
NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन
13 CRM
COMMON REVIEW MISSION 2019

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Ministry of Health & Family Welfare
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व पृथ्वी विज्ञान मंत्री, भारत सरकार
Union Minister for Health & Family Welfare,
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MESSAGE

It is with great pleasure that I write this foreword to the report of the 13th Common Review Mission (CRM). This CRM marks fourteen years of implementation of the National Rural Health Mission and six years of the National Urban Health Mission.

2. The National Health Mission (NHM) denotes a coordinated effort towards health systems' reforms in the country. The report demonstrates that all States appear to have made remarkable improvements, particularly in the area of maternal, new-born and child health. It is also relevant to note that NHM's sustained investments in strengthening the public health systems have enabled last mile delivery of health services particularly those related to pregnancy, delivery, immunization, new-born and child care.

3. I am also happy to note that longstanding programmes such as ASHAS, the Ambulance services and Mobile Medical Units continue to play a key role in improving access to healthcare services. NHM initiatives to reduce out of pocket expenditures such as Free Essential Medicines Services Initiative, Free Essential Drug Services Initiative and the Pradhan Mantri National Dialysis Programme have particularly been popular among the masses.

4. The report also shows that all states are putting their best efforts to provide Comprehensive Primary Health Care by operationalizing the Ayushman Bharat-Health and Wellness Centres (AB-HWCs) and at this rate, I am confident that we will achieve the target of 1,50,000 AB-HWCs needed to ensure the delivery of CPHC closer to the community.

5. I am sure that States will use the findings of this CRM in order to ensure better health outcomes and leverage these learnings for further strengthening of their public health systems in rural and urban areas of the country.

(Dr. Harsh Vardhan)

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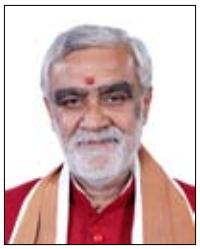

Message

Common Review Missions (CRMs) have played a key role as a key monitoring tool particularly for assessing the progress of National Health Mission (NHM) implementation on ground. It has proven to be a valuable mechanism for the Ministry of Health & Family Welfare to review programme and policy changes. From a governance point of view, it provides both Centre and the States an opportunity to take stock of the present situation and adopt appropriate mid-course policy/strategy changes.

The 13th Common Review Mission has covered 16 states, with the task of assessing various domains of health systems. The improvements in key indicators in the field of child and maternal survival, fertility rates have been validated in all states. We must learn from and sustain these gains beyond maternal, new-born and child health. The states must be congratulated for their achievements.

Moving forward, such initiatives within the national Health Mission will help in strengthening secondary care services and integrate primary and higher services. The Health and Wellness Centres would be a key platform for such integration.

I am also glad to note that multi-sectoral convergence was an active focus area of this CRM, since health relies on multiple other determinants and it is important for all sectors to work together.

States should use this report to take action on specific, contextual challenges for effective implementation to reach the goal of Universal Health Coverage.

I would like to convey my appreciation to all the team members who undertook this mammoth exercise and helped prepare this report. I am sure it has been an enriching experience to all involved and I am also sure the observations and recommendations will help move the mission forward.

(Ashwini Kumar Choubey)

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Dated : 21st July, 2020

FOREWORD

It is a great pleasure to write a foreword for the Common Review Mission (CRM), which is unique to the National Health Mission.

National Health Mission (NHM) has many creditable features and CRM is a distinctive characteristic. Organized annually with multiple teams, each with over fifteen technical experts, the CRM report captures the pooled insights of many public health practitioners and researchers. The report of the 13th CRM is no exception.

It is heartening to note the many successes recorded across the ten Terms of Reference. Efforts such as Ayushman Bharat Health and Wellness Centres, Poshan Abhiyaan, Mission Indradhanush and Aspirational districts have demonstrated gains in reaching last mile populations, which would have been more difficult without the strong public health systems to which contribution of the integrated approach on mission mode of NHM has been substantial.

Besides the impressive progress in certain areas, implementation challenges have been highlighted in several areas by the CRM teams, especially, governance and equity in coverage, are highlighted.

The success we have achieved in maternal, child new-born and child health need to now be replicated for communicable and non-communicable diseases. The challenge before us now is to creatively use the structures and service delivery platforms already in place to strengthen an expanded range of services and public health actions.

The multiple stakeholders involved in the Common Review Mission bring valuable perspectives to the task and we are grateful for their insights.

It is my sincere hope that States pursue these successes further and leverage the NHM to improve their public health systems at district and sub district levels.

(Preeti Sudan)

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21st July 2020

The 13'h Common Review Mission (CRM) marks nearly a decade and half since the launch of the National Rural Health Mission. It is encouraging to see from the report that the vision of universality, equity and affordability continue to guide the States in the implementation of National Health Mission (NHM).

Apart from improvements in key indicators, the areas where efforts and investments were made, have shown impressive gains. Oven the past few years, multiple components were included in NHM, including the Urban Health Mission. The test of health systems strengthening is the ability to perform well on existing activities and absorb newer intervention components. NHM has withstood that test well.

The report highlights that a focus on continuum of care and quality of services require expedited attention. Public health functions particularly in urban areas also need focus. Use of technology in improving access, quality and accountability, are areas that need further attention.

The involvement of stakeholders from States, academic institutions, research agency, civil society and development partners, in this exercise brings multiple perspectives to bear on implementation assessment. Their involvement enriches this exercise and enables the CRM to serve as a useful sharing and learning platform.

I hope that States now use these findings as an input to programme planning as they work towards implementing the goal of Universal Health Coverage

(Vandana Gurnani)

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FAVOURITE

ABBREVIATIONS

AAA	ASHA, ANM and Anganwadi
AB	Ayushmaan Bharat
ABER	Annual Blood Examination Rate
ABS	ASHA Benefit Scheme
ABSULS	ASHA based Surveillance for Leprosy Suspects
ACSM	Advocacy Communication & Social Mobilization
ACT	Artesunate Combination Therapy
AEFI	Adverse Effect Following Immunization
AERB	Atomic Energy Regulatory Board Certification
AES	Acute Encephalitis Syndrome
AFB	Acid Fast Bacilli
AFHC	Adolescent Friendly Health Clinics
AH	Adolescent Health
AHD	Adolescent Health Day
AIDS	Acquired Immune Deficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ALS	Advanced Life Support Ambulances
AMB	Anemia Mukt Bharat
AMC	Annual Maintenance Cost
AMO	Assistant Medical Officers
AMR	Anti-Microbial Resistance
AMTSL	Active Management of Third Stage of Labour

ANC	Antenatal Care
ANCDR	Annual New Case Detection Rate
ANM	Auxiliary Nurse Midwifery
ANMMCH	Anugrah Narayan Magadh Medical College
ANMOL	Auxiliary Nurse Midwifery Online
ANMTC	Auxiliary Nurse Midwifery Training Centre
APHC	Additional Primary Health Centres
API	Annual Parasitic Index
APL	Above Poverty Line
APMSIDC	Andhra Pradesh Medical Services & Infrastructure Development Corporation
ARI	Acute Respiratory Infections
ARSH	Adolescents Reproductive & Sexual Health
ART	Anti-Retroviral Therapy
ARV	Anti-Rabies Vaccine
ASHA	Accredited Social Health Activists
ASV	Anti-snake venom
ATI	Administrative Training Institute
AVD	Alternate Vaccine Delivery
AWC	Anganwadi Centres
AWW	Anganwadi Workers
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy
B.Sc.	Bachelor of Science

BAC	Block ASHA Coordinators
BAMS	Bachelors of Ayurvedic Medicine and Surgery
BCC	Behaviour Change Communication
BCG	Bacillus Calmette–Guérin
BCM	Block Community Mobilisers
BCPM	Block Community Process Manager
BCTU	Blood collection and Transport Unit
BER	Beyond Economic Repair
BERA	Brainstem-evoked response audiometry
BLS	Basic Life Support Ambulance
BME	Biomedical Engineer
BMGF	Bill & Melinda Gates Foundation
BMMP	Biomedical Equipment Maintenance and Management program
BMO	Block Medical Officer
BMW	Bio Medical Waste
BMWM	Bio Medical Waste Management
BOR	Bed Occupancy Rate
BP	Blood Pressure
BPHC	Block Primary Health Centre
BPL	Below Poverty Line
BPM	Block Program Manager
BPMU	Block Program Management Unit
BSBY	Bhamashah Sisthya Beema Yojana
BSKY	Biju Sisthya Kalyan Yojana
BSU	Blood Storage Unit
BTT	Block Training Team
CAC	Comprehensive Abortion Care
CAH	Community Action for Health
CARE	Cooperative for Assistance and Relief Everywhere
CAS	Computer Application Software
CATS	Centralised Ambulance and Trauma Services
CBAC	Community Based Assessment Checklist
CBE	Community Based Event
CBMWTF	Common Bio-medical Waste Treatment Facility

CBNAAT	Cartridge- Based Nucleic Acid Amplification Test
CBWTF	Common bio-medical waste treatment and disposal facility
CCCH	Certificate Course in Community Health
CDAC	Centre for Development of Advanced Computing
CDO	Chief Development Officer
CDPO	Child Development Project Officer (CDPO)
CDR	Child Death Review
CEA	Clinical Establishment Act
CEMoNC	Comprehensive Emergency Obstetric and New-born care
CFMS	Centralised Funds Management System
CFN	Certificate in Food and Nutrition
CGHS	Central Government Health Scheme
CH	Child Health
CHC	Community Health Centre
CHD	Congenital Heart Disease
CHO	Community Health Officers
CIG	Certificate in Guidance
CLD	Central Leprosy Division
CMC	Comprehensive Maintenance Contract
CMCHIS	Chief Minister's Comprehensive Health Insurance Scheme
CMHA	Central Mental Health Authority
CMHIS	Chief Minister's Comprehensive Health Insurance Scheme
CMHO	Chief Medical Health Officer
CMO	Chief Medical Officer
CMTC	Child Malnutrition Treatment Center
COPD	Chronic Obstructive Pulmonary Disease
COTPA	Cigarettes and Other Tobacco Products Act 2003
CP	Community Processes
CPCH	Certificate Program in Community Health
CPD	Continuing Professional Development

CPHC	Comprehensive Primary Health Care
CPMU	Central Project Management Unit
CPS	College of Physician and Surgeon
CPT	Clotrimazole Preventive Therapy
CQSC	Central Quality Supervisory Committee
CRM	Common Review Mission
CSR	Corporate Social Responsibility
CSSD	Central Sterile Supply Department
CSW	Commercial Sex Workers
CT	Computed Tomography
CTD	Central TB Division
CTF	Common Treatment Facility
CUG	Closed User group
CXR	Chest X-Ray
DACP	Dynamic Assured Career Progression
DAK	Delhi Aarogya Kosh
DAMAN	Durgama Anchalare Malaria Nirakaran
DAPCU	District AIDS Prevention and Control Unit
DBT	Direct Benefit Transfer
DCC	District Counselling Center
DCM	District Community Mobiliser
DDMS	Drug Distribution Management System
DDT	Dichloro Diphenyl Trichloroethane
DDW	District Drug warehouse
DEIC	District Early Intervention Centre
DEO	Data Entry Operator
DGHS	Director General of Health Services
DH	District Hospital
DHAP	District Health Action Plan
DHQ	District Headquarter
DHS	District Health Society
DJB	Delhi Jal Board
DLO	District Leprosy Officer
DM	District Magistrate
DMC	Designated Microscopic Centre
DMCHO	District Maternal and Child Health Officer

DMF	District Mineral Fund
DMHP	District Mental Health Programme
DMMU	District Mobile Medical Unit
DMO	District Malaria Officer
DNB	Diplomate of National Board
DOTS	Directly observed treatment, short-course
DPC	District Planning Coordinator
DPHL	District Public Health Laboratory
DPM	District Programme Manager
DPMU	District Programme Management Unit
DPT	Diphtheria-Pertussis-Tetanus
DQAC	District Quality Assurance Committee
DQAMO	District Quality Assurance Medical Officer
DQAU	District Quality Assurance Unit
DRG	District Resource Group
DRTB	Drug Resistance TB
DSSSB	Delhi Subordinate Services Selection Board
DST	Drug Sensitivity Test
DTC	District Tuberculosis Centre
DTCC	District Tobacco Control Cell
DTO	District Tuberculosis Officer
DVDMS	Drugs and Vaccines Distribution Management Systems
DWH	District Women Hospital
EAG	Empoared Action Group
EBF	Exclusive Breastfeeding
ECCE	Early Childhood Care and Education
ECD	Early childhood Development
ECG	Electro Cardiography
ECP	Emergency Contraceptive Pills
ECRC	Emergency Care and Recovery Centre
EDD	Expected Delivery Date
EDL	Essential Drug List
EGSA	Extended Gram Swaraj Abhiyan
EHR	Electronic Health Record
EHS	Electronic Health Services

ELISA	Enzyme-linked Immune Sorbent Assay
EMRI	Emergency Management and Research Institute
EMS	Emergency Medical Services
EMT	Emergency Medical Technicians
EMTC	Elimination of Mother to Child Transmission
ENBC	Essential New-born Care
ENT	Ear Nose Throat
EPTB	Extrapulmonary TB
EQAS	External Quality Assurance Standards
ERCP	Emergency endoscopic retrograde cholangiopancreatography
ERIG	Equine Rabies Immunoglobulin
ESB	Ensuring Spacing at Birth
ESI	Employees' State Insurance
ESRD	End Stage Renal Disease
ETP	Effluent Treatment Plan
e-VIN	Electronic Vaccine Intelligence Network
FBNC	Facility Based Neonatal Care
FDC	Fixed Dose Combinations
FDI	Free Diagnostics Initiative
FDS	Fixed Day sterilization
FDSI	Free Drug Service Initiative
FEFO	First Expiry First Out
FGD	Focussed Group Discussions
FICTC	Facility Integrated Counselling and Testing Center
FIFO	First In First Out
FLC	Focused Leprosy Campaign
FLW	Frontline Workers
FMG	Financial Management Group
FP	Family Planning
FPLMIS	Family Planning Logistic Management Information System
FRU	First Referral Unit
FSW	Female Sex Workers
GAK	Gram Arogya Kendra

GDMO	General Duty Medical Officer
GH	Government Hospital
GIS	Geographic Information System
GKS	Gao Kalyan samitis
GMD	Growth Monitoring Device
GNM	General Nursing Midwifery
GOI	Government of India
GPS	Global Positioning System
GRS	Grievance Redressal System
GSA	Gram Swaraj Abhiyan
HBNC	Home Based New-born Care
HBPNC	Home Based Post Natal Care
HBV	Hepatitis B Virus
HBYC	Home Based Care for Young Child
HCF	Health Care Facility
HCM	Hot Cooked Meals
HCT	Health Care Technology
HCV	Hepatitis C Virus
HCW	Health Care Workers
HDU	High Dependency Unit
HIE	Hypoxic-ischemic encephalopathy
HIV	Human Resource Information Management System
HLFPPT	Hindustan Latex Family Planning Promotion Trust
HMIS	Health Management Information System
HPD	High Priority Districts
HR	Human Resource
HRH	Human Resource for Health
HRIMS	Human Resource Information Management System
HRP	High Risk Pregnancy
HSC	Health Sub-Centre
HTN	Hyperattention
HUD	Housing and Urban Development
HWC	Health and Wellness Centre
ICDS	Integrated Child Development Scheme

ICTC	Integrated Counselling and Testing Centre
ICU	Intensive Care Unit
IDD	Iron Deficiency Disorder
IDSP	Integrated Disease Surveillance Project
IDU	Injectable Drug Users
IEC	Information Education Communication
IFA	Iron Folic Acid
IGIMS	Indira Gandhi Institute of Medical Sciences
IGNOU	Indira Gandhi National Open University
IHIP	Integrated heath Information platform
IIPH	Indian Institute of Public Health
IIPHG	Indian Institute of Public Health, Gandhinagar
IIPS	International Institute for Population Sciences
IKDRC	Institute of Kidney Diseases and Research Centre
ILA	Incremental Learning Approach
ILC	Innovation and Learning Centre
ILR	Ice Line Refrigerator
IMI	Intensified Mission Indradhanush
IMNCI	Integrated Management of New-born and Childhood Illness
IMR	Infant Mortality Rate
INAP	Indian New-born Action Plan
INC	Indian Nursing Council
INH	Isoniazid
INR	Indian National Rupees
IOL	Intra Ocular Lens
IPC	Inter Personal Skills
IPD	In Patient Department
IPHS	Indian Public Health Standards
IPV	Inactivated Polio Vaccine
IQC	Internal Quality Control
IRL	Intermediate Reference laboratory
IRS	Indoor Residual Spray

ISO	International Organization for Standardization
IUCD	Intra Uterine Copper Device
IUD	Intra Uterine Device
IV	Intravenous
IWD	International Women's Day
IYCF	Infant and Young Child Feeding
JDS	Jeevan Deep Samiti
JE	Japanese Encephalitis
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
JIPMER	Jawaharlal Institute of Postgraduate Medical Education and Research
JNIMS	Jawaharlal Nehru Institute of Medical Sciences
JSAC	Jharkhand Space Applications Center
JSSK	Janani Sisthya Suraksha Karyakaram
JSY	Janani Suraksha Yojna
KGMU	King George Medical University
KKS	Khushion Ki Sawari
KOI	Key Output Indicators
KPI	Key Performance Indicators
KTPL	Kirloskar Technology Private Ltd
KTS	Kala-azar Technical Supervisors
LBW	Low Birth Weight
LCDC	Leprosy Case Detection Campaign
LF	Lymphatic Filariasis
LHMC	Lady Harding Medical College
LHV	Lady Health Visitor
LIMS	Laboratory Information Management System
LLIN	Long Lasting Insecticide Nets
LPA	Line Probe Assay
LPG	Liquified Petroleum Gas
LR	Labour Room
LSAS	Life Saving Anaesthetic Skills
LT	Laboratory Technician
MAA	Mother Absolute Affection

MAM	Moderate Acute Malnutrition
MAS	Mahila Aarogya Samiti
MBBS	Bachelor of Medicine and Bachelor of Surgery
MCB	Mother Circuit Board
MCD	Municipal Corporation of Delhi
MCH	Maternal and Child Health
MCHN	Maternal, Child Health Nutrition Day
MCP	Mother and Child Protection
MCR	Microcellular Rubber
MCTS	Mother and Child Tracking Systems
MCW	Maternity, Child and Welfare Centre
MDA	Mass Drug Administration
MDG	Millennium Development Goals
MDR	Maternal Death Review
MDSR	Maternal Death Surveillance and Response
MDT	Multi Drug Therapy
MEPMA	Mission for Elimination of Poverty in Municipal Area
MERM	Medication Event and Monitor Reminder
MGCA	Mentoring Group for Community Action
MH	Maternal Health
MHIP	Mizo Hmeicchhia Insuihhawm Pawl
MHS	Menstrual Hygiene Scheme
MHT	Mobile Health Team
MHU	Mobile Health Unit
MIS	Management Information System
MLA	Member of Legislative Assembly
MLHP	Mid-Level Health Care Providers
MMJAA	MukhyaMantri Jan Arogya Abhiyan
MMR	Maternal Mortality Ratio
MMU	Medical Mobile Unit
MNH	Maternal and Neonatal Health
MO	Medical Officer
MOHFW	Ministry of Health and Family Welfare
MOU	Memorandum of Understanding

MP	Member of Parliament
MPA	Medroxy Progesterone Acetate
MPH	Master of Public Health
MPHW	Multi-Purpose Health Worker
MPV	Mission Parivar Vikas
MPW	Multi-Purpose Worker
MR	Measles Rubella
MRI	Magnetic Resonance Imaging
MSF	Medecins Sans Frontieres
MTP	Medical Termination of Pregnancy
MUP	Mizo Upa Pawl
MVA	Manual Vacuum Aspiration
NABL	National Accreditation Board for Testing and Calibration Laboratories
NACO	National AIDS Control Organisation
NACP	National AIDS Control Programme
NAQS	National Quality Assurance Standards
NAS	National Ambulance Services
NBCC	New Born Care Corner
NBE	National Board of Examinations
NBSU	New Born Sick Unit
NCD	Non- Communicable Disease
NCDC	National Centre for Disease Control
NDMC	New Delhi Municipal Council
NEIGRIHMS	North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences
NERRC	Regional Resource Centre for North Eastern States
NFHS	National Family Health Survey
NGCP	National Goitre Control Programme
NGO	Non-Government Organisation
NHAI	National Highways Authority of India
NHM	National Health Mission
NHSRC	National Health Systems Resource Centre
NIC	National Informatics Centre
NICU	New-born Intensive Care Unit

NIDDCP	National Iodine Deficiency Disorder Control Programme
NIHFW	National Institute of Health and Family Welfare
NIN	National Institute of Nutrition
NIOS	National Institute of Open Schooling
NIPI	National Iron Plus Initiative
NITI	National Institution for Transforming India
NLEP	National Leprosy Eradication Programme
NMEP	National Malaria Elimination Plan
NMHP	National Mental Health Programme
NMR	Neonatal Mortality Rate
NOC	No Objection Certificate
NOHP	National Oral Health Programme
NPCB	National Programme for Control of Blindness
NPCDCS	National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke
NPHCE	National Programme for Health care of Elderly
NPPC	National Programme for Palliative Care
NPPCD	National Programme for Prevention and Control of Deafness
NPPCF	National Programme for Prevention and Control of Fluorosis
NPPMBI	National Programme for Prevention & Management of Burn Injuries
NPY	Nikshay Poshan Yojanan
NQAP	National Quality Assurance Program
NQAS	National Quality Assurance Standards
NRC	Nutritional Rehabilitation Centre
NRCP	National Rabies Control Programme
NRHM	National Rural Health Mission
NSP	National Strategic Plan
NSSK	Navjat Sishu Suraksha Karyakaram
NSSO	National Sample Survey Organisation
NSV	Non-Scalpel Vasectomy
NTCP	National Tobacco Control Programme
NTCC	National Tobacco Control Cell
NTEP	National Tuberculosis Elimination Programme
NUHM	National Urban Health Mission
NULM	National Urban Livelihoods Mission
NVBDCP	National Vector Borne Disease Control Programme
NVHCP	National Viral Hepatitis Control Program
OBGY	Obstetrics & Gynaecology
OC	Oral Contraceptives
ODF	Open Defecation
OGTT	Oral Glucose Tolerance Test
OMHS	Odisha Medical & Health Services
OOPE	Out of Pocket Expenditure
OPD	Out Patient Department
OPV	Oral Polio Vaccine
ORS	Oral Rehydration Solution
OSCC	One Stop Crisis Centres
OT	Operation Theatre
PAIUCD	Post Abortion Intra Uterine Copper Device
PALS	PL-HIV ART Linkage System
PAP	Papanicolaou
PBS	Population based screening
PCC	Pollution Control Committee
PCPNDT	Pre-Conception and Pre-Natal Diagnostic Techniques
PCV	Pneumococcal Conjugate vaccine
PDCA	Plan Do Check Act
PEP	Post exposure prophylaxis
PFMS	Public Fund Management System
PG	Post Graduate
PGDHQM	Post Graduate Diploma in Healthcare Quality Management
PGIMER	Postgraduate Institute of Medical Education and Research
PHACO	Phacoemulsification
PHC	Primary Health Centre
PHFI	Public Health Foundation of India

PHI	Peripheral Health Institution
PHMC	Public Health Management Cadre
PHN	Public Health Nurses
PICME	Pregnancy and Infant Cohort Monitoring and Evaluation
PICU	Paediatric Intensive Care Unit
PIH	Pregnancy Induced Hypertension
PIP	Programme Implementation Plan
PKDL	Postkala-azar leishmaniasis
PLA	Participatory Learning and Action
PLHIV	People Living With HIV/AIDS
PLP	Performance linked payments
PMCH	Patna Medical College and Hospital
PMJAY	Pradhan Mantri Jan Aarogya Yojana
PMJJBY	Pradhan Mantri Jeevan Jyoti Bima Yojana
PMMVY	Pradhan Mantri Matru Vandana Yojana
PMNDP	Pradhan Mantri National Dialysis Program
PMSBY	Pradhan Mantri Suraksha Bima Yojana
PMSMA	Pradhan Mantri Surakshit Matritva Abhiyan
PMSYMY	Pradhan Mantri Shram-Yogi Maandhan Yojana
PMTCT	Prevention to Mother to child transmission
PNC	Post Natal Care
POC	Point of Care
POSHAN	Prime Minister's Overreaching Scheme for Holistic Nourishment
PPE	Personal Protective Equipment
PPIUCD	Postpartum intrauterine contraceptive devices
PPP	Public Private Partnership
PPPBI	Pilot Programme for Prevention of Burn Injuries
PPTCT	Prevention of Parent to Child Transmission
PRI	Panchayat Raj Institution
PSC	Program Study Centres
PSS	Patient satisfaction surveys

PTK	Pregnancy testing kits
PUHC	Primary Urban Health Centres
PW	Pregnant Women
QA	Quality Assurance
QI	Quality Improvement
RBD-1969	Registration of Births and Deaths Act, 1969
RBS	Random Blood Sugar
RBSK	Rashtriya Bal Sisthya Karyakaram
RBTC	Regional Blood Transfusion Centre
RCH	Reproductive and Child Health
RCS	Reconstructive Surgery
RCT	Root Canal Treatment
RDK	Rapid Diagnostic Kits
RDT	Rapid Diagnostic Test
RFID	Radio Frequency Identification
RHFWTC	Regional Health and Family Welfare Training Centres
RHS	Rural Health Statistics
RI	Routine Immunization
RIHFW	Regional Institute of Health and Family Welfare
RIMS	Rajendra Institute of Medical Sciences
RIO	Regional Institutes of Ophthalmology
RKS	Rogi Kalyan Samiti
RKSK	Rastriya Kishor Sisthya Karyakram
RLTRI	Regional Leprosy Training and Research Institute
RMC	Respectful Maternity Care
RMNCH+A	Reproductive, Maternal, neonatal, child and Adolescent Health
RMO	Resident Medical Officer
RNA	Ribonucleic acid
RNTCP	Revised National Tuberculosis Control Program
ROP	Record of Proceedings
RRT	Rapid Response Team
RTA	Road Traffic Accident

RTI	Road Traffic Injuries
RTO	Regional Transport Office
SAM	Severe Acute Malnutrition
SBA	Skill Birth Attendant
SC	Sub-Centres
SCD	Sickle cell disease
SDG	Sustainable Development Goals
SDH	Sub Divisional Hospitals
SHC	Sub-Health Centres
SHG	Self Help Group
SHS	State Health Society
SICS	Small-Incision Cataract Surgery
SIHFW	State Institute of Health & Family Welfare
SIMS	Strategic Information Management System
SJH	Safdarjung Hospital
SKMCH	Sri Krishna Medical College and Hospital
SLAC	Sparsh Leprosy Awareness Campaign
SLEC	Sparsh Leprosy Elimination Campaign
SMC	Surat Municipal Corporation
SMHA	State Mental Health Authority
SN	Staff Nurse
SNCU	Special New-born Care Unit
SNO	State Nodal Officer
SNP	Supplementary Nutrition Programme
SOHC	State Oral Health Cell
SOP	Standard Operating Procedure
SPCB	State Pollution Control Board
SPM	State Programme Manager
SPMU	State Programme Management Unit
SQAC	State Quality Assurance Committee
SQAU	State Quality Assurance Unit
SRG	State Resource Group
SRS	Sample Registration System
SSH	Sentinel Surveillance Hospitals
SSS	Swachh Sisth And Sarvatra
STCC	State Tobacco Control Cell
STG	Standard Treatment Guidelines
STI	Sexually Transmitted Infections
STK	Spot Testing Kits
STLS	Senior TB Laboratory Supervisor
STP	Sewage Treatment Plant
SUMAN	Surakshit Matritva Aashwasan
TAEI	Trauma Accident and Emergency Care Initiative
TBHV	TB Health Visitor
TCC	Tobacco Cessation Centres
TFR	Total Fertility Rate
THR	Take Home Rations
TIMS	Training Management Information System
TISS	TATA Institute of Social Science
TLD	Thermoluminescent dosimeter
TMIS	Training Management Information System
TNMSC	Training Management Information System
TNPSC	Tamil Nadu Public Service Commission
TNULM	Tamil Nadu Urban Livelihood mission
TOT	Training of Trainers
TT	Tetanus Toxoid
TU	Tuberculosis Unit
UCHC	Urban Community Health Centre
UDST	Universal Drug Susceptibility. Testing
UHC	Universal Health Coverage
UHIS	Universal Health Insurance Scheme
UHND	Urban Health Nutrition Day
UHSND	Urban Health, Sanitation and Nutrition Day
UID	Urban Immunization Day
ULB	Urban Local Body
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations International Children's Emergency Fund
UPHC	Urban Primary Health Centre
UPT	Urine Pregnancy Test
URI	Upper Respiratory Infections

URR	Urea Reduction Ratio
USAID	United States Agency for International Development
USG	Ultrasonography
VA	Verbal Autopsy
VBD	Vector Borne Disease
VDRL	Venereal Disease Research Laboratory
VHC	Village Health Committee
VHND	Village Health Nutrition Day
VHNSD	Village Health, Sanitation and Nutrition Day
VHSNC	Village Health Sanitation and Nutritional Committee

VI	Visually Impaired
VIA	Visual Inspection with Acetic acid
VL	Visceral Leishmania
WASH	Water, Sanitation and Hygiene
WCD	Women and Child Development
WEDS	Women’s Economic Development Society
WHO	World Health Organization
WHV	Women Health Volunteers
WIFS	Weekly Iron Folic Supplementation program
WKS	Ward Kalyan Samiti
YMA	Young Mizo Association

MANDATE AND METHODOLOGY

MANDATE AND METHODOLOGY

of 13th common review mission

Overview

Every year Ministry of Health & Family Welfare (MOHFW) organizes the Common Review Mission (CRM) in various states across the country. This year the CRM is organized between 16th October 2019 to 23rd October, 2019 in 15 State /UTs namely Andhra Pradesh, Chhattisgarh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Rajasthan, Tamil Nadu, Uttarakhand, and Uttar Pradesh. In the 16th state, Bihar, the CRM visit is deferred and is conducted from 8th to 14th November 2019 due to water-logging following floods.

The objective of the CRM is to undertake a rapid assessment of the functional status of various health programmes running under NHM and to understand key drivers and challenges impacting their implementation. It also documents innovations and best practices of each state that can be replicated elsewhere for achieving better health outcomes. All the previous 12 Common Review Missions (CRMs) held under NHM/NRHM provided valuable information about the state strategies that are successful and those that are not, enabling mid-course corrections, wherever found necessary, to happen.

This report is the thirteenth in the series, covering the findings from sixteen states visited during the CRM.

Introduction and Objectives

The 13th CRM is conducted to assess the implementation of the programmes from the citizen's perspective. Therefore, the interactions are planned to begin with the community and continued to examine service provision from Sub centres/HWCs onwards upto the district/state levels, on the principle of the continuum of care.

Moreover, one of the key objectives of this CRM is to assess the implementation of Ayushman Bharat-Health and Wellness Centres (HWCs) in the states. Visits to the upgraded PHCs-HWCs and SC-HWCs are undertaken to understand the bouquet of services available at these centres. Interactions with various stakeholders such as pregnant woman & lactating mothers, AWWs, PRI members, School teachers, health facility staff, VHSNC/MAS members are included in the assessment plan for various levels of health institutions.

Of particular focus during the assessment is to assess interventions/strategies undertaken at state, district, and sub-district levels to address institutional racism, gender inequity, social issues impacting health- seeking behaviour and reaching the marginalized in urban and rural areas. Observations while officials are on duty job observations including inputs, processes and, adherence to SOPs and innovations are made to gain a better understanding of state's policies and practices in these domains.

Implementation of newly launched health programmes like National Viral Hepatitis Control Program, Pradhan Mantri National Dialysis program and Atomic Energy Regulatory Board program is also analyzed to understand their impact and bottlenecks, if any, for better coverage and access to health services.

Evaluation of the status of Public Health Management Cadre (PHMC), Clinical Establishment Act, and other key laws at state/district and sub-district level is also one of the key focus areas of the visit.

Furthermore, progress towards conditionalities and follow up on recommendations of past CRMs is gauged (teams are given last CRM visit reports) to understand the state's commitment and challenges in meeting the required standards of service delivery and to recommend appropriate interventions.

Terms of Reference for 13th CRM

The Terms of Reference along with a detailed checklist for the 13th CRM is decided at the National level and intended to review the availability, acceptability, and accessibility of comprehensive health care in the selected districts through a bottom-up review approach. The districts where more number of HWCs is present are purposefully chosen for the review.

The 10 Terms of Reference (TORs) are broadly divided under two themes viz. Service delivery and Health System Strengthening for an overall assessment of the healthcare landscape in the districts/states visited.

Under Service delivery, provision of comprehensive primary health care at HWCs, and PMJAY benefits under Ayushmaan Bharat scheme and functional status of RMNCH+A programme including POSHAN Abhiyaan, Non-Communicable and Communicable Diseases programme and Urban Health programme at the community as well as facility-level is assessed.

Under Health Systems Strengthening, Community processes and gender, Quality assurance framework, Human Resource status, Governance & Accountability- implementation of various healthcare acts, Healthcare Financing and Access & Equity related issues at all levels of healthcare facilities are assessed.

A comprehensive booklet including the objectives of each TOR and the facility wise checklists (Community, HWC, PHC/UPHC, CHC/UCHC, District Hospitals, State, and District) is disseminated to the teams for an in-depth understanding of the various programmes. Team members are also provided with a set of background material that included MIS Reports, NUHM factsheets, Survey reports (RHS, SRS, NFHS, HMIS), district and state health profiles data, and relevant findings from past CRM reports.

Geographical Coverage of 13thCRM

The 13th CRM covered sixteen states. Eight of these are High Focus States (Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, and Uttar Pradesh), four are in the North East (Meghalaya, Mizoram, Nagaland, and Manipur) and rest four are Non-High Focus States (Andhra Pradesh, Gujarat, Tamil Nadu, and Delhi).

Process and Methods of the 13thCRM

The thirteenth CRM covered sixteen states purposively chosen to be representatives of High Focus, Non-High focus, North Eastern, and hilly states.

Of these states so far, Uttar Pradesh has been visited in all thirteen CRMs, while Chhattisgarh has been visited in all except the seventh & tenth CRM. Bihar and Odisha have been part of eleven CRMs while Madhya Pradesh and Rajasthan have been part of ten CRMs. Jharkhand & Uttarakhand have been included in nine CRMs. Andhra Pradesh and Tamil Nadu have been visited eight times during CRMs while Gujarat and Delhi have been included six and four times respectively in CRM visits. Among northeastern states, Meghalaya and Nagaland

are included in five CRM's. Mizoram and Manipur have been part of CRM's for three and four times respectively.

Team Composition

Each State is visited by a 12-14-member team comprising a mix of the following:

i. **Government Officials** from:
   a. MoHFW
   b. Representatives of State
   c. Regional Directors of Health & Family Welfare
   d. Other Central Ministries and NITI Aayog

ii. **Public Health Experts** from:
   a. Non-official members of Mission Steering Group of NHM
   b. Non-official members of Empoared Programme Committee of NHM
   c. National Health Systems Resource Centre (NHSRC), National Institute of Health & Family Welfare (NIHFW), Public Health Foundation of India (PHFI), other credible institutions including Medical Colleges and Schools of Public Health

iii. **Population Research Centre's** (PRCs)

iv. **Development Partners**

v. **Representatives of Civil Society** (from amongst the following)
   a. Advisory Group on Community Action
   b. National ASHA Mentoring Group

vi. Consultants from various divisions of the Ministry

List of States And Districts Visited In 13thCRM

S. No.	State	Districts	
		High Numerical Density of HWCs	Aspirational districts
1.	Andhra Pradesh	Vishakhapatnam	Kadappa
2.	Bihar	Bhagalpur	Begusarai
3.	Chhattisgarh	Korba	Rajnandgaon
4.	Delhi	East Delhi	New Delhi
5.	Gujarat	Surat	Dahod
6.	Jharkhand	Gumla	West Singhbhum
7.	Madhya Pradesh	Chhindwara	Khandwa
8.	Manipur	Bishnupur	Chandel
9.	Meghalaya	West Garo Hills	Ri-Bhoi
10.	Mizoram	East Aizwal	Mamit
11.	Nagaland	Phek	Kiphire
12.	Odisha	Mayurbhanj	Kandhamal
13.	Rajasthan	Churu	Sirohi
14.	Tamil Nadu	Villupuram	Virudhnagar
15.	Uttar Pradesh	Meerut	Bahraich
16.	Uttarakhand	US Nagar	Haridwar

TERMS OF REFERENCE


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TOR 1
COMPREHENSIVE PRIMARY HEALTH CARE

National Overview

About 1.5 lakh Sub-Centres and Primary Health Centres are expected to be transformed as Health & Wellness Centres by 2022 to provide comprehensive and quality primary care close to the community while ensuring the principles of equity, affordability, and universality. The delivery of CPHC through HWCs rests substantially on the institutional mechanisms, governance structures, and systems created under the National Health Mission (NHM).

Over the past two years, states have made efforts to operationalize HWCs through essential inputs such as Strengthening primary health care team at the SHC and PHC level (by posting a Community Health Officer/ Mid-Level Health Provider at the SHC level and filling vacancies at PHC level), Multiskilling and Capacity building of primary healthcare teams, Expanded range of medicines and diagnostics, Upgrading infrastructure alogn with newer IT initatives such as tablets and desktops, use of CPHC – IT application, telemedicine/ information technology platforms, Undertaking activities related to health and wellness promotion and Introducing performance linked payments.

In FY 2018- 2019, about17,149 HWCs are operationalized against the target of 14,000. So far 22,362 (as on Oct 15th, 2019) HWCs have been operationalized against the target of 40,000 by the end of FY 2019-20

Key Findings

Planning for operationalizing Health and Wellness Centres

Of the 16 states visited, 15 have initiated operationalization of Health and Wellness Centres to provide Comprehensive Primary Health Care. Delhi has adopted a strategy for providinga Common Minimum Services Package through Urban Primary Health Centres, in place of operationalizing HWC, supplemented by Mohalla Clinics.

- **Roll out plan and achievement-** Gujarat, Meghalaya, Uttar Pradesh, Odisha and Andhra Pradesh had prepared year wise plans, including implementation strategies to upgrade all primary healthcare facilities to HWCs by December 2022. Findings from some states reflect slow progress made against the targets for number of SHCs and PHCs/UPHCs to be operationalized as Health and Wellness Centers in FY 2019-20. E.g. In Jharkhand-the gap in meeting targets is on account of training inadequate number of CHOs vis a vis the SHCs planned for upgradation. In Bihar, inadequate number of CHO training and shortfall of MOs is the reason for delay in achieving the targets to operationalize SHC and PHC to HWC respectively.
- **Upgradation of SHCs to HWCs-** It relies on the state's capacity to train and position Community Health Officers (CHO) and the

status of infrastructure availability at SHC. All states have prioritized upgradation of facilities with better infrastructure and have left out SHCs which either require new infrastructure or major repairs. In Bihar, CHOs have been posted on a rotational basis i.e., 43 CHOs have been posted at 86 SHC-HWCs in an attempt to operationalize more number of SHC-HWCs to meet the target.

- **Block saturation-** The strategy of selecting facilities with better infrastructure has led to the development of HWCs scattered across blocks and districts without following the principle of saturation within a block and district to facilitate referrals and be able to provide CPHC to a contiguous geography. In Gujarat, this has resulted in leaving out underserved rural and urban areas and clustering of HWCs within a radius of 5-6 km. Only three states i.e, Uttar Pradesh, Odisha, Meghalaya have adopted block saturation approach, wherein all the primary healthcare facilities within a block have been upgraded to HWCs.
- **Operationalization of PHCs as HWCs in rural and urban area-** States have prioritized upgradation of rural and urban Primary Health Centres to HWCs in FY 2019-20 to facilitate referral linkages after CHOs have been posted at sub centres. Another reason for prioritizing the PHCs is better infrastructure and the requirement of relatively lesser investment in terms of human resource. Andhra Pradesh, Odisha, Gujarat, Tamil Nadu have operationalized more than 60-70% of the target PHCs in urban and rural area. In other states also, a large number of rural and urban PHCs have been operationalized but constraints are noted on account of high proportion of vacant positions of MBBS Medical officer at PHCs as highlighted in Odisha, Uttar Pradesh and Bihar. Inadequate number of primary health care facilities as per population norms emerged as a major constraint in delivery of comprehensive primary health care in the state of Jharkhand. In Chhattisgarh, Assitant Medical Officers, who are Community Health Officer (CHO) equivalent are posted in rotation between their parent SHC & other SHCs to ensure functional facilities.

Program Management and Monitoring

- In all visited states, a dedicated program management team at state level for implementation of CPHC had been set up. At district level, nodal officers of existing programmes (like Quality MO in Gujarat, NCD coordinator in Bihar, community mobilizer in UP and Meghalaya) are designated as CPHC nodal officers in most states, except Andhra Pradesh, and Jharkhand. There is progress observed in terms of understanding and ownership of the initiative compared to the 12th CRM. However, challenges regarding coordination with different programs persist.
- Involvement of Directorate of Health Services in CPHC implementation is reported only in the states of Tamil Nadu and in Andhra Pradesh

to some extent. Development partners are supporting the state and district program management unit in Jharkhand, Odisha, Meghalaya and UP. In Dahod (Gujarat), as part of Innovation and Learning Centres, Charutar Arogya Mandal is supporting the roll out of CPHC.

- State CPHC management units monitored services through field visits and report assessment. However, none of the visited states had a robust mechanism for monitoring. Independent monitoring of HWCs is reported only in the state of Odisha, where medical college at Mayurbhanj has adopted one block and 10 HWCs for capacity building, monitoring and supervision.

Infrastructure

- Most HWCs visited are functioning in government buildings, as these are prioritized during the initial phase of operationalization. Adequate space is available in visited HWCs in Meghalaya, Mizoram, Nagaland, Odisha and Uttarakhand but space constraint is reported in a few facilities in Gujarat, Madhya Pradesh, Andhra Pradesh, Nagaland and Uttar Pradesh.
- Land acquisition and administrative process delays are reported in Dahod district (Gujarat) and Gumla (Jharkhand). For example, 34 out of 79 SHC in remote Fatepura block of Dahod district did not have buildings due to issues reported in land acquisition.
- In some Sub Centre- HWCs in Meghalaya, staff quarters are available (SHCs are delivery points) and utilized by the staff. In Manipur and Nagaland, non-availability of staff quarters is reported to be a constraint in service delivery as this affected HR retention. In Nagaland, village councils had made some arrangements for CHOs to support their accommodation, but these are not found to be adequate.
- Irregular water supply is reported in HWCs in Meghalaya and electricity back up is not available in most of the SHC-HWCs visited. Availability of private space for examination is available in most of the SHC-HWCs visited either through availability of a separate room or using curtains. External branding has been completed in most of the visited facilities.

Human Resources

Community Health Officers

Certificate course in Community Health

- All visited states (except Tamil Nadu) have adopted model of training a BSc/GNM nurse or Ayurveda candidate in six months' Certificate Program in Community Health (CPCH). In Tamil Nadu, state has trained the Village Health Nurses (MPREGNANT WOMEN-F) in a one year course and an additional VHN is posted at sub centres. The team of two trained VHNs is providing expanded range of services at SHC-HWCs.
- In most visited states, CPCH is rolled out through IGNOU (Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand). In Gujarat, IIPH Gandhinagar is supporting CPCH course roll out in the following- curriculum, examination and certification of candidates. The CHOs are also given 15 days training in

soft skills on behavior change, team building, community leadership and yoga at IIPH, which is reported to be helpful by CHOs in Gujarat.

- Chhattisgarh also has an existing cadre of Mid- level health providers known as Assistant Medical Officers (AMO), who are trained in three and half year course equivalent to the BSc. Community Health course. The AMOs are posted at Primary Health Centres and currently visit the sub centers under their PHC area twice a week, to provide service delivery even closer to the community. Due to these rotational posting, disruption of service delivery at PHC is noted. State has now also initiated training of nurses in CPCH to be positioned at SHC.
- In Jharkhand, BSc Community Health course is started in affiliation with Ranchi University through Institute of Public Health (IPH) in 2016. Currently 260 students are undergoing training in all three batches and first batch of 60 is expected to graduate in Dec 2019 and is planned to be posted at SHC- HWCs. Critical challenges are observed such as non-registration of IPH, no examination conducted for any batch and inadequate training HR at IPH.
- Most states (Andhra Pradesh, Chhattisgarh, Meghalaya, Mizoram, Nagaland, Odisha, Uttar Pradesh and Uttarakhand) have included only nurses (BSc or GNM) for training under CPCH. Odisha has recruited Ayurveda practitioners in initial few batches but has now decided to recruit nurses as CHOs. In states of Gujarat, Bihar, Jharkhand and Uttarakhand, Ayurveda practitioners are also undergoing training along with nurses in CPCH. However, BAMS candidates are less as compared to nurses in these states. Most states have enrolled candidates through open recruitment after an entrance examination except in Rajasthan, Jharkhand and Meghalaya, where in-service candidates are enrolled in initial batches of CPCH. However subsequently even in these states, candidates are being enrolled through open recruitment.
- Challenges in delay of enrollment are also reported in states of Bihar, UP and Rajasthan due to litigations. In Bihar, admission of BAMS candidates is not done due to stay order from high court in view of petition from Homeopathy association.
- Adequate number of Program Study Centres (PSC) which are either medical, nursing colleges or district hospitals are available to roll out CPCH are available in most states. Availability and understanding of program counsellors regarding the course is varying in the visited PSCs across states. In Meghalaya, state had conducted ToT for academic counsellors of PSCs in 2019 and had also included training on NHM and basic Yoga (in coordination with state AYUSH department) in CPCH course. State also has six state observers for conducting monthly visits to PSCs to monitor the quality of training.
- In Gumla, (Jharkhand), four counsellors are available at the PSC but classes are found to be irregular as the counsellors had clinical duties at DH. The counsellors had not received any orientation regarding CPHC-HWC and are not using the IGNOU modules. This is reflected in the limited clarity of candidates regarding CPHC-HWC and their roles. Similar challenge in CPCH training is reported in Chhattisgarh due to other priorities of faculty. In Gujarat, CHOs expressed concerns about lack of handholding support during practical skill training at community level in PHCs and SHCs and also during their clinical postings in district hospitals because of inadequate supportive supervision by one supervisor designated per hospital for 15 students.

Additional Trainings of CHOs

Some states had conducted additional trainings of CHOs after their posting at SHC-HWC. In Gujarat, CHOs are trained in Yoga and Arogya Samanvay (mediation, ayurvedic medicines). In Rajasthan, CHOs are trained in NCD (one day) and Yoga (three days) after posting.

HR Policies & Career progression for CHOs

Regarding the HR policies for CHOs, only Odisha has planned to develop a cadre for CHOs and

create a post of staff nurse at SHC-HWCs which will enable CHOs to follow the career progression options of staff nurses. In Uttar Pradesh, challenge of attrition of CHOs is reported and state is thus planning for career progression plan for better retention. Posting of CHOs is being done as per the preference given by CHOs as reported from Jharkhand and Gujarat. On the other hand, CHOs are posted in non-home districts in Nagaland which is reported to be a major challenge in retention.

Irrational Use of Antibiotics

Reports from Jharkhand, Gujarat and Nagaland raise concerns about irrational use of medicine by CHOs. While in Jharkhand and Gujarat rampant use of antibiotics is reported, in Nagaland CHOs are initiating treatment of HT/ DM after phone consultation with MO due to community demand. This indicates the need for regular monitoring of CPCH training and regular mentoring of CHOs as well as better coordination with PHC MO.

Primary Healthcare team at SHC-HWC

As specified in the Operational Guidelines a three member team i.e 1 CHO, 2MPREGNANT WOMENs (both Female or one male and one female) and ASHAs, is available in most states, except in UP (one CHO and one MPREGNANT WOMEN-F).

- **Allocation of Roles & Responsibilties**- Although HR is available at SHC-HWCs in most states, understanding of respective roles and responsibilities is limited between team members, resulting in task duplication and compromised effective service delivery. This is highlighted in both districts of Gujarat where duplication of efforts is noted in terms of home visits and activities related to disease control programmes being done by ANM, ASHAs and MPHW-M.
- **ASHAs as part of primary healthcare team-**
  a) ASHAs are participating in all the activities at SHC-HWC as a member of the primary healthcare team. In most visited states, ASHAs had initiated population enumeration and risk assessment of individuals of 30 years and above age, through CBAC form filling. The quality of forms filled however varied across states and is largely reflective of the gaps in training and handholding. In few states where, NCD screening and treatment provision is initiated at SHC-HWCs, ASHAs had started maintaining follow up records (AP, Gujarat, Jharkhand, MP, UP), however this function is limited in most other states. Lack of clarity among ASHAs about CBAC form is reported from Bihar, Meghalaya and Nagaland while in Manipur slow pace of population enumeration, filling of CBAC forms and screening for NCD is reported. ASHAs across most states are taking active part in mobilizing the community members for wellness activities.
  b) Challenge of inadequate number of ASHAs against the target is reported in UPHCs in Uttar Pradesh, affecting the population enumeration and CBAC activities.
  c) In Tamil Nadu, Women Health Volunteers are undertaking outreach activities for NCD services- namely- population enumeration, risk assessment, and follow up.

Primary Healthcare team at PHC-HWC

- Full complement of HR as per IPHS is reported in few states. HR shortage at PHCs is reported in Bihar, Jharkhand, Odisha, Uttar Pradesh, Rajasthan and Madhya Pradesh. In Gumla (Jharkhand), 12 out of 13 PHCs are nonfunctional on account of non-availability of HR.
- In Odisha, MBBS MO is visiting PHC twice/thrice a week. In Khandwa (Madhya Pradesh), the MO is visiting PHC only two days a week. Shortage of LTs is reported in MP and Jharkhand.
- Steps to address shortfall is reported from Bihar as recruitment of 330 full time MOs is done against the 500 vacant positions at APHC and UPHCs through an identified HR agency. State of Tamil Nadu has posted an additional staff nurse at PHCs for providing NCD screening and for follow up services.

Training/Multiskilling

- Limited understanding of CPHC-HWCs is observed among service providers at SHC and

PHCs in states of Bihar, Mizoram, Uttar Pradesh, Jharkhand, Uttarakhand which could be attributed to lack of training on CPHC- HWC.

- As NCD services are the first additional package of services to be rolled out in HWCs, training of service providers (MO, Staff nurse, MPREGNANT WOMEN-F and ASHAs) in NCD services is an important input for HWC operationalization. In most of the visited states, training had been completed (except Madhya Pradesh, Odisha). However, the training quality is reported to be variable. Issues like reduction in number of days of training and limited hands on training is reported in Andhra Pradesh, Gujarat, Odisha. Training of Staff nurses and MOs in cervical cancer screening using VIA is reported only from Meghalaya and Tamil Nadu.

Expanded range of medicines

- In addition to availability of medicines for RMNCH+A and Communicable diseases, the list of medicines at SHC-HWCs is to be expanded to include medicines for hypertension and diabetes. Most states have revised the state EDL accordingly (except Bihar and Jharkhand).
- Among the states visited, medicines for hypertension and diabetes are being dispensed by CHOs at SHC-HWCs, based on prescription by PHC-MO, in Andhra Pradesh, Manipur, Gujarat, Meghalaya, Nagaland, Uttar Pradesh, Uttarakhand, Odisha and Tamil Nadu (by trained VHNs). In Rajasthan, antihypertensive and antidiabetic medicines are available, but these are not being dispensed due to limited guidance from state/district resulting in lack of clarity among CHOs.
- In Andhra Pradesh, vending machine for medicines is installed at SHC-HWCs as a part of e-Sub Centre initiative. After teleconsultation, medicines are dispensed from this machine as per prescription of MO at telemedicine hub. However, issues in dispensing are observed due to irregular internet connectivity.
- Adequate availability of medicines is reported at SHC-HWCs in Gujarat, Andhra Pradesh, Uttar Pradesh, Tamil Nadu and Odisha while stock out of essential medicines is reported in SHC-HWCs in Chhattisgarh and Mizoram.
- Limited knowledge and practice of standard treatment protocols is observed at HWCs in some states. E.g. In Gujarat, PHC-MO is initiating antihypertensive treatment based on single reading. In Madhya Pradesh, confirmation for diabetes is based only on Random Blood Sugar measurement. Excessive antibiotic usage without clinical indication is also a concern in most states.
- Duration of prescription of medicines for hypertension and diabetes varied in states (Nagaland- 5/7 days, Meghalaya, Gujarat, Tamil Nadu- 30 days). In Tamil Nadu, newly diagnosed patients of hypertension and diabetes have to visit PHC for first three months and subsequently medicines are dispensed by VHNs at SHC.
- Display of Essential Drug List at the facility is observed only in Gujarat, Meghalaya, Nagaland.
- DVDMS is functional till PHC level in most states except Nagaland and Mizoram. CHOs are submitting the demand manually to linked PHCs, most commonly at frequency of a month. There is no systematic mechanism in place to track consumption of medicines and demand medicines accordingly in most SHC-HWCs.

Expanded range of diagnostics

As per the revised guidelines for diagnostics at HWCs, number of diagnostics is expanded to 14 tests at SHC-HWC and 61 tests at PHC-HWC. These are to be provided either through point of care diagnostics and/or transport of samples using hub and spoke model. At the time of CRM visit, the HWCs are expected to provide at least 7 essential diagnostic tests at SHC-HWCs and 19 tests at PHC-HWC.

- **SHC-HWC-** Availability of basic point of care diagnostics-Haemoglobin (Hb), Urine Pregnancy Rapid Test, Urine Dipstick – Urine Albumin / Urine Sugar, Blood Glucose (Glucometer), Malaria (Rapid test/slide) is observed at SHC-

HWCs at Meghalaya, Uttar Pradesh, Tamil Nadu, Rajasthan, Odisha, Gujarat, Andhra Pradesh and Jharkhand. Availability of point of care diagnostics for Dengue, HIV and transport of sputum samples for TB is variable and observed in limited SHCs. Availability of required consumables and kits is reported to be a challenge at HWCs in Jharkhand, Mizoram, and Uttarakhand.

- **PHC-HWC**-At the level of PHCs, point of care diagnostic tests are available in most facilities. Shortage of Lab technicians is reported to be a challenge in providing expanded rang of diagnostic services at PHCs in Bihar and Madhya Pradesh. In house Hub and spoke model (with hub at PHC/CHC/DH) is functional in Madhya Pradesh and Tamil Nadu and had facilitated expansionof the diagnostic services.

Service delivery

Community outreach and IEC activities

- Display of IEC material, citizen charter is observed in most HWCs visited except in Bihar. One of the good practice observed in Rajasthan included display of information regarding referral facilities at SHC-HWCs. Community awareness regarding HWCs and the services offered there varies across states. In Gujarat, Meghalaya and Nagaland and Uttar Pradesh, community members are aware about the HWC, CHOs and expanded range of services for NCDs. However, in Odisha, Rajasthan Jharkhand, and Mizoram, awareness about the sameis low.

Wellness and Health Promotion

- Wellness activities, such as Yoga sessions are being organized in HWCs at Andhra Pradesh, Gujarat, Gumla in Jharkhand and Madhya Pradesh. Celebration of Health days is organized at HWCs in Meghalaya, during which activities are planned to promote healthy life style viz. sports activities for adolescents, screening camps for service providers and role plays.
- In most states, open space around HWC is utilized for conducting wellness activities including Yoga sessions. Space for wellness activities is reported to be a constraint in few HWCs such as Andhra Pradesh, Meghalaya, Odisha and urban areas in Madhya Pradesh. Availability of limited number of yoga instructors is reported to be a constraint in Uttar Pradesh, Manipur and Meghalaya.

Expanded range of service delivery

- HWCs are envisioned to provide integrated service delivery for 12 service packages. The first six packages regarding reproductive, maternal and child health, family planning, acute common illnesses, communicable diseases are being provided and are expected to be strengthened with addition of a service provider and improvement in availability of medicines and diagnostics. The seventh package is Universal Screening, Prevention and Management of Non-Communicable Diseases (Hypertension, Diabetes and three cancers – Oral, Breast and Cervical Cancers). Thus, currently all SHC-HWCs are expected to provide at least first seven service packages.

remain RCH centric, which also reflects healthcare needs of community. Involvement of CHOs in service delivery for RMNCH+A services showed differences. Eg- In Meghalaya, delivery services are started after upgradation of SHC to HWC while in Mizoram, Uttar Pradesh and Jharkhand, involvement of CHO is minimal in conducting ANC, RI and providing FP services. Across all states MPREGNANT WOMENs-F have been allocated the RCH related work and CHOs are providing OPD services and NCD services. In Tamil Nadu, one VHN is providing outreach services, mostly RCH related, while second VHN is providing OPD services. The outreach services for NCD, viz- risk assessment, screening and follow up are provided by Woman Health Volunteers.

- CHOs are attending the VHNDs and VHSNCs in states of Meghalaya and Gujarat. In Gujarat, good coordination is observed between RBSK team and SHC-HWC team, facilitating the integration of service delivery. In Meghalaya, CHOs are also undertaking home visits for NCD and TB cases. Patient support groups for NCDs are reported to be functional in Tamil Nadu.
- Major change reported across HWCs is availability of a service provider at the facility on all working days. As fixed duration OPD services are available at SHC-HWCs, on six days a week, increased service utilization is reported. Average daily OPD of 10-20 is reported at SHC-HWCs across states.
- Population enumeration and CBAC form filling had been initiated at HWCs and screening for hypertension and diabetes has been initiated in all the states visited. However, in case of oral and breast cancer, only symptom based examination is being done i.e examination is conducted only for those cases presenting with any symptoms. In Gujarat, it is reported that only specific symptoms are asked for oral, breast, and cervical cancers with no examination and this is misconstrued for screening.
- Additional service packages have been rolled out in few states. For instance, home based palliative care services, elderly care, screening of Mental Health and basic Oral Health care has been initiated at HWCs in state of Manipur. Outreach camps for mental health and oral health have also been organized by SHC and PHC-HWC team. In Tamil Nadu, home based palliative care is being provided by staff nurse at block level and mental health counselling services are available through toll free no. 104.

Continuum of care

- Good coordination between SHC-HWC and its linked PHC team is observed in states of Gujarat, Meghalaya and Tamil Nadu. This facilitated forward and backward referral linkages. In Meghalaya, medicines for NCDs are prescribed by HWC-PHC, MO-MBBS for a period of 30 days. Staff members at HWC-SHCs follow-up with diagnosed NCD patients especially living far-off from health facilities and mobilise them to visit HWC-PHC for follow-up care. CHOs at HWC-SHC are regularly in contact with MOs through telephone for referral patients, follow-up care of referred cases and loss to follow-up patients.
- In most states, limited engagement of PHC-MOs is reported in supporting SHC-HWCs. Lack of commensurate strengthening of linked facilities such as PHCs and secondary care facilities has affected continuum of care in states.

Telemedicine

Teleconsultation at PHC-HWCs

- Facility for teleconsultation with specialists is available at visited rural PHC-HWCs in Meghalaya and SHC and UPHC-HWCs in Andhra Pradesh. In Meghalaya, hub is established at DH, while in Andhra Pradesh, hub is a private partner-
- In Jharkhand, telemedicine services have been initiated at 100 PHCs in collaboration with private partners. In West Singhbhum, one PHC had an operational telemedicine centre with hub at Apollo. All basic diagnostics including ECG are available separately at telemedicine centre. Two separate OPDs- one by PHC-MO and other with teleconsultation by MPREGNANT WOMEN-F with MBBS doctor at Apollo are being run. Use of telemedicine is being done at the discretion of patient rather than at the discretion of service provider. This has led to

suboptimal use of resources with MPREGNANT WOMEN-F consulting MO via hub rather than the MO available at the PHC.

- In Meghalaya, tele-consultation set up has been installed at headquarters (DH/MCH) and initiated in Ri Bhoi district but services are disrupted due to intermittent internet connectivity, power failure, dysfunctional desktop and camera and lack of coordination/ time from specialists in MCH. State is planning to engage with specialists from North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS) and placed a nodal officer for tele-consultation there.
- In Uttar Pradesh, tele Consultation hubs have been created at PGI, BHU, KGMU, MLB Jahnsi, BRD- Gorakhpur medical colleges. CDAC has initiated a pilot with KGMU as hub and five UPHC-HWCs in Lucknow and 5 PHCs of Meerut as spokes. Tele Consultation has also started in nine HWCs of Shravasti and Fatehpur with support from Wish Foundation.
- States of Bihar, Gujarat and Jharkhand are in the phase of planning for telemedicine services with establishment of hubs at state medical colleges/district hospitals and spokes at rural PHC-HWCs.

Teleconsultation at SHC-HWCs

- At SHC-HWC, teleconsultationis currently available in the form of call to PHC-MO in most states except AP. In AP, 287 e- SHCs are linked with teleconsultation in PPP mode with Dhanush and World Health Partners. However, multipara monitor and noninvasive Hemoglobinometer linked with the teleconsultation device at e-SCs are not calibrated affecting the quality of services. Issues are also reported with internet connectivity affecting the uploading of data and dispensation of medicine via drug vending machine after teleconsultation.

Reporting and Recording: IT system

Information regarding service delivery is being maintained at SHCs and PHCs in manual registers in all states. It is also being entered in IT applications in most states.

IT infrastructure

- Most SHC-HWCs had one functional tablet (with MPREGNANT WOMEN-F in Bihar, Jharkhand, Meghalaya and with CHO in Uttar Pradesh, Uttarakhand, Odisha). In Tamil Nadu, each VHN had a tablet and a laptop is available at the facility. In Gujarat, MPREGNANT WOMEN-F had a smartphone, while few CHOs are also provided with smartphones. In Andhra Pradesh, CHOs are provided tablet under e-SHC initiative and MPREGNANT WOMEN-F are given tablets as state has planned to roll out of a new ANMdigi application. This is affecting data entry and ANMs are paying out of pocket for data entry in cyber café. ASHAs are provided with smartphones only in Meghalaya, although they are not being used.

IT applications

- Among the states visited, most have implemented CPHC-NCD IT application, although the pace of roll out is slow, on account of limited availability of tablets and lack of training. CPHC-NCD application is being used in visited SHC-HWCs in Jharkhand, Meghalaya, Nagaland, Uttar Pradesh, Odisha, and Uttarakhand. ANMOL application is being used by MPREGNANT WOMEN-F in Jharkhand and Odisha. In Gujarat, a state specific application, TechoPlus is being used for recording RCH and NCD related service delivery. In Tamil Nadu also a state specific UHC application is being used by VHNs (MPREGNANT WOMEN) to enter the OPD information in centers where UHC pilot of the state is being implemented, while RCH related data is being entered in state specific-PICME application.
- At the time of visit, CPHC-NCD application is not being used in visited SHC-HWCs in Andhra Pradesh, Bihar, Rajasthan, Mizoram, Chhattisgarh, Manipur and MP. At the level of PHC, MO portal is being used only in Odisha and Meghalaya.

- Challenges in using the IT application included issues with creating ANMOL ID (Jharkhand), irregular internet connectivity (Meghalaya, Mizoram, Nagaland and Uttarakhand) and issue of synchronization of data in CPHC-NCD IT app (Meghalaya).
- The envisioned use of CPHC-IT application to support service providers in decision making and facilitating continuum of care across levels is nominally observed. In most states, multiple registers are being maintained but the key outcome of being able to ensure treatment adherence and early recognition of complications in the case of hypertension and diabetes is not yet achieved.

Financing

Performance linked payments (PLP) and Salary of CHOs

- Disbursal of PLP had been initiated in few states such as Odisha, Uttar Pradesh, Gujarat and Rajasthan. CHOs reported receiving timely salary and incentive in Gujarat and Rajasthan. In other states, challenges are reported in streamlining the process of performance monitoring with involvement of PHC-MO, block and district team. Limited clarity regarding PLP among CHOs and program management (Jharkhand) and insufficient funds with states (Nagaland, Meghalaya) are reported to be the reasons for non-initiating the process. In Nagaland, CHOs had received amount of Rs. 4500 per month for two months, above the salary norms, however the payment is not linked with performance monitoring. Delay in receiving salary (Nagaland) and PLP (Uttar Pradesh) is also reported by CHOs.

Team based incentive for SHC-HWC

- It has not been initiated in any of the visited states.

Recommendations

Over two years, states have advanced in implementation of CPHC through HWCs. Although improvements have been observed, certain challenges still persist and newer implementation challenges are arising as the progress is being made. Recommendations include:

- District wise planning - During the first two years of HWC implementation, most states have identified and strengthened SHC/ PHC/ UPHCs which are relatively better equipped with HR and infrastructure. Since efforts required in terms of strengthening health facilities which are not adequately staffed and have relatively poor infrastructure would be much more, states need to undertake district wise situation analysis of resources including infrastructure, finances and human resources and prepare a district wise roadmap for delivery of CPHC services.
- Strengthen “primary care units”: Findings from states have demonstrated better service delivery when there is better coordination between SHCs and its linked PHC. Sector saturation (upgrading all SHCs under a PHC area) and block saturation (upgrading all SHCs and PHCs in a block) are required to be implemented to establish a continuum of care. States therefore need to map all PHCs and linked SHCs to prioritize upgradation of PHCs and linked SHCs as a HWC primary health care unit.
- Organization of service delivery within SHC-HWC: States to orient the primary healthcare teams on CPHC and role clarity among team members for coordinated service delivery. This can be done by institutionalizing weekly calendar at all HWC to indicate schedule of OPD and community outreach by CHOs, MPREGNANT WOMEN-F and MPREGNANT WOMEN-M with clear roles and responsibilities.
- Strengthening logistics and supply system: Service utilization at HWCs is largely dependent on availability of medicines and diagnostics. Therefore, its supply of medicines and consumables needs to be ensured for chronic diseases in addition to services for pregnant women and children.
- Expedite use of IT system: States need to expedite action on the procurement, supply,

training in IT along with continuous handholding of the team in using the IT application. Duplication of team's efforts in maintaining paper based and IT based records need to be reduced substantially.

- Supportive Supervision and mentoring: As CHOs are a new cadre, there is an urgent need to nurture them by providing strong mentoring support to CHOs during and after training. Two pronged approach of building capacities of counsellors at Program Study Centres to train CHOs for their future role at SHC- HWCs and training of PHC and Block MOs in supporting CHOs needs to be adopted. Use of digital technology can be explored to create tele mentoring platforms. Findings also indicate the requirement for strong monitoring of CPCH training to ensure quality. High quality training of CHOs cannot take place just by focusing on the six month training. Given the varied nature and quality of in service training of the candidates being trained as CHOs, ongoing intensive hand holding and mentoring through blended mechanisms after they are posted in the SHC is critical to avoid the issues of poor quality service delivery as highlighted by the findings.
- **Streamline performance linked payments (PLP):** PLP to CHOs and team based incentives to the HWC team is a key element of HWCs. Its objective is to instill team spirit, strengthen quality of services and enhance accountability for population health outcomes. There is an urgent need to orient PHC, block and district team on the processes of performance measurement and timely disbursal of PLP and team based incentives.
- **Monitoring:** Since the delivery of CPHC involves re-organizing service delivery and includes many new components, it is essential that a robust monitoring mechanism is created for regular review of service delivery as per standard protocols and to assess the coverage of services. Strong programme management teams and wide network of partners drawn from academic institutes like medical colleges and school of public health and Civil society are key to build such processes. Given the use of IT, the focus of monitoring should gradually encompass population basedhealth outcomes.
- Strong referral linkages: Strengthening of secondary level health facilities also needs to be synergized with creation of HWCs to support continuum of care across levels of health care and reduce patient hardships and OOPE.
- **Wellness activities:** Health promotion and wellness activities need to be institutionalized in the system in all HWCs. This is also an area where the CHO posted in SHC will need a strong orientation, mentoring support and motivation through visits and online discussions on the benefits of wellness and community engagement.

State Specific Findings

Andhra Pradesh

- State has operationalized all rural and urban PHCs to HWCs. Upgradation of SHCs is underway and 779 SHC-HWCs are operational at the time of visit.

- State has13 Program Study Centres and 358 candidates are enrolled for July 2019 batch.
- State has also upgraded 205 sub centres to e-SC, operating under Public Private Partnership with Dhanush and World Health Partner. These centres are equipped with multipara monitor, medicine vending machine and teleconsultation facility. ANM/CHO at the centre undertakes teleconsultation with doctors/specialists at private set up.. Vending machine for medicines is installed at e-sub centre, which dispense medicines after teleconsultation as per prescription by MO at hub. However, multipara monitor and noninvasive Hemoglobinometer linked with the teleconsultation device at e-SCs are not calibrated affecting the quality of services. Irregular network availability is affecting the uploading of data and dispensation
- Limited clarity regarding HWC observed among the staff interacted at all levels
- Service providers (MO, staff nurse, MPREGNANT WOMEN, ASHAs) are trained in NCDs but the training duration is reduced.
- ASHAs and CHOs are maintaining referral and follow-up records of patients with common NCDs meticulously however this is not done at PHC level which affected continuum of care.
- State has planned to replace the tablets and provide new tablets with ANMdigi application. However, ANMs are yet to receive ANM-digi tablet which is affecting HWC /RCH/NCD Portal entry. ANMs are paying Rs. 25 per CBAC entry at Cybercafe.
- Performance Based Incentives to CHOs and team bases incentives are yet to be initiated
- Inadequate space for wellness activities observed at HWCs.

Bihar

- State has so far operationalized 612 HWCs against approvals of 2205 HWCs. State has prioritized strengthening of Additional-PHCs (A-PHC)as HWCs in FY 2018-19
- Availability of Service-delivery and Programme management staff is a major challenge to operationalize HWCs. Concerted efforts are made to recruit MBBS Medical Officers at APHCs & UPHCs for 500 positions, against which 330 are recruited.
- Recruitment process of 2 State HWCs coordinators is completed and District Planning Coordinators (DPCs) are being efficiently used for rolling out all activities related to HWCs.
- 19 Program Study Centres (PSC) are functional in the state with approximately 118 counsellors and 339 candidates enrolled in June 2019 batch.
- State has appointed total 43 CHOs are at 86 SHCs-HWCs with rotational postings in an attempt to operationalize more number of SHC-HWCs to meet the target.
- Branding of HWC is done with display of services and citizen charter
- ANMs have been provided with tablets but training on CPHC app is yet to be done
- State has identified AIIMS Patna and IGIMS as Hubs for commencing Tele-consultation services
- Yoga trainer has been hired to promote Yoga activities at HWCs.
- DVDMS is operationalized up to A-PHCs level and EDL has been expanded to include 109

medicines for HWCs (APHCs-HSCs) and 167 for DH (71 for OPD and 96 IPD).

- Selection of the facilities in FY 2019-20 is not based on sector or block saturation which has compromised continuum of care.
- State had advertised for 1200 candidates to be enrolled in July 2019 session, however due to stay order from high court in view of petition from Homeopathy association, the admissions of BAMS candidates for the July session are not done. State has enrolled only Nursing candidates for July 2019 session leading to shortfall of candiadates for operationalizing the approved number (726) of SHCs.
- Community is aware about HWCs but awareness about provision of free medicines, diagnostics & expanded range of services is low.
- One- day orientation of ASHAs is undertaken on CBAC to start the NCD screening services at HWCs. APHCs & UPHCs staff had not been trained for universal screening, prevention and management of NCDs. Service providers at the HWCs lacked orientation about the concept of Comprehensive Primary Health Care.
- Service providers at HWCs are not undertaking outreach activities related to communicable diseases such as vector control, preparation of malaria slides, referral of suspected TB cases and monitoring for DOTS compliance.
- Only limited medicines are available at SHCs-HWCs. For e.g. basic antibiotics, eye and ear drops, analgesics, antihypertensive and anti diabetic medicines are not available at SHC-HWC.
- Non availability of Laboratory Technician is a key challenge in expanding the range of diagnostics.

Chhattisgarh

- HWCs are functional but gaps are observed in terms of branding, IT systems and lab services in the functional HWCs.
- AMO posting at SHCs for 2 days hampering service delivery at PHCs.

- Stock outs of IFA, Zinc, Oxytocin, Misoprostol and MgSo4 at SHCs.
- Systems of referrals from HWCs & follow-up is weak.
- Focus on treatment adherence for NCD patients is missing.
- Poor quality of tablets is reported to be an issue.
- Tele consultation is limited to phone consultation with PHC MOs/AMOs.
- Teaching at PSCs hampered due to other priorities of Faculty.
- First month stipend for the CHOs is delayed.

Delhi

- Sate has not planned to implement Ayushman Bharat- HWCs, however, state has prepared a strategy to provide CPHC through a Common Minimum Services Package through UPHCs covering 50,000 population by involving key stakeholders for its implementation. The package covers all services except natal care.
- Geographic mapping of health facilities has been done on a web-based portal and unreserved / under-served population is identified.
- CPHC Orientation has not been done at the UPHCs, though curative and promotive

services for diabetes and hypertension are being provided after opportunistic screening in OPD. CBAC forms are not being filled.

Gujarat

- By March 2020, 73% of PHCs, 41% of SHC and 71% of UPHCs will be strengthened as HWC.
- State has prioritized operationalization of Health and Wellness Centres (HWC) based on those facilities that have buildings, both at the level of the PHCs and SHCs, resulting in clustering of centres. In Dahod, there are three or four HWC within a radius of about five kms. In Surat, two Sub Health Centres in the same compound are converted into HWC. This indicates that in first phase, underserved rural and urban areas are left out due to lack of buildings and paucity of HR.
- At the state level there is a team of three nodal officers to plan and support HWC in all 33 districts,
- At the district level, the MO in charge of Quality has been given charge of managing HWC but this is less than optimal. MOs in PHC-HWCs do not see HWC- SHCs as an extension of their own centres.
- Availability of land is expressed as a key constraint in Dahod, as well as in the prolonged approval process at the level of the Collector. Problems in land acquisition /collector approvals will likely delay achievement of targets by 2022. In Dahod, land acquisition is pending in 22 PHC and 114 SHC, with Collector permissions pending in 02 PHCs and 91 SHCs.
- State has opted to use the 'Indian institute of Public health Gandhinagar' as the agency to adapt the curriculum, conduct the examination and certify candidates, rather than IGNOU.
- Four batches of 1565 CHO training have been conducted so far with 97% passing rate and no attrition, and additional 2212 CHOs will be placed by March 2020.
- Of the 1565 community health officers trained, 1102 are GNM nurses, 214 are BSc Nursing and 293 are BAMS. Declining trend is noted in enrolment of Ayurveda practitioners into CCCH course in successive batches.
- IIPHG has been running a whatsapp group of all previous batches of CHOs to provide a common platform for sharing grievances and provide continuous mentoring and support.
- CHOs however expressed concerns about lack of handholding support during practical skill training at community level in PHCs and SHCs and clinical skills training at DH – due to inadequate supportive supervision as one supervisor is designated per hospital for 15 students.
- Despite the full complement of HR at SHC-HWCs, there is little understanding between the team of their respective roles and responsibilities resulting in task duplication between ASHAs and MPREGNANT WOMEN-F or between CHO and MPREGNANT WOMEN.
- Average daily OPD count of about 20 per day at HWC-SHC and about 45-50 at PHC is noted by the visiting teams..
- Wellness through yoga is undertaken at all HWCs. CHOs have been trained in a three week course: Arogya Samanwaya that combines ayurveda training, yoga and reiki.
- Coordination between the HWC and RBSK team at PHC and SHC levels is an excellent example noted in Tehri area.
- The HWC teams at SHC levels, except the MPREGNANT WOMEN-M had been trained in the NCD module.
- Universal Screening of NCDs is taking place only in HWC catchment areas. Screening for hypertension and diabetes is done as a combination of population based and opportunistic screening but cancer screening is not being done. Only specific symptoms are asked for oral, breast, and cervical cancers with no examination being done and this is misconstrued for screening. VIA has not been institutionalised anywhere in the state, across the facilities.
- No standard treatment protocols in place for hypertension and diabetes at PHC, patients

are started on antihypertensives based on a single reading with no counselling on lifestyle management.

- Excessive antibiotic usage without clinical indications also is an area of concern. Prescription audits are not in place at any facility level.
- EDLs are in place in HWC-PHC.Stockout of antimalarials are seen in a few PHC in Dahod, but in all other facilities medicine supply is not a constraint.
- DVDMS is not in use below the district level.
- Telemedicine facilities have not been operational yet, but there are plans to establish about 20 spokes across the state.
- CHOs are receiving their salary including performance linked payments on time.
- State has opted to use Techo Plus, which integrated the RCH component, (used hitherto as ImTeCHO), the NCD application (using the same fields as the one recommended by the Centre) and Nikshay. Currently all MPREGNANT WOMEN-F are using this programme, but it is not yet operational at the level of the MO in Dahod. MPREGNANT WOMEN-Females are using the application for RCH, but reported experiencing difficulty in the NCD application.
- HWC team in Dahod district expressed the need for more training on HWC portal.
- In all HWC-PHC and SHC visited it is observed that registers continue to be used in addition to the IT application but the key outcome of being able to ensure treatment adherence and early recognition of complications in the case of Hypertension and Diabetes is not yet achieved.
- In Dahod, one Innovation and Learning Centre, (ILC) supported by the National Health Systems Resource Centre (NHSRC) is in place – Charutar Arogya Mandal is supporting the HWCs. It is noted that the CHOs supported by the agency had a better understanding of roles and responsibilities and are undertaking more outreach activities. However even here, the delivery of CPHC is hampered by systemic constraints such as lack of a uniform induction training, irregular support and supervision, a lack of supervision of primary health care and public health functions.

Jharkhand

- State has operationalized 22% of primary healthcare facilities out of total approved facilities till 2019-20. However, out of the total primary healthcare facilities in state, only 10% facilities have been upgraded to HWCs.
- Targets for each district for HWCs are decided by the state without consultation with district program management. Block saturation approach is not adopted, primarily due to limited infrastructure availability.
- In Gumla district, total 13 PHCs are sanctioned for a population of 12 lakh. Since most areas are tribal and difficult areas, the sanctioned PHCs are short of IPHS by around 40-45 PHCs. Similarly, number of SHCs is less compared to IPHS for tribal and difficult areas.
- State has received approval for total 1452 SHC-HWCs but number of CHO positions advertised is 1140. In addition, state has pending target of FY 2018-19. Thus, candidates graduating from Jan 2019 session will be filling gap of 493 SHCs from 2018-19.
- State has 13 functional PSCs with capacity of 570 in the state. Three new PSC have been proposed. Capacity is increased to 120 for two PSC with more than 200 beds.
- State nodal officer for NCDs is in charge of CPHC. At districts, DPM is the nodal person for HWCs, who is not oriented to CPHC through HWCs. Jhpiego is supporting the state in establishing the Health and Wellness Centres. Coordination is lacking between CPHC team and other program divisions.
- CHOs are given preferential transfer to place of residence at district level.
- Only in service candidates and nurses (GNM and BSc) are enrolled in first two batches but from third batch, fresh candidates (nurses as well as Ayurveda practitioners) have been enrolled.

- State has initiated B Sc Community Health in affiliation with Ranchi University in 2016.
- At PSC in Gumla, Program counsellors had not received any orientation/training regarding HWCs and CHO training. The counsellor (MBBS, MPH) had not read the IGNOU modules and noted that the presentations shared by Jhpiego are not updated and need to be reviewed.
- The second batch at PSC Gumla commenced from 12th September 2019 with a delay of 2 and 1/2 months. Classes are held irregularly as there is shortage of specialists at DH and number of counsellors isless compared to requirement as per guidelines.
- In Gumla, full complement of HR at SHC-HWC (1 CHO+2 MPREGNANT WOMEN-F+1 MPREGNANT WOMEN-M), is available at only 1 SHC-HWC. In West Singhbhum, required staff is available at SHC-HWC, however, at PHC-HWC, MO is posted on rotation basis and Lab Technician is not available.
- Induction training of CHOs is not conducted and CHOs had limited clarity about her roles at HWC.
- Training of ASHAs, MPREGNANT WOMENs-F, nurses and MOs is completed on NCDs as per the guidelines.
- Universal screening for NCDs had been initiated at all HWCs as reported by district officials.
- CHOs involvement is limited in outreach and community mobilization activities and RMNCH+A and communicable diseases service delivery.
- CHOs are primarily conducting daily OPD from 9 am to 3 pm. At SHC-HWC Silam (Gumla), irrational prescription by CHO are observed with over use of antibiotics.
- Since the posting of CHOs, OPD are functional on all days and there is increase in overall utilization at SHC-HWCs. However, in both the districts, even though CHOs in visited SHC-HWCs had been posted for a year, the daily OPD is reported to be from 10am -12pm.
- Teleconsultation services have been started in 100 PHCs in state in collaboration with Apollo. Apart from these, state has also planned to initiate teleconsultation at PHC-HWCs using e-sanjivani, with medical colleges as hub.
- At West Singhbhum, one PHC had an operational telemedicine centre with hub at Apollo. All basic diagnostics including ECG are available, separately at telemedicine centre. Two separate OPDsare being run- one of PHC-MO and other of teleconsultation run by MPREGNANT WOMEN-F at the PHC with MBBS doctor at Apollo. Use of telemedicine is at the discretion of patient and therefore there is no added advantage of telemedicine services.
- State has facility wise EDL with 35medicines for SHCs. However, the list is not revised for SHC-HWCs. The district program manager or service providers at SHC-HWC are not aware about the EDL for HWCs and hence, indenting at SHC is done as per the utilization at SHCs and no reference list is available with CHOs.
- In both the districts, required number of medicines are supplied as indented. There is no systematic mechanism to track consumption of medicines.
- All seven minimum necessary diagnostics are available in across all SHC-HWCs. However, at West Sighbhum, supply for glucose strips is through local purchase, as a stop gap arrangement. Quantity of glucose strips available with facility is not near to even 1/10th of requirement, if population based NCD screening isto be implemented. Hb strips are also procured locally and they are not sufficient for ANCs check-ups for even 1/4th of estimated number of pregnancies.
- At PHC-HWC in West Singhbhum, no diagnostics are being conducted due to unavailability of LT. In Gumla district, non-functional PHCs had affected continuum of care for all services. All the cases from SHC are referred to CHCs resulting in drop outs. Medicines for diabetes are not available at CHCs but Metformin is available at SHC-HWCs. However CHO does not dispense the medicine due to lack of

awareness about the same. Confirmatory tests for diabetes areavailable at CHCs.

- Cancer screening had not been initiated at SHC-HWCs and confirmatory tests for these are not available at secondary care facilities.
- Community members in both the district are not aware about health and wellness centres and expanded range of services.
- In Gumla, 12 Yoga instructors had been identified in the district. Yoga sessions have been initiated in the HWCs recently, in the month of September 2019. In West Singhnhum, interview process for Yoga teachers is complete.
- CHOs had not received performance linked payments and are not oriented about the indicators.
- Tablets are available in the facility with MPREGNANT WOMENs-F and 3 applications are available in it, namely- FPLMIS, ANMOL and CPHC-NCD application. However, in West Singhbhum, none of the applications are being used by MPREGNANT WOMENs, while in Gumla, only CPHC-NCD application is being used. CBAC forms filled by ASHAs have been digitized in Gumla but digitization is yet to be initiated in West Singhbhum.

Madhya Pradesh

- There is a lag in meeting the target of 2867 with a huge backlog of 1883 HWCs to be operationalized. State has started upgrading existing PHCs to HWCs. In the districts of Khandwa and Chindwara, no SHCs are yet upgraded to a HWCs.
- EDL medicines are available at the visited PHC-HWC facilities. Many of the staff members have expressed that this is one of the key benefits they see after upgradation to HWCs.
- Shortage of Medical Officers and Lab technicians in both the districts is noted.
- More than 85% of MPREGNANT WOMENs & MOs trained in NCD in Khandwa. In Chindwara, ASHA & ANMs training is yet to be completed. VIA training is not done in the state for cervical cancer for any of the staff.
- Out of the 25, only the rapid tests (9 no. of tests) are done at most PHC-HWCs.
- Hub & spoke model has been established at some facilities. A CHC Lab has been identified as a hub for the PHCs in the area. This model is a temporary measure put in place to address the shortage. At CHC Mundi in Khandwa, the 16 tests not available at the PHCs in the block are being processed. Helper is paid Rs. 300/ day for transporting of samples and collection of results within in the same day.
- At PHC-HWC, diagnosis for diabetes is being made based on only Random blood sugar. Fasting/Post prandial sugars are not being conducted for confirmation.
- MPREGNANT WOMENs have been provided with tablets for usage of ANMOL and CPHC-NCD application. There is no dedicated device like a laptop or a desktop for the MOs at any of the facilities. While the NCD application in tablets is being used by the ANMs and MPREGNANT WOMENs, the usage by MOs is still low.
- Teleconsultation is not yet implemented in the district. At Khandwa, it is stated that the required hub with specialists is not available to operationalize the tele-consultation services.
- Interactions with the community highlighted the low awareness of HWC services in community.
- Referral and follow up mechanism are not well established for those on treatment and those referred out.
- Yoga sessions have begun in few centres. Schedule of wellness activities is made in a few places, but no activities are undertaken as per plan.

Manipur

- State has established HWC in all 16 districts.
- 85 PHC, 220 PHCs and 7 UPHCs have been approved for upgradation to HWCs, out of which 83 HWCs are operational. Most of the HWC's are upgraded PHCs
- Regularity of clinic services by CHO and ANMs, availability of laboratory investigations

and medicines for Communicable and Non-Communicable diseases has improved utilization.

- Medicines and Consumables are available especially for NCDs, CDs and RMNCH+A
- For Palliative Care, the state has taken initiative to bring teams from Institute of Palliative Medicine Calicut, Kerala and Karunashraya Bangalore for Capacity building trainings.
- Home based palliative and elderly Care has started in 48 HWC.
- Beside 7 basic packages of CPHC, Elderly and Palliative Care Services, Screening and Basic Management of Mental Health Ailments & Basic Oral Health has been started in HWCs.
- Pace of population enumeration, filling of CBAC form, screening for NCD and timely referral of suspected cases is insufficient.
- Staff quarters are not available at any of the HWC-SHC which is a big constraint in delivering the service in Chandel district with difficult terrain and bad road.
- Limited availability of Yoga trainers reported.

Meghalaya

- State has planned year- wise targets to operationalize all SHCs, PHCs and UPHCs to Health and Wellness Centres (HWCs) by December, 2022.
- State has identified five HWCs intervention districts- East Khasi Hills, West Jaintia Hills, Ri Bhoi (aspirational district), West Khasi Hills and West Garo Hills. These five targeted districts are also NCD intervention districts.
- PHC sector and Block saturation approach has been undertaken in operationalising health facilities to HWCs.
- At SHC and PHCs, there is availability of OPD room, space for laboratory/diagnostic services and privacy during examination is maintained using screen or curtains. However, irregular/ no water supply and low voltage with no power back up aresome of common problems noted.
- Programme management unit is in place at state/district/block levels. CPHC committee has been formed and functional at state level and in four intervention HWCs districts (West Khasi Hills- in process) for monitoring of CPHC. State nodal officer- CPHC is also SNO-NPCDCS programme. State orientation for all nodal officers in different programmes on 12 packages of services has been conducted.
- Three state-level workshops and 5 district workshops have been conducted for orientation of team members in Comprehensive Primary Health Care (CPHC). Orientation of VHSNC members in CPHC is given during VISHWAS training.
- Development partner Jhpiego is providing technical support in operationalizing HWCs and roll out of Certificate Programme in Community Health
- Percentage of nursing candidates enrolled in CPCH from open market is only 9% in July 2018 (mostly are in-service contractual NHM-GNM nurses), 50% in Jan 2019 and 87% in July 2019.
- PSCs are maintaining 1:10 ratio of academic counsellors. Sessions and practical demonstrations are being conducted as per IGNOU guidelines.
- 4 state trainers are available for induction and supplementary training of CHOs; 6 state observers are available, notified and are conducting monthly visits to monitor the quality of training of CHOs.
- First batch of CHOs are trained for 3 days with MPREGNANT WOMEN-F/ANM regarding NHM, their roles and responsibilities, performance-linked payments etc.
- Basic yoga skill training in collaboration with AYUSH division has also been included in CPCH course from July 2019 session. Due to lack of yoga instructors (only 2) in the state, AYUSH department has appointed a yoga instructor at PSC to provide basic yoga skills training for a period of 30 days.
- State faces the challenge of attrition of NHM nurses from hospitals to join CPCH course due

to insufficient number of nursing candidates and different language dialect followed across state.

- Training in CPHC-NCD IT app for all HWCs of 2018-19 has been completed for MPREGNANT WOMEN-F/ANM, MO and CHOs in state headquarters.
- The OPD timings varied among HWCs 10am to 2pm (e.g. Asanang, 24x7 PHC) / 8am to 2pm (e.g. Jeldupara, 24x7 PHC) / 10am to 4pm (e.g. Baljek, a delivery point). The average OPD number varied between 10 to 100.
- An NCD kit (blood pressure machine, glucometer, glucose strips, spatula, mouth mirror, torch, lancet, cotton, gloves, weighing scale, height scale and measuring tape) and VIA screening kit at HWC-PHC/CHC level has been procured by State.
- CHOs at HWC-SHC attend VHNSD and VHSNC meetings. Also, outreach camps such as NCD camps, RCH camps, Mental health, Dental health camps, Elderly camps etc. are conducted on a monthly basis in village. Outreach visits by CHO are also undertaken for NCD cases and TB cases for ensuring compliance to treatment, follow-up and for mobilising resistant patients.
- Medicines required at HWC-PHCs and CHC, hypertension, diabetes are available. Anti-eplieptic drugs had a stock out in certain places (e.g. CHC, Selsella).
- Medicines for NCDs are prescribed by HWC-PHC, MO-MBBS for a period of 30 days. Staff members at HWC-SHCs follow-up with diagnosed NCD patients especially living far-off from health facilities and mobilise them to visit HWC-PHC for follow-up care. CHOs at HWC-SHC are regularly in contact with MOs through telephone for referral patients, follow-up care of referred cases and lost to follow-up patients.
- Essential point of care diagnostics are available at SHC-HWCs.
- Four HWCs-SHC (Umsong, Bamundangga, Rombagre and Pingwait) in the state have started conducting deliveries after being upgraded to HWCs.
- Tele-consultation set up has been installed at headquarters (DH/MCH) and services initiated in Ri Bhoi. The services are disrupted due to intermittent internet connectivity, power failure, dysfunctional desktop and camera and lack of coordination/time from specialists in MCH. State is planning to engage with specialists from North Eastern Indira Gandhi Regional Institute of Health and Medical Sciences (NEIGRIHMS) and place a nodal officer for tele-consultation there.
- Manual reports and records (suspected NCD cases, screening details, referral of NCD cases, follow-up cases, etc.) are being maintained at HWCs for follow up. In addition, NCD data is also being recorded in CPHC-NCD IT application by

MPREGNANT WOMEN-Female/ANM/CHO and by MO in MO portal.

- VHSNC members are supporting the HWC team for mobilising community for NCD screening, conducting outreach activities and conducting health promotion activities
- Outreach camps for NCD services, mental health, eye care, elderly care etc. are undertaken with involvement of primary healthcare team members and doctors/specialists from DH.
- CHOs are receiving a fixed salary of Rs. 25,000/ month. In addition, Rs. 15,000/month is linked to their performance (performance-linked payments). Performance-linked payments have been initiated from July, 2019 but due to insufficient funds the amount has not been paid to CHOs.
- No RCH-ANMOL application has been initiated by MPREGNANT WOMEN-F/ANM at HWC-SHCs, WGH. Afew instances of pharmacists using their own mobiles for using DVDMS (eg. CHC, Selsella, WGH) are noted.
- IT-tablets have been issued to 1 MPREGNANT WOMEN-Female/ANM per HWCs-SHC, PHC and UPHC during the CPHC-NCD IT app training. About 400 ASHAs in WGH under HWCs have received smartphones in 2019. In Ri Bhoi, 590 ASHAs and 30 ASHA Facilitators have been provided smartphones
- Erratic internet facility across all health facilities in both districts, loss of NCD app data after repair of IT tablet, issue of synchronization in CPHC-NCD IT appand real data not being reflected in NCD app are major challenges in IT being faced by the State.
- Community members are aware regarding presence of an additional staff member (CHO) at HWC-SHC and reported availability of better health services at HWCs- free medicines, testing for sugar, blood pressure, lifestyle advice for reducing alcohol and tobacco consumption.

Mizoram

- In the state, 2 PHCs and 2 UPHCs have been operationalized as HWCs.
- Building and cleanliness of all visited HWCs of both the districts is good and external branding had been completed in both the districts. Adequate HR is available at all visited HWCs.
- General OPD services are being provided from 9am-5pm
- Population enumeration and NCD screening at facility and community level is initiated but follow-up of NCD cases is limited. Cancer screening is only performed at DH level.
- CHOs and MOs are not very well-versed with the concept of Comprehensive Primary Health Care. It is assumed by the field staff that CHO has come for NCD, ANM's role is for RCH, MO is for OPD, and MPREGNANT WOMEN-M is for malaria and TB.
- Desktops are available at all visited HWCs. Internet connectivity is not available in few functional HWCs
- IT based Daily reporting is not yet initiated in any of the visited HWCs. Data entry is being done at CHC level.
- Tele-consultation not yet initiated in District/ State under CPHC-HWC.
- Community awareness about HWCs is poor.
- Drugs are not available as per EDL.
- Online Drugs and Vaccine management system (DVDMS) is non-functional due to State's plan to incorporate in-house team for back hand technical support for Drugs inventory management system.
- POC diagnostics are available at HWCs and for other tests, patients are referred to CHC/DH.
- Wellness related activities have not been yet initiated.

Nagaland

- Against the target of 327 HWCs, 54 HWCs have been operationalized so far.
- Village Committees and Community members appreciated the concept of upgrading the health care facilities as HWC, and are actively involved in HWC related activities.

- State has two Programme Study Centres with a capacity of 30 seats each.
- So far, 49 CHOs have been posted and 60 CHOs are under training in these two Programme Study Centres. Due to unavailability of funds, state is yet to initiate the work towards achieving the targets for FY 2019-20.
- Utilization of services has increased after upgradation of the facilities as HWC as the OPD of the health care facilities has increased by 30 – 40%.
- Every HWC has a map displayed within the facilities for nearby villages and health facilities. In addition, emergency contact numbers are displayed on the outer walls of the HWCs across the district.
- Status of infrastructure and Human resource is satisfactory across the HWCs.
- Every HWC had a team of Female Multi-Purpose Workers (02), Male attendants, sweeper, chowkidar and one cleaner, led by a Community Health Officer.
- Lack of clarity is observed amongst the HWC team with regards to promotive and preventive care approach in the community.
- CHOs posted at the HWCs are mostly from other districts which is cited as a main challenge by CHOs.
- Availability of space is a constraint for expanding the construction of HWCs, though in many of the places community/village had donated land to health department to help building HWCs in their village. VHCs had also contributed in arranging accommodation facilities for CHOs.
- Wellness activities are not being undertaken at either of the HWCs. HWCs have also been identified as a platform for prayers and general talks by the Pastors.
- At present, there is no coordination or integration with other existing programmes at HWC level. HWCs are undertaking majorly NCD screening activities, where only hypertension and diabetes screening is being done through a combination of population-based approach and already existing opportunistic screening.
- It is observed that individuals suspected with NCDs refuse to go to the PHC-MO for confirmatory diagnosis, due to poor transportation facilities, and pressurize CHO to prescribe medicine. CHOs consult MOs on phone and initiate treatment at HWC-SHC itself, based on single reading taken at the centre. CHOs are not well versed with the standard protocols and are dispensing anti-hypertensive medicines for a period of 5-7 days.
- Screening for Oral, Breast and Cervical cancer is not being undertaken at HWC-PHC.
- DVDMS is not functional in the state.
- CHOs had not received their remuneration for last two months due to lack of funds. Performance linked payments (PLP) for HWC team is yet to be institutionalized at the HWC-SHCs. However, CHOs reported receiving Rs. 9,000 under performance-based payments for two months (Approx. Rs. 4,500 per month) but there is no clarity for the break up and details of the incentive received.
- The remuneration of CHO being almost half of that of a regular MPREGNANT WOMEN-F is cited as a reason for MPREGNANT WOMEN not accepting CHOs as the team lead.
- NCD module of CPHC IT application has been rolled out at all HWCs. Unavailability of network is a major reason in hampering the data entry and thus not reflecting the actual functioning of the HWC on the dash board.
- Reporting and recording are a major concern at the HWCs as multiple registers being maintained at the centre but due to lack of orientation incorrect documentation is seen.

Odisha

- State has defined the targets for HWCs for the year 2019-20 and up to 2022 and also has a career progression and cadre creation plan for CHOs.

- Post of the staff nurses are being sanctioned at sub-center level HWC so that the career progression of CHO will synchronize with career progression path of staff nurses.
- Existing structure is oriented to cater to the needs of the programme management. Jhpiego is providing support for HWC.
- Medical college at Mayurbhanj has adopted one block and 10 HWCs for capacity building, monitoring and supervision. However, at present only one HWC is properly adopted.
- 18 PSCs have been identified in the state. CHO vacancies are planned to be filled by the state through regular recruitment and posting. As of July 2019, 132 candidates are undergoing sessions in 5 PSCs.
- Most of the HWCs identified are in underserved rural areas in Kandhamal. PHC and/or block saturation is not followed. Universal screening has been prioritized for those identified as HWCs.
- Unavailability of adequate infrastructure and CHO is a major bottleneck at SHCs eg. in Kandhamal, one CHO is posted two days ago, and did not have any place to stay.
- Infrastructure at PHC is adequate and allopathic doctors are visiting these PHCs at least twice/ thrice a week. At some of the facilities, AYUSH doctors are available.
- In Mayurbhanj district, overall 64% PHC are converted into HWC. However, it is also noted that the MO is deputed 2 days in week at other facilities, affecting the service delivery.
- Medicines and diagnostics in visited facilities are adequate in both the districts.
- HWCs had initiated Population based screening. Antihypertensive and antidiabetic medicines are available at the facilities from District Hospital to Sub-centres along with required diagnostics.
- In both the districts CHOs are getting performance based incentives besides salary.
- Yoga instructors have been appointed in visited HWCs at Mayurbhanj. Wellness activities have not yet been rolled out universally however, yoga instructors are in the process of being recruited and posted.
- ANMOL, NCD applications, NIKSHAY, DVDMS (up to CHC level) are functional but internet connectivity remains a challenge.
- Tele-consultation services are not yet rolled out.
- Stock registers, indent process need to be streamlined in near future in both the districts.

Rajasthan

- State has target to operationalize 4127 Health and Wellness Centres for 2019-20. During 2018-19 the State is able to operationalize only 492 HWCs against the target of 679.
- The selection of the SHCs is based on the criteria related to the infrastructure of the building and availability of land for additional room.
- The progress is delayed and the planning for making the HWCs is not comprehensive.

- HWCs visited had good infrastructure with adjunct hatcheries. Water harvesting systems are installed in all the HWCs with support from Gram Panchayats.
- Shortfall of the Medical Officers at PHCs has delayed operationalization of PHC-HWCs.
- CHOs from both regular (mostly GNMs) and contractual (mostly AYUSH practitioners) cadre are receiving incentives timely in addition to their salary (upto Rs 15,000 Incentive + Rs 250 mobile allowance).
- In addition to six-months Certificate Programme in Community Health (CPCH) by IGNOU, CHOs have undergone one day NCD training and 3 days Yoga trainings. However, the NCD component covers only diabetes and hypertension and wellness part is found to be limited
- Use of IT, is still at a nascent stage, procurement of tablets yet to be initiated. The app on the mobiles of the CHOs is functional but largely unutilized. Also, application based reporting is irregular due to software related issues. In Urban areas, HWC Portal entry is done by ACDEO.
- Screening services for NCDs are currently limited to hypertension and diabetes.
- Wellness activities not initiated at some of the facilities and wherever initiated, regