District Plans nearing completion; done by contracting out; while planning is participatory, district level health functionaries needed to be more fully involved in the process; District Health Society meetings being held; need more focus on NRHM.
7.	**MADHYA PRADESH**	Good system of District Health Action Plans and their appraisal; District Plans as basis for monitoring and review as well; village plans being developed. Need more participatory processes at community level.
8.	**ORISSA**	District Health Action Plans prepared for 2007-08; being prepared for 2008-09; District Health Mission involved but process needs more decentralisation to be able to capture needs.
9.	**RAJASTHAN**	26 of the 32 districts have prepared integrated plans; 23 plans already appraised; remaining plans being prepared; District Missions active.

10.	**TAMIL NADU**	2007-08 plans complete; Plans for 2008-09 are under way; will be completed by January 2008; Facility surveys nearing completion for PHCs and Sub-centres; Household surveys are in progress.
11.	**TRIPURA**	Village Plans are prepared based on household health data and with involvement of PRIs; facility surveys were conducted but without involvement of community/PRI; Planning and Monitoring Committees have to be established; District Plans prepared for all the four districts.
12.	**UTTAR PRADESH**	District Health Action Plans have been prepared but the involvement of district teams is weak; need to improve involvement of local stakeholders.
13.	**WEST BENGAL**	2007-08 Plans made by all 23 districts; process for 2008-09 under way; likely to be completed in January 2008; *Panchayat*s fully involved at each level; Chairman of *Zila Parishad* heads the District Health Mission that meets regularly;

X SYSTEMS OF FINANCIAL MANAGEMENT

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Quality of accounts in Area Hospitals and project Hospitals is satisfactory; need for improvement in untied fund accounts at PHC/CHC/Sub-centre and VH&SC level; need for more capacity building.
2.	ASSAM	Very good accounting system with proper account books, payment and receipt records, referral details, etc., being maintained; well performing system for flow of funds.
3.	BIHAR	SPMU, DPMU, Block Managers are all in place; SPMU needs to improve supervision; Monthly district audit proposed.
4.	CHHATTISGARH	SPMU and DPMU have been set up. Need to improve their acceptance within main stream health system. Clarity of role required.
5.	GUJARAT	The overall financial management system seemed to be properly streamlined; District Accounts Managers managing accounts at the district level; delegation of administrative and financial powers needed.
6.	JAMMU & KASHMIR	Need to improve financial management system; SPMU/DPMU in place since April 2007; need for orientation and training of functionaries; need to follow financial procedures as laid down in NRHM system; need to ensure timeliness of fund releases.
7.	MADHYA PRADESH	Excellent system of monthly district audit; SPMU/DPMU fully functional; timely audit of accounts; governance issues regarding procurement need attention.
8.	ORISSA	Need for dedicated accounting personnel at Block level; SPMU and DPMU is in place; no delay in release of funds to districts.
9.	RAJASTHAN	Societies have merged; SPMU/DPMU are functional; Block Management structure being put in place; fund flow is smooth; very good use and accounting of untied funds.
10.	TAMIL NADU	System of record keeping right from the village and

		sub health centre levels to PHC/*Taluk* hospitals and District Societies is extremely good; system of financial reporting is very good.
11.	**TRIPURA**	Untied funds have increased the need for better financial management as there are many more details needed; strengthening of the system is going on; needs some more attention.
12.	**UTTAR PRADESH**	SPMU/DPMU not set up as yet; however systems, mainstream health functionaries are satisfactorily managing the financial system, including of JSY.
13.	**WEST BENGAL**	Accounts Managers provided in Districts and Blocks; Financial management system is very effective; PRIs involved in decision making at all levels.

XI HMIS AND ITS EFFECTIVENESS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Effective reporting system for surveillance; ANMs reporting weekly; data being acted upon.
2.	ASSAM	The availability of information and its use at the State level is very good; district level needs to do more data analysis rather than mere mechanical data collection.
3.	BIHAR	Data Centre at State level collecting Block PHC data regularly; data being used for effective monitoring; district level needs to be activated.
4.	CHHATTISGARH	System of reported through sub-centres. Needs further strengthening.
5.	GUJARAT	Useful institution specific data being generated and regularly monitored; helps in focusing on under performing institutions.
6.	JAMMU & KASHMIR	HMIS being collected by facilities and submitted to district/State; however, analysis of data collected not happening at facility and district level; need for facility specific monitoring to ensure full utilisation of professionals at institutions.
7.	MADHYA PRADESH	Useful MIS work; reporting systems getting streamlined.
8.	ORISSA	A weak area in the State; Monthly Sub-centre reports submitted to PHC; needs more local level analysis. State is proposing training of staff for better data management.
9.	RAJASTHAN	Report has not commented on HMIS.
10.	TAMIL NADU	Excellent reporting system is in place; All districts are reporting on the new MIES format on time.
11.	TRIPURA	Integrated MIES data formats found at lowest levels; Multiple reporting still in vogue; contractual staff reporting on NRHM; needs more support of regular staff; community monitoring is not in place as yet but PRIs are involved in sanction and expenditure of untied funds across all facilities.
12.	UTTAR	

	PRADESH	Need to improve system of HMIS and quality of data. Facility specific data has been devised for monitoring service guarantees. More effective use of the data is possible for district planning.
13.	**WEST BENGAL**	Not commented upon in the CRM Report; Good data collected as part of planning for Health System Reform in West Bengal; need for integrating data sets effectively.

XII RATIONAL USE OF MANPOWER AT VARIOUS LEVELS TO ENSUREAPPROPRIATE SKILLS FOR BETTER OUTCOMES

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	Rationalisation calls for pooling of hospitalised, in patient services; Sub-centre, PHC, CHC Nursing needs provided for; shortage of Specialist; need to ensure assured services.
2.	**ASSAM**	Though manpower is being used optimally, there is room for some further rationalisation; shortage of Specialists; under utilisation of 2nd ANM due to non residence – need for corrective action; ASHAs helping put pressure on public system.
3.	**BIHAR**	Serious efforts at rationalisation by Block pooling of doctors at Block PHC, Sub Divisional and District Hospital; more service guarantees, especially with regard to surgery and in patient care possible with this rationalisation, but not happening as yet; shortage of nurses/ANMs.
4.	**CHHATTISGARH**	Governance reforms needed to ensure rationale deployment of specialists, doctors and nurses. System of incentives introduced to encourage doctors and nurses to work in remote areas. Better governance and cadre management needed.
5.	**GUJARAT**	Since large vacancies will continue to occur at all staff and professional levels, the skill mix would have to be constantly evolving and shortages will have to be met by trying many innovations; one third of the PHCs in a district had staff shortages.
6.	**JAMMU & KASHMIR**	Need for rationalisation from large pool of manpower available to the State to guarantee services; need to carefully look at facility and service mix; need for orientation and training of staff nurses.
7.	**MADHYA PRADESH**	Report has not commented on this separately; while staff availability has improved, more work needed to ensure better rationalisation of services in remote areas; need for improved promotional avenues and regularised (not contractual) employment for PHC and CHC doctors to attract more medical human-power to the rural public health system.
8.	**ORISSA**	Lack of rational use of manpower is an area of

		concern; Specialists posted in PHC is wasting of skill; need for system of posting and transfers. State has engaged 259 AYUSH doctors.
9.	**RAJASTHAN**	Deployment is rational but shortages persist, especially for Specialists; GNMs being appointed as ANM but MPW (M) vacant.
10.	**TAMIL NADU**	'Counselling' an integral part of the posting system; Human resource shortages made up by hiring of services whenever required.
11.	**TRIPURA**	State is rationally using manpower; ANMs from outside the district poses problems in remote areas of non-residence since malaria is a problem, State has filled up posts of MPW (Male) on contract.
12.	**UTTAR PRADESH**	Lot more rationalisation needed in the management of cadre of Specialists and Doctors; need for rational use of Nurses, Paramedics as well, based on case load.
13.	**WEST BENGAL**	Efforts have been made to rationalise manpower and make the system efficient and effective; few key vacancies (Specialists, Lab Technicians) posing problems; decentralisation of contractual recruitments at local level, even by *Gram Panchayat*s for fixed day services.

XIII THRUST ON DIFFICULT AREAS AND VULNERABLE SOCIAL GROUPS

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	More inpatient treatment in public facilities will improve access of vulnerable groups; outpatient facilities and availability of drugs is useful.
2.	**ASSAM**	District PIPs reflect special thrust on SC/ST and minorities; separate record of OPD cases of SC/ST/Minorities, available for inspection; coverage of Char areas by camps; demand for health services in Char areas.
3.	**BIHAR**	Poor flocking government hospitals for drugs, doctors and diagnostics; operationalising Sub-centres and Additional PHCs will further help in attending to needs of vulnerable groups.
4.	**CHHATTISGARH**	*Mitanin* programme very pro poor. Provides communities an opportunity to seek health services. Need to improve health services faster.
5.	**GUJARAT**	Data on SC/ST being generated by HMIS; closer monitoring of data driven monitoring required.
6.	**JAMMU & KASHMIR**	Special action on remote areas through RCH camps/sessions.
7.	**MADHYA PRADESH**	Mobile units for remote areas; more camps needed in remote areas. In tribal areas, ASHAs are required at hamlet or cluster of hamlets level (may be below 1000 population) to ensure adequate coverage of remote and far-flung households.
8.	**ORISSA**	State has initiated a large number of activities for tribal areas; *Swasthya Melas*, incentives for posting in difficult areas, etc.
9.	**RAJASTHAN**	Clear BPL focus in RMRSs for cashless hospitalised treatment of BPL; provision for generic drugs for poor.
10.	**TAMIL NADU**	Ambulance services and RCH camps take care of many needs; Specialist camps are also being organised; thrust is on vulnerable groups.
11.	**TRIPURA**	Helicopter service health camps in remote, inaccessible tribal villages; State needs to analyse

	STATE	KEY FINDINGS
		disaggregated data on health parameters.
12.	**UTTAR PRADESH**	Activation of Sub-centres though untied grants and presence of ASHAs helps households to connect with health facilities; almost two third of deliveries at the PHC/CHC were of SC and OBC, but coverage still low; need to further increase focus on marginal groups.
13.	**WEST BENGAL**	Vulnerable groups are a focus; ASHA only for tribal areas and minority concentration areas with unsatisfactory indicators; ANMs from difficult areas from such communities.

XIV ASSESSMENT OF PERFORMANCE OF ASHAs, LAB TECHNICIANS, MEDICAL DOCTORS, ETC.

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	ASHAs selected and completing 23 day training; very high quality of training by NGOs; likely to make a difference in the demand for public services.
2.	**ASSAM**	ASHA enthusiastic and enjoys confidence of community; ASHAs given radios; ASHA radio programme well received; 2nd training going on; Non resident 2nd ANM is a concern; ASHAs demanding services for communities.
3.	**BIHAR**	ASHAs are local and very enthusiastic; well trained for basic activities; handling JSY, Immunisation, DOTS; playing social mobilisation role; very active; payments not timely; need for facilitation and resource support.
4.	**CHHATTISGARH**	*Mitanin*s are an outstanding success. ANMs in the field working very well. More Lab Technician, Doctors, Specialists required with better governance and incentive system.
5.	**GUJARAT**	ASHA/*Gram Arogya Sathi* selected; first round training nearing completion; drug kit must be provided to ASHAs immediately on completion of training.
6.	**JAMMU & KASHMIR**	ASHA selection completed; first round training complete; second round in a few districts; ASHAs found to be quite knowledgeable; non payment against activities is an issue. Need to record output of all functionaries in institutions.
7.	**MADHYA PRADESH**	Most ASHAs selected and first round training completed; lack of role clarity between ASHAs and AWWs/ TBAs; creating conflicts regarding compensation money.
8.	**ORISSA**	ASHAs are visible everywhere; selection complete; 36% have advanced training and 88% had done induction training; Trained ASHAs have badges; induction training has been found to be very helpful.

	STATE	KEY FINDINGS
		.Performance of ANM is not satisfactory; delay in release of ANM salaries; shortage of para-medical staff; performance of doctors not satisfactory at PHC/CHC level; overburden on doctors at Sub Divisional and District Hospital level.
9.	**RAJASTHAN**	ASHA *Sahayoginis* are doing very well; handling malaria, TB, immunisation, JSY and family planning; well integrated with ICDS; blended payment of stipend and performance based payment is a good model; ANMs are doing well.
10.	**TAMIL NADU**	The patients, the community, and all stake holders have a very high opinion of health personnel in the State; known for their devotion to work; ASHAs not provided for Tamil Nadu.
11.	**TRIPURA**	Health staff are generally motivated, committed and enthusiastic; ASHAs selected by transparent process involving the PRIs; trained in first module and provided drug kits; training included training on use of Rapid Diagnostic Kits for malaria; bright red coats and blue kit bags have given a unique sense of pride and identity to the ASHAs; ASHAs working as drug dispensers and JSY motivators. Doctors playing important role in remote areas;
12.	**UTTAR PRADESH**	ASHAs have had one round of training; there is drop out especially of those who were looking for government employment; immunisation, JSY work focus; payments are not timely; need to ensure drug kits and involvement in more public health activities. Almost two third of deliveries at the PHC/CHC were of SC and OBC, but coverage still low; need to further increase focus on marginal groups.
13.	**WEST BENGAL**	ASHAs not in position as yet; ANMs doing very well at Sub-centres; Doctors and Nurses meeting additional load at PHCs, Block PHCs and Rural Hospitals.

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory system of disease surveillance in place; regularity of report by Sub-centres; good quality labs at PHC/CHC level; IDSP getting well established. 108 and 104 emergency and Counselling services to be used for surveillance as well.
2.	ASSAM	Surveillance limited to TB and Malaria; District Surveillance Unit not fully functional; new computers supplied but not installed.
3.	BIHAR	Weak system; Disease Surveillance Team not effective; ASHA is active but not reporting to the surveillance team; need to activate below Block PHC for effective surveillance and reporting systems.
4.	CHHATTISGARH	Disease surveillance through *Mitanin*s and ANMs need to improve receptivity of PHCs, CHCs to information from below. Labs at PHCs level were found to be satisfactory with trained technicians. *Mitanin*s visiting household regularly for fever survey. *Mitanin*s having drug kits.
5.	GUJARAT	The system is working satisfactorily and the time taken for reporting surveillance data is within stipulated time frame; IDSP central monitoring cell has been established; District surveillance Officers placed and manpower trained.
6.	JAMMU & KASHMIR	Reporting of IDSP has started in selected districts.
7.	MADHYA PRADESH	Not commented upon separately. Needs attention; disease surveillance units need to be made active and functional; current focus is much more on maternal and child health alone.
8.	ORISSA	Surveillance system not functioning very effectively, though cell has been constituted.
9.	RAJASTHAN	No comment in the Report.
10.	TAMIL NADU	IDSP trying to integrate communicable and non communicable diseases; 28 District Surveillance Units fully functional; Lab facility modernised under IDSP.

	STATE	KEY FINDINGS
11.	TRIPURA	IDSP Centres are operating at all levels and registers are being maintained; Supervisors and ANMs/MPWs have been trained under IDSP and are sending reports; PHCs have received computers but software is not installed yet; data operators being shortly placed at PHCs.
12.	UTTAR PRADESH	Not reported on.
13.	WEST BENGAL	ANM doing disease surveillance work as well; involved in leprosy, TB, Malaria and blindness control programmes; malaria a focus.

XVI PREVENTIVE AND PUBLIC HEALTH MEASURES FOR VECTOR CONTROL AND EFFORTS AT INTER SECTORAL CONVERGENCE

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	Untied funds of VH&SCs and Sub-centres have been used for sanitation and water purification activities; wider public health focus will emerge.
2.	**ASSAM**	VH&SC Not set up as yet – waiting for *Panchayat* elections; spray of DDT, etc., reported but specific efforts for inter-sectoral convergence were not visible.
3.	**BIHAR**	Community involvement in select Kalazar districts in DDT spray; new initiative of *'Muskaan'* for 100% immunisation and 100% institutional delivery involves ICDS Centres, AWWs and ASHAs together as a team; Constitution of VH&SC in partnership with the water and sanitation committee (as proposed) under the umbrella of PRI will be helpful in inter sectoral convergence.
4.	**CHHATTISGARH**	*Mitanin*s playing critical role in the behaviour change communication and community activities.
5.	**GUJARAT**	The measures for control of vector borne diseases under NVBDCP guidelines are in position and working satisfactorily; involvement of PRIs has been there; inter sectoral convergence for vector control in position through institutions.
6.	**JAMMU & KASHMIR**	Inter sectoral convergence not started as yet.
7.	**MADHYA PRADESH**	Nutrition Resource Centres have been established in 60 places; effective in handling extreme forms of malnutrition; a pilot initiative; more inter-sectoral convergence required.
8.	**ORISSA**	Malaria major vector borne disease; New measures – involvement of NGOs in spray, epidemic response team in each district, sensitisation of traditional healers, message transmission through school students and SHGs, ASHA trained on a pilot basis in 50 Blocks, GIS mapping, etc.
9.	**RAJASTHAN**	Good partnership with ICDS through ASHA *Sahayogini*; Sub-centres have improved performance though untied funds and are better

	STATE	KEY FINDINGS
		placed for convergence; Maternal, child and nutrition days being organised in every village; Village health and Sanitation Committees have been constituted at *Gram Panchayat* level but are not fully functional as yet.
10.	**TAMIL NADU**	Health Inspectors (MPWM) at PHC level doing malaria surveillance; VHNs trained in various diseases; Lab Technician available at every PHC; Regular system of monitoring and review besides availability of trained personnel with earmarked responsibilities.
11.	**TRIPURA**	Village Health Committees to be constituted by merging with the water and sanitation committee; PRIs fully involved.
12.	**UTTAR PRADESH**	RNTCP and malaria programmes in place, case detection in RNTCP poor due to lack of staff in some key facilities and poor coordination with private sector; more integration with district planning needed.
13.	**WEST BENGAL**	VH&SC constituted in 16770 villages as *Gram Unnanyan Samiti,* under the umbrella of PRI; PRIs involved at all levels; provides useful platform for inter-sectoral convergence.

XVII EFFECTIVENESS OF THE DISEASE CONTROL PROGRAMMES

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	Satisfactory performance of disease control programmes; apprehension in RNTCP that integration of Labs could affect DOTS performance; need for integration of services.
2.	**ASSAM**	Satisfactory within the limitation of resources available in health institutions; PHCs have facilities for sputum examination for TB and blood smear for malarial parasite; Rapid diagnostic kits are available; consumables are available; Malaria Surveillance Workers and MPW(M) are being engaged; need to break verticality in diagnostic activities.
3.	**BIHAR**	Thrust on *Kala-azar* treatment visible in Block PHCs and District Hospital; Loss of wage payments from RKS for *Kala-azar*; Improved case detection for TB and Malaria due to improved diagnostic facilities and functional Block PHCs; Health system strengthening has positive impact on disease control programmes.
4.	**CHHATTISGARH**	Malaria, Leprosy, TB programmes need better follow up. Better monitoring required by sector medical officers.
5.	**GUJARAT**	Merger of programmes has taken place under the Mission Director; supervisory cadre vacancies; contractual Lab Technicians help.
6.	**JAMMU & KASHMIR**	RNTCP has done well; Lab services at PHC are integrated; technician doing routine and TB work; case detection is satisfactory.
7.	**MADHYA PRADESH**	It has not been commented upon. Report does say that the focus in MP seems to be on JSY and other family welfare programmes; need for a public health approach covering all sectors has been reported.
8.	**ORISSA**	Sectoral Microscopy Centre not working in some places due to shortage of Lab Technicians; RDT available in plenty; ASHA may be trained as FTD; use of RDT Kits. Leprosy needs more attention; Blindness Control programme audited statements are pending; Need for improvement in record keeping of RNTCP.

	STATE	KEY FINDINGS
9.	**RAJASTHAN**	TB programme doing well; ASHA *Sahyogini* involved in DOTS; 1978 treatment centres in the State; ASHA *Sahyogini* involved in bringing cataract patient in camp; ASHA *Sahyogini*n involved in distribution of anti-malaria drugs; high incidence of malaria in State.
10.	**TAMIL NADU**	Very effective implementation with clear responsibilities at each level; Human resources and effective monitoring makes the difference.
11.	**TRIPURA**	Malaria prone are drug resistant as well; RDKs are being used by peripheral level health workers; slide examination at PHC level; RNTCP staff positions filled up and satisfactory cure rate; tele-ophthalmology being tried out; good IEC.
12.	**UTTAR PRADESH**	
13.	**WEST BENGAL**	Satisfactory performance of all disease control programmes; ANMs and Sub-centres fully involved; shortage of Lab Technicians; need for integrating TB and Malaria Lab Technicians.

XVIII PERFORMANCE OF MATERNAL HEALTH, CHILD HEALTH AND FAMILY PLANNING

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	More attention needed for child health; satisfactory performance of family planning; maternal health facilities being upgraded.
2.	ASSAM	Remarkable increase in institutional deliveries; need to keep women in facility longer; Family Planning services need improvement; erratic distribution of condoms and pills; IUD services not provided by ANMs.
3.	BIHAR	Family planning picking up; useful PPP with *Janani*; need to improve quality of institutional delivery and hospital stay; basic availability of equipments in Labour Rooms needed immediately.
4.	CHHATTISGARH	Need to improve quality of maternal and child health.
5.	GUJARAT	Appreciable new initiatives for maternal and child health; blood storage facilities need attention; Lab technicians have helped JSY; *Chiranjeevi* Scheme of PP for BPL women in institutional deliveries has contributed in a big way.
6.	JAMMU & KASHMIR	Compromise of quality seen at many places; low performance on family planning; need to improve quality of services.
7.	MADHYA PRADESH	RCH activities have received thrust resulting in significant increase in institutional deliveries; family planning services have also picked up.
8.	ORISSA	Significant increase in institutional delivery; multi-skilling for Anaesthesia and Emergency Obstetric Care being tried out; 33% increase in institutional deliveries; need to improve referral transport system.
9.	RAJASTHAN	Dramatic increase in institutional deliveries; PPP for JSY and sterilisation programmes; additional posts

	STATE	KEY FINDINGS
		created to meet large demand for maternal health services; IMNCI being implemented in 9 districts; immunisation performance is satisfactory; improvement in sterilisation after decline over the last two years.
10.	**TAMIL NADU**	High quality maternal health, child health and family planning services being provided at institutions; quality of labour rooms and wards is very good; shift from private sector to government sector in the last one year.
11.	**TRIPURA**	Strategies need to be developed to reach out to remote areas; arrangements tackling neonatal mortality need to be strengthened.
12.	**UTTAR PRADESH**	Health facilities are clean even where there is over crowding; shortage of nurses is a limiting factor in quality of care. With only one ANM at SC and many hamlets to cover, absence of ANM limiting care and ASHA not yet given second round training. Neonatal unit being opened in the district hospital, but difficulties of transport.
13.	**WEST BENGAL**	Excellent Sick and New Born Care Units established; increasing institutional deliveries along with strengthening of the system; family planning picking up with more functional health system at all levels.

XIX PRFORMANCE OF MOBILE MEDICAL UNITS/ SYSTEMS OF AMBULANCES

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Outstanding system of emergency medical service throughout the State; excellent example of PPP; provides opportunity for Mandal pooling as transport system ensures timely referrals.
2.	ASSAM	Ambulances available in all PHCs with drivers; log books provide details of referrals and other use; MMUs established in 8 districts; Boat clinics in four districts.
3.	BIHAR	Ambulances by PPP in every Block PHC working very well; PPP experiment in MMU did not work well – has been discontinued.
4.	CHHATTISGARH	Not set up as yet.
5.	GUJARAT	85 GPS enabled Mobile units working in the State; more strengthening of the Mobile Health unit will improve access in difficult areas; Ambulance service also started on EMRS pattern.
6.	JAMMU & KASHMIR	Ambulance services available in each health facility visited; MMUs not procured as yet.
7.	MADHYA PRADESH	*Deendayal Chalit Aspatal* (Mobile Health Clinics) for remote tribal pockets, providing all services; *Janani Express Yojana* by PPP for meeting referral transport need; improved availability of ambulances in most areas.
8.	ORISSA	NRHM Mobile Units not procured as yet; State's own Mobile Health Units are functional; need to improve planning and monitoring of Mobile unit.
9.	RAJASTHAN	Orders have been placed for 52 Mobile Medical Units; tenders for 52 diagnostic vans and 100 ambulances have been floated.
10.	TAMIL NADU	100 mobile outreach units working; another 146 units proposed in 2008-09; successful mobile health camps; ambulances available on call.

	STATE	KEY FINDINGS
11.	TRIPURA	Ambulances are available at PHCs; Referral transport funds are also spent through the RKS; demand for ambulances to bring patients from villages.
12.	UTTAR PRADESH	Not functional in the districts visited.
13.	WEST BENGAL	Ambulances at all Block PHCs with the involvement of NGOs working well.

XX PROGRESS OF INFRASTRUCTURE AND SYSTEMS FOR IMPROVEMENT OF CIVIL WORKS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory progress in infrastructure development.
2.	ASSAM	Community perceives improvement in health infrastructure; need for improvement in design of civil works; demolish unusable old buildings; waste management needs attention.
3.	BIHAR	Excellent use of Finance Commission funds to improve Block PHCs; Sub-centres being constructed with in built ANM residence; low utilisation of NRHM funds for infrastructure so far due to Finance Commission works; 24X7 generator and ambulance at Block PHCs working very well.
4.	CHHATTISGARH	Civil construction completed. Overall improvement needs more attention.
5.	GUJARAT	Project Implementation Unit is the nodal agency for infrastructure; has done commendable job in construction and repair; need to delegate minor repairs to districts and institutions.
6.	JAMMU & KASHMIR	Need to plan the entire health facility in a systematic way; current approach is piecemeal; need for detailed facility survey and institutional plan; three different agencies are doing construction work in J&K.
7.	MADHYA PRADESH	Not commented upon.
8.	ORISSA	6 public sector agencies have been entrusted the civil works task for up gradation of infrastructure in Hospitals.
9.	RAJASTHAN	Civil works planned very systematically in conjunction with RHSDP; Facility Survey completed in 290 out of 352 CHCs; planned up gradation of facilities with a focus of NRHM on residential quarters; work complete in 42 CHCs and under progress in232.

	STATE	KEY FINDINGS
10.	TAMIL NADU	Funds for upgradation of 75 PHCs have been given to PWD.
11.	TRIPURA	PWD doing the infrastructure up gradation; progress is slow; PWD note able to cope with work load; need to explore possibility of central construction agencies for infrastructure up gradation.
12.	UTTAR PRADESH	Sub-centre buildings needed on a priority; upgradation work has been taken up in many places; need to speed up infrastructure development, electricity connections and provision of quarters.
13.	WEST BENGAL	Civil works development through the PWD; progress is satisfactory; need to further improve the pace of infrastructure development.

XXI SYSTEMS OF PROCUREMENT AND LOGISITICS FOR EQUIPMENT AND DRUGS AND ITS EFFECTIVENESS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory system of procurement and logistics; drugs available everywhere.
2.	ASSAM	Procurement from TNMSC and by State Government; improved drug availability everywhere; needs to be made need based; logistics and demand for drugs needs to be incorporated with procurement system (as in TNMSC); need based system being put in place.
3.	BIHAR	Remarkable improvement in drug availability; rate contract with manufacturers at State level and resources with District Health Societies; cash and carry system working well; wants to do TNMSC like procurement and logistics system.
4.	CHHATTISGARH	Availability of drugs is satisfactory. Quality of procurement needs more attention.
5.	GUJARAT	Efficient system of drug and equipment procurement in place; system is working well.
6.	JAMMU & KASHMIR	Mixed picture regarding drug availability and its management; need for improvement; storage facility available in health facilities; need to monitor drug availability.
7.	MADHYA PRADESH	Non-availability of medicines to certain patients reported; significant portion of RKS expenditure on medicines, logistics support to peripheral facilities needs strengthening.
8.	ORISSA	State Drug Management Unit in place; has improved system but there are shortages in the field. Inventory management needs to be improved.
9.	RAJASTHAN	Very good availability of medicines at all levels.
10.	TAMIL NADU	TNMSC doing a remarkable job of procurement and logistics not only of drugs but also of equipments.
11.	TRIPURA	Adequate availability and off take of drugs in

	STATE	KEY FINDINGS
		facilities; need to sensitise doctors to prescribe generic drugs. Equipment/ drug procurement is also being done through the RKS and Sub-centre committees.
12.	UTTAR PRADESH	Drugs are available everywhere. But prescription for buying from outside also high. The procurement and disbursement system needs to be rationalised to prevent delays in procurement by the central store and make distribution responsive to demands.
13.	WEST BENGAL	Good system of procurement of drugs by districts based on rate contract; further refinement attempted to make it need based, like TNMSC. Availability of drugs is satisfactory.

XXII ASSESSMENT OF NON GOVERNMENTAL PARTNERSHIPS FOR PUBLIC HEALTH GOALS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	EMRI – excellent example of PPP that helps professional emergency ambulance services in the entire State.
2.	ASSAM	Very few partnerships other than the MNGO programme.
3.	BIHAR	A few PPPs working well – diagnostics, ambulance, generator; NGO partnership for running Additional PHCs has been discontinued as payments are not timely; lack of trust; need for clear responsibilities and timelines for payment and assessment by both sides; another attempt to give Additional PHCs to NGOs and *Panchayat*s.
4.	CHHATTISGARH	NGOs involved in *Mitanin* programme on a large scale.
5.	GUJARAT	Strong tradition of partnerships; *Chiranjeevi* scheme; many small partnerships with NGOs for specific tasks.
6.	JAMMU & KASHMIR	Not seen in any of the institutions visited.
7.	MADHYA PRADESH	Useful innovations in *Janani Express* and *Deendayal Chalit Aspatal* (Mobile Health Clinic); supporting SC/ST trainees from remote villages for nursing in private institutions.
8.	ORISSA	MNGO scheme is working well; very few other PPPs.
9.	RAJASTHAN	Private institutions accredited for JSY, sterilisation and IUD insertion.
10.	TAMIL NADU	NGOs helping in operationalising the toll free ambulance system.
11.	TRIPURA	Telemedicine partnership established for eye care; PPP Medical College and Nursing College recently started.
12.	UTTAR PRADESH	Several NGOs evidently working in the health field

	STATE	KEY FINDINGS
		but public health services not yet develop partnerships.
13.	WEST BENGAL	Large number of partnerships in ANM training, ambulance services and mobile clinics, diagnostic services, etc.

XXIII PREPARATION FOR MEETING HUMAN RESOURCE NEEDS, ESPECIALLY WITH REGARD TO NURSING AND PARAMEDIC STAFF AND FUNCTIONING OF ANM TRAINING SCHOOLS AND OTHER NURSING INSTITUTIONS

	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	State needs to focus on multi-skilling of doctors for anaesthesia and obstetrics; no shortage of nursing training institutions; quality needs attention.
2.	ASSAM	ANM Training Schools are functional but need to improve quality of their infrastructure and training; repair work funds provided under NRHM and plans approved but work yet to begin; more practical orientation required in ANM curriculum – hands on!
3.	BIHAR	Highest focus needed on Nursing institutions as that is the most important and critical constraint; mopping up of trained ANMs and Nurses not enough; 12 ANM schools have started again but they are not in a satisfactory state; much faster improvement of infrastructure, equipment and trained human resources needed to make ANM Training Schools vibrant; funds are already available under NRHM.
4.	CHHATTISGARH	State needs to develop long term and short term plan for enhancing health human resource in the State. Three year programme started in Chhattisgarh some years ago.
5.	GUJARAT	State needs to plan its nursing staff needs; ANM vacancies; Staff Nurse vacancies; thrust needed on strengthening ANM/Nurse training Schools.
6.	JAMMU & KASHMIR	While manpower availability is good, need to guard against over deployment without service guarantees; ANMs and Staff Nurses being recruited; Staff Nurses need.
7.	MADHYA PRADESH	SPMUs and DPMUs in place and functional; DPMUs may need more synergy with district officials and block level staff.
8.	ORISSA	State is aware of the long term needs of human resources; many actions already initiated; further

	STATE	KEY FINDINGS
		long term strategy to be firmed up.
9.	RAJASTHAN	State has tried to strengthen ANM Training Schools; faster implementation required; MPW(M) is neglected.
10.	TAMIL NADU	No ANM School needed; 6000 Nurses completing training from Nursing Institutions are adequate to meet State's needs. More thrust on Staff Nurses.
11.	TRIPURA	State has drawn up a plan for human resources; new institutions will help.
12.	UTTAR PRADESH	Need to prioritise human resource thrust, especially nursing personnel. ANM TCs reopening and MPW (M) need a priority thrust.
13.	WEST BENGAL	Exemplary focus on selecting local ANMs and creating additional capacity to train them; high vulnerable group representation; thrust on under performing areas.

XXIV ASSESSMENT OF PROGRAMME MANAGEMENT STRUCTURE AT DISTRICT AND STATE LEVEL

	STATE	KEY FINDINGS
1.	**ANDHRA PRADESH**	State is in the process of setting up SPMU and DPMUs; currently being managed by regular Directorate of Health services team; need for administrative rearrangements that provide a convergent platform; too many Directorates currently managing health services in AP.
2.	**ASSAM**	SPMU/DPMU/BPMU actively and enthusiastically involved in the field; lack of adequate participation of Directorate staff needs to be consciously addressed; need to push integration of all programme management structures for effectiveness and efficiency.
3.	**BIHAR**	Enthusiastic Block Managers, DPMU and SPMU; need for better integration with mainstream; enthusiasm for service delivery not internalised by mainstream task leaders.
4.	**CHHATTISGARH**	SPMU & DPMU is in place, but linkage with directorate needs further attention. Role and functions need clearer articulation.
5.	**GUJARAT**	System is in place and working very well; DPMUs and BPMUs are functional; coordination is effective; need for integration of programmes in spirit – not only in letter.
6.	**JAMMU & KASHMIR**	SPMU/DPMU in place since April 2007; need for PMU teams to visit facilities more often; capacity building needs should be met on priority.
7.	**MADHYA PRADESH**	SPMU/DPMU working very effectively.
8.	**ORISSA**	SPMU/DPMU in place; BPMU in some Blocks; improved monitoring system.
9.	**RAJASTHAN**	SPMU and DPMUs are fully functional; BPMUs being established; Management systems have greatly improved performance; Directorate staff also involved in implementing NRHM; greater integration will be beneficial.

	STATE	KEY FINDINGS
10.	TAMIL NADU	Directorate of Public Health staff provides support for programme implementation; efforts to set up SPMU/DPMU; care should be taken to ensure that the involvement of DPH staff remains total.
11.	TRIPURA	Coordination of contractual NRHM staff with mainstream staff needs to improve. Staff is in position.
12.	UTTAR PRADESH	SPMU/DPMU not in place as yet; need to set them up on a priority basis, or to give management training to the existing CMO/deputy CMOs.
13.	WEST BENGAL	Strengthening of accounts system at all levels; mainstream well integrated with implementation of NRHM; need for further convergence of functions at State level.

STATE SUMMARIES OF KEY FINDINGS

1.	ANDHRA PRADESH
2.	ASSAM
3.	BIHAR
4.	CHHATTISGARH
5.	GUJARAT
6.	JAMMU AND KASHMIR
7.	MADHYA PRADESH
8.	ORISSA
9.	RAJASTHAN
10.	TAMIL NADU
11.	TRIPURA
12.	UTTAR PRADESH
13.	WEST BENGAL

1. ANDHRA PRADESH

THE REVIEW TEAM:

1. Dr. I.P. Kaur, Dy. Commissioner, Maternal Health, MOHFW
2. Manish Kakkar, Public Health Foundation of India
3. Shri Rajesh Kumar, Consultant Finance, FMG, MOHFW
4. Dr. Kamla Mohan, Regional Director, MOHFW

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Nalgonda**: PHC – Yadagirigutta, Peddakura & Chandampet, Sub-centre – Muthireddy Gudem, Area Hospital – Bhongir, District Hospital – Nalgonda
2. **District Panchmahal**: PHC – Srisailam & Atmakur, Subsidiary Health Centre – Bairlutely, CHC- Atmakur

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
► Excellent Emergency Ambulance Service with a single state wide call number ► Well designed, good quality ASHA Training ► Good availability of drugs at all facility levels ► Dedicated and well informed ANMs, ASHAs and Staff Nurses at all the locations visited by the team ►Good utilisation of untied funds at all levels. RKS not centred on user feed or cost recovery ► Functional disease surveillance system-computerisation up to PHCs	►Major staffing gaps, especially of specialists, at CHCs and hospitals – this can be reduced by multi-skilling, and reducing mismatches and better recruitment policies ►Private practice government doctors (as allowed) interfering with utilisation of services from public facilities ►More capacity building for systems of financial management ► Need to improve/provide institutional care for newborns ► Laboratory bio-safety and biomedical waste management was lacking generally across all facilities visited by the team in both districts and needs to improve

2. ASSAM

THE REVIEW TEAM

1. Mr Amardeep Singh Bhatia, Deputy Secretary, MOHFW
2. Dr. J.N. Sahay, Advisor, NHSRC
3. Dr. Parthajyoti Gogoi, Regional Director, H&FW
4. Mr. K.K. Kalita, Advisor, RRC, NE, Guwahati

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Kamrup Rural**: CHC/FRU- Bezara, PHC – Hajo, SDH – Rangia, FRU – Sualkuchi, BPHC – Kamalpur, MPHC – Ramdia, Halugaon, SC – Dora Kuhara, Koilbortapara, Dhupagiri, Borkaboragaon, Kharikhot, Kekenikuchi
2. District Darrang: Civil Hospital – Mongoldoi, CHC – Kharupitia, MPHC – Gorukhuti, CHC/FRU – Sipajhar, PHC – Pathurighat, SC – Kathpati, Dohkhola, Moamari, Hatimura, Maroi Bijuli

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
► Increased caseload and bed occupancy at most facilities – due to better availability of doctors, improved infrastructure, and increased institutional deliveries ►Commendable role played by ASHAs and ANMs, especially in organising immunisation where good progress is reported ►RKS and untied funds have worked as enablers for improvement in amenities and over all functioning of CHC/FRUs ►Perception of community is that there is a good improvement of services ► Good Ambulance availability along with good logbooks and accounting system ► 24 districts have completed District health plans	► Availability of Nurses is a pressing issue ►Village Health and Sanitation Committees have not been formed ►Quality of care is varied with biomedical waste disposal being a problem everywhere ►Diagnostics provision is very weak ►Training infrastructure and training systems need improvement – essential skills not in place even where qualified staff is present ► Logistics of drugs and supplies needs improvement ►HMIS weak and needs much improvement ►Delivery of family planning services weak

3. BIHAR

THE REVIEW TEAM

4. Dr. Thelma Narayan, Public Health Specialist
5. Dr. D. Thamma Rao, Mission Director, NRHM, Puducherry
6. Dr. M.S. Jayalakshmi, D.C. Family Planning MOH&FW, GOI
7. Dr. Dileep Kumar, Nursing Advisor, MOH&FW, GOI
8. Mr. Amarjeet Sinha, Joint Secretary, MOH&FW,GOI

THE DISTRICTS/INSTITUTIONS VISITED

Patna District: Patna Medical College
Gaya District: Pilgrim Hospital; Sub-centre - Monara; PHCs - Phanania, Rajgir Makhadumpur, Belajganj, Bodhgaya, Manpur, Vazirganj, Harnaut
Vaishali District: Sub-centre and AWC - Jayanthi Gram PHC's – Lalganj, Garaul , Sarai, Paru, Vaishali
Muzzaffarpur District: S.N. Medical College, Nalanda Medical College District Hospital – Sarai, & Hajipur
Jehanabad District: District Hospital Jehanabad & District Hospital Hajipur

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
► Dramatic increase in caseload at BPHCs and district hospitals and increase in institutional deliveries ►Facility improvement of BPHCs, especially in infrastructure and drugs and doctors availability by block pooling ►PPP for generators and for diagnostic services and for ambulance services ►State, district and block managers in place ►Improving disease control programmes, especially in *kala-azar* ►Promising ASHA programme with links to village health and water & sanitation committee	►Huge gap in skilled human resources for health – for almost all cadres ►Slow pace of expansion of nursing and ANM education ►Quality of all services, especially of institutional delivery, inadequate ►Frequent Polio rounds taking time ► Rate of improvement of peripheral facilities not commensurate ►Timely payments for ASHAs ► Institutional Neonatal care service provision and family planning service provision inadequate and needs to increase

4. CHHATTISGARH

THE REVIEW TEAM

1. Ms. Ganga Murthy, Economics Advisor, MOHFW
2. Ms. Neidino Angami, NGO, Mizoram
3. Dr. K. S. Gill, MOHFW
4. Manoj Kar, Advisor, NHSRC

THE DISTRICTS/INSTITUTIONS VISITED

Distict Kanker: CHC/PHC – Charama and Hardula, Sub-centre – Jaiskara and Jaipara Pandhari Pani, Hospitals – DIstrict Hospital Kanker and Dhamtari
DIstrict Durg: CHC/PHC – Bhilai-3, Ghotia, Dondi, Chikhlakasa Kala and Balod, Sub-centre – Katro, Kusum Kasa, Hospitals – DIstrict Civil Hospital, Durg
District Rajnandgaon: CHC/PHC – Dongergarh, Sub-centre – Khaprikalan and Indamara, Hospitals- DIstrict Hospital, Rajnandgaon

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
➢ Successfully put in place community health activists - *Mitanins* - with high degree of commitment ➢ District Health Mission established and functional ➢ Effective involvement of PRIs and Community Processes noticeable. *Panchayat* health diary introduced for *Panchayat sarpanches*. Village health planning systematic ➢ Hospital development committees (*Jeevan Deep Samities*) have focus on quality care and provide for adequate representation of NGOs ➢ State health resource centre effective and makes a positive contribution to health planning and community processes	➢ Issues of "Governance of NRHM" are critical and need immediate attention. Poor coordination at the senior levels ➢ Health Infrastructure neither properly maintained nor fully utilised, needs immediate action steps for improvement ➢ Increase in institutional delivery not matched by any quality of care improvement ➢ Programmes of CHCs into FRUs/ IPHS standards doing poorly ➢ HMIS functioning poor ➢ Financial Management, especially in some programmes like annual maintenance grants

5. GUJARAT

THE REVIEW TEAM:

1. K.S. Srinivasan, Consultant and former secretary, MOHFW
2. Madhukar Chaudhury, Mission Director, Maharashtra
3. Sandhya Ahuja, Senior Consultant, NHSRC

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Sabarkantha & Panchmahal**: DH - Sabarkantha, DH - Panchmahal, Civil Hospital - Himmatnagar, General Hospital – Gandhinagar CHC – Sivaliya, Halol, Vijaynagar & Samalaji, PHC – Hadiyal, Atarsumba, Viralia & Bhiloda, Sub-centre – Palla & Lalpur

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENTS
Overall increase in caseloads in public health system Effective Programme Implementation Unit for infrastructure development that serves as national benchmark in this area Good Drug supply and distribution system Diagnostic Facilities in public health facilities improved *Mamta Abhiyan* and involvement of voluntary sector provides for better community involvement Effective PPP model – *Chiranjeevi* Scheme - for institutional delivery Effective disease control and disease surveillance	Sharp decline in deliveries conducted by Public Institutions Plans needed for taking care of acute shortage, at almost all levels, of human resources for public health system Proper utilisation of untied and RKS funds and promptness of payments in JSY Greater involvement of PRIs required HMIS system is relatively much better but data reports need to be acted upon

6. JAMMU & KASHMIR

THE REVIEW TEAM

1. Dr. Amarjeet Singh, Mission Director & Commissioner, Health, Gujarat
2. Dr. Tarun Seem, Director, MOHFW, GOI
3. Dr. A.C. Baishya, RRC – NE, Guwahati

THE DISTRICTS/INSTITUTIONS VISITED

1. **District Udhampur**: medical aid centre at Jhajjar Kotli, PHC at Tikri, CHC at Chennai and Batot, and Katra and sub-centre at Jakhani.
2. **District Jammu and District Samba**: CHCs at Ramgarh, Akhnoor,Vijaypur, PHC at Anandpur, SHC at Karalia, District hospital at Samba and Missionary Hospital at Samba
3. District Anantnag & Baramula: Kokernag SDH, Sagem PHC, Achabol PHC, Shalnard SC, Tanmarg SDH

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
► Good, well maintained infrastructure ► Good availability of equipment and supplies ► RKS at PHCs reported to have started working and untied funds have worked as enablers for improvement in amenities and over all functioning of CHC/FRUs ► Manpower position is relatively better	► Poor quality of services, even for institutional delivery ► Poor utilisation of available manpower due to skill and motivation and management issues. Village Health and Sanitation Committees have not been formed ► District action plans and facility surveys contracted out and being done with poor participation and behind schedules ► HMIS almost non functional ► RKS in CHCs and district hospitals and village health and sanitation committees not yet constituted and not yet functional ► Financial management poor

7. MADHYA PRADESH

THE REVIEW TEAM

1. Mr. Praveer Krishn, Joint Secretary, MOHFW, Government of India
2. Mr. Sushil Kumar Lohani, NRHM Mission Director, Orissa
3. Dr. Abhay Shukla, Senior programme coordinator, SATHI - CEHAT, Pune
4. Ms. Shruti Pandey, Senior Consultant, NHSRC

THE DISTRICTS/INSTITUTIONS VISITED

1. Jabalpur: Office of Collector, District Victoria Hospital, Lady Elgin Hospital, Civil Hospital, Tehsil Sinhora, CHCs, Patan; Majhauli; PHCs: Chargaon and Sub Health Centres, Nunsar, Bijori and village Gosalpur, Tehsil Sinhora
2. **Barwani:** CMHO office; DPM office; District Hospital, Barwani; CHCs at Thikri; Pati and Niwali PHC at Anjad; Sub Health Centre at Sawariyapani and Village Sawariyapani (Pati Block)

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
► Increased caseload and bed occupancy at most facilities – largely due to impact of increased institutional deliveries ► System of concurrent audit is unique and very effective in ensuring timely reports ► PPPs in *Jananai Express* - for emergency services and Deendayal Chalit Aspatal (Mobile Health Clinics) are promising ► Supporting SC/ST trainees from remote villages for nursing in private institutions ►Nutrition Resource Centres have been established in 60 places; effective in handling extreme forms of malnutrition ►District health action planning completed in all districts and considerable mechanisms for this are built	► Significant portion of RKS expenditure being spent on medicines and other inputs which substitute state government budgetary expenditures. RKS tends to be perceived as mainly a form of cost recovery ►Large human resource gaps with more long range planning needed to address these ►Serious issues of governance ►Need for greater decentralisation and PRI involvement ► Major gaps in drugs supplies: logistics of drugs and supplies needs improvement ►HMIS weak and needs much improvement ►ASHA programme needs to use flexibilities in sanctioned numbers, in training and selection process as applicable to tribal areas for achieving its goals

8. ORISSA

THE REVIEW TEAM

1. Shri. K.B. Saxena: Former Secretary, Health and Family Welfare, GoI
2. Dr. S.K. Satpathy: Director - Training, Public Health Foundation of India
3. Dr. P.K. Mohapatra: Sr. Regional Director, Bhubaneshwar, GoI
4. Dr. K.S. Sachdeva: CMO, Central TB Division, GoI

THE DISTRICTS/INSTITUTIONS VISITED

1. Sundergarh District: Rourkela Government Hospital, Sub-divisional Hospital, Bonai; CHCs at Kinjerkela; Bisra, and Gurundia; PHCs at Sikajore; Senpatrapali and Tangarpalli; Sub-Centres at Tileikani, Ujjalpur, Kopatomundla; Tamra, Urban Slum Health Centre – Tillea Nagar, Rourkela (PPP model)
2. Bolangir District: District hospital, Sub-divisional Hospital – Patnagarh, CHCs at Kantabanji; Luisinga. Saintala; PHCs at Block PHC Tureikela; Kushang; Khaprakhol; Lathore; Gudvela; Sub-Centres at Ghunesh; Badabanki; Kandajuri; Sargad; Kushang; Ghunson; Rengali; Telanpali; Orriyapali; Gambhriguda; Ghuna

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
►Overall increase in outpatient caseload in secondary hospitals ►RKS have been well constituted and are functional and untied funds have worked as enablers for improvement in amenities and overall functioning ►Keeping to time schedules and expected outputs on the ASHA programme ► NGO support good and is being harnessed ► Financial Management and financial flows much improved	► Primary health centres and sub-centres still remain very weak and no significant increases – due largely to staffing problem ► Logistics management are not streamlined and there are shortages or stock-outs of key drugs and consumables ►Human resource planning for public health system needs to improve. Both non availability and lack of adequate performance are the issues ►Training systems need improvement – essential skills not in place even where qualified staff is present ►HMIS weak and needs much improvement ►Village health and sanitation committees not in place and weak social mobilisation and community participation

9. RAJASTHAN

THE REVIEW TEAM

1. Mr. Arun Baroka, Director, MOHFW, GOI
2. Dr. T. Bir, Faculty, NIHFW
3. Dr. D.C. Jain, D.C., MOHFW, GOI
4. Dr. Sunil D. Khaparde, Director, MOHFW, GOI
5. Dr. A.K. Shiva Kumar, Consultant, Member MSG, NRHM
6. Dr. H.P. Yadav, Regional Director, GOI

THE DISTRICTS/INSTITUTIONS VISITED

Alwar District: District Hospital, CHC: Kishengarh; Thangaje, PHC Harore and Sub-centres Dhane
Churu District: One DH and CHCs in Bidasar & Salasar, PHCs in Talchapar and Charawas, Sub-centres and the community in Gulariya, Lodiya Sub-centres/ villages

THE KEY FINDINGS

	AREAS FOR IMPROVEMENT
► Sharp rise in institutional deliveries ►Increased confidence and utilisation in government facilities with a noticeable increase in inpatient treatment, outdoor care, surgical operations and laboratory investigations ►ASHA *Sahayoginis* – positive innovative adjustments - in selection and compensation and support. Functional programme ►Functional hospital development committees with clear guidelines ►Improved integration of national health programmes	► Poor availability of specialists and poor compensation package for doctors leading to shortages. Human resources planning for para-medicals also needed, especially with regards to the MPWs ►Need for better integration of PMUs with regular programme officers at state and district level ►Need for better awareness and understanding of NRHM and its provisions at all levels ►Physical conditions of health facilities, especially hygiene and cleanliness need improvement ►Village Health and Sanitation Committees not adequately functional, and ASHA and JSY payments poor ►Introduction of incentives for JSY and sterilisation compensation having deleterious effects

10. TAMIL NADU

THE REVIEW TEAM

1. Shri. Javed Chaudhary, Retd. Secretary, MOHFW
2. Shri. P.K. Agarwal, Consultant Finance, FMG, MOHFW
3. Ms. Vandana Krishna, Commissioner - Family Welfare, Maharashtra

THE DISTRICTS/INSTITUTIONS VISITED

Thiruvellur District : Taluk hospital - Ponneri, Block PHC - Puzhal; PHC - Padianallur, Budur, Naravarikuppam, Health Sub-centre - Chinnakavanam, Arani, Nallur, Kummanur, Chinnakavanam
Kancheepuram District: CEmONC Kancheepuram, Taluk hospital - Maduranthagam, Block PHC - Walajabad, PHC - Ayyampettai, Gnanagririsaranapettai, Health Sub-centre - Uthukada
Villupuram District: Block PHC - Mailam, Additional PHC - Omandur & Avalurpet

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
►Good pre-existing services with admirable transparency in postings and procurement, efficiency in logistics; Public health cadre exists as well as three to five year rural posting for all on joining service **Consequent to NRHM:** ►Untied funds improve ambience of facilities, empower local health providers and motivation of community ►Block PHCs now working 24x7 with additional nurses (3 now) ►Upgradation of PHCs to B-PHC and CHC undertaken and expedited ►Active PRI and community participation, VHSCs functional ►NGO partnerships for emergency ambulance network expanded to the entire state	►*Janini Suraksha Yojana* and Dr. Muthulakshmi Reddy scheme for SC/ST/BPL needs further inputs, poorly known/utilised and delay in payment, and no JSY incentives for taluk and district hospitals ►Upgrading Block PHCs to CHCs to be expedited ► District Planning with focus on equity issues slow to take off ► Urban health planning lags behind

11. TRIPURA

THE REVIEW TEAM

1. Ms. Archana Varma, Deputy Secretary, Ministry of Health & Family Welfare
2. Mr. Praveen Srivastava, Director M&E, Ministry of Health & Family Welfare
3. Dr. Charan Singh, Joint Director - NVBDCP, MoHFW
4. Mr. Gautam Chakraborty, Senior Consultant - Health Care Financing, NHSRC

THE DISTRICTS/INSTITUTIONS VISITED

INSTITUTIONS/ PLACES VISITED
Dhalai District: Gandachara and Kamalpur Hospital, PHC- Ganganagar, Kulai, Salema, Sub Centres - Harinchara, Durbajoy, East Nalichara, Kolachari, Training Institute - District Health Training Institute, Village - Baligaon
West Tripura District: SDH - Sonamura and Bishalgarh, CHC – Mohanpur, PHC - Narsinghgarh, Bamutia, Anandapur, Bishramgarh, and Kathalia Sub-centres - Airport, Laxmilunga, Tulabagan, Bishalgarh, Bhabanipur
South Tripura District: Tripura Sundari District Hospital, Udaipur, PHC – Kakraban, Sub-centre - Purba Mirza, Village - Purba Mirza

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
Institutional deliveries showed a significant increase	There are key shortage of trained professionals like Specialists, Doctors, paramedics, Nurses and Lab Technicians. Need for more ANM Schools
Village Health Days are popular	Need for integration and mutli-skilling of Lab Technicians and other paramedics to improve availability of diagnostic services
Doctors' Association playing very important role in reducing absenteeism by promoting rotational posting for remote areas	Untied funds have increased the need for better financial management as there are many more details needed
RKS funds and untied funds very well utilised	State needs to analyse disaggregated data on health parameters
Very high and effective involvement of PRIs	PHCs have received computers but software is not yet installed; data operators being in short supply.
Village Plans are prepared	Village Health Committees are yet to be constituted by merging with the water and sanitation committee
Helicopter service health camps in remote, inaccessible tribal villages	Malaria prone are drug resistant as well
ASHAs selected by transparent process involving the PRIs; bright red coats and blue kit bags have given a unique sense of pride and identity to the ASHAs	PWD not able to cope with workload; need to explore possibility of central construction agencies for infrastructure upgradation.
Adequate availability and off take of drugs in facilities; need to sensitise doctors to prescribe generic drugs. Equipment/ drug procurement is also being done through the RKS and Sub-centre committees	Arrangements tackling neonatal mortality need to be strengthened
Telemedicine partnership established for eye care; PPP Medical College and Nursing College recently started	

12. Uttar Pradesh

THE REVIEW TEAM

1. Dr. T. Sundararaman, Executive Director NHSRC
2. Dr. Shalini Bharat, Dean, School of Health Systems Studies, TISS, Mumbai
3. Dr. Ritu Priya, Advisor, NHSRC
4. Dr. Dinesh Biswal, Asst. Commissioner, MOHFW, GOI
5. Dr. Siddharth Choudhury, Regional Director, GOI

THE DISTRICTS/INSTITUTIONS VISITED

District Rae Bareilly: General Hospital - Rae Bareilly, Female Hospital - Rae Bareilly, CHC – Bachraoan, Khiron, New PHC - Karahiya Bazar, Sub-centre - Rampur Kasiya, Beni Madhoganj, Village - Singhor Tara, Bheera, Ganagaganj-Sohra, ABR Girija Devi Charitable Hospital, Raalpur
District Jhansi: General Hospital and Female Hospital Urai, General Hospital and Female Hospital Jhansi, CHC Moth, Block PHC Chirgaon & Gorsarai, Additional PHC Baghera, Todi Fatehpur, Raven, Sub-centre Baghera, Raven, Gugua

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
► Functional health institutions; clean and well maintained ► PHCs upgraded, functional 24x7 ► CHC and District Hospital upgradation to IPHS in process ►JSY is being utilised widely; institutional deliveries increased at all levels ►Untied funds used for essential infra-structure and has enabled and given confidence to local health care providers	►Poor HR planning in all aspects, opening of new institutions, reviving of training centres, recruitment of doctors, nurses, ANMs, lab technicians; rational deployment/ transfers of personnel/ facilitating; multi-skilling needed but not yet started ► Objective of each facility reaching a certain level of service provision needs to be put in place ►ASHA second round training overdue, support and mentoring systems need to be set up. Village health and sanitation committees to be started ►Adequate and timely disbursement of JSY funds

13. West Bengal

THE REVIEW TEAM

- Mr. S.K. Das, Addl. DG
- Dr. P.L. Joshi, DDG – L
- Mr. Sunil Pal, Consultant

THE DISTRICTS/INSTITUTIONS VISITED

1. District Birbhum: BPHC Illambazar, Sub-centre Ruppur, PHC Sattare, RH Labour, ANM Training Centre Suri, District Hospital Suri
2. District Bankura: Bankura Sarmelini Medical College Hospital, Nursing Training Centre – Bankura, RLTRI Gauripur, BPHC Amarkanan, PHC Beliatod, SC– Beliatod - W.

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
► Sub-centre doing fixed day clinics ►GPs authorised to hire doctors for few days a week ►Drug availability increase institutional deliveries ►Upgradation of PHCs & BPHCs ►Appointment of doctors, specialists & nurses ►Satisfactory immunisation ►Strong nursing cadre & directorate ►Physical infrastructure handed over to *Panchayat*s for maintenance. Active involvement of *Panchayat*s in the management of health system	►Demand for PPP for diagnostics ►Getting specialists ►To integrate data sets effectively ►Satisfactory indicators for ASHAs in tribal & minority concentration areas (ASHAs not in position) ►Shortage of lab technicians ►Need for integrating & malaria lab technicians levels ►Need to improve pace for infrastructure development ►Refinery of system of procurement of drugs to make it need base, like TNMSC key findings ►Further convergence of functions of accounts system at staff level

NATIONAL RURAL HEALTH MISSION
MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA
NIRMAN BHAWAN, NEW DELHI.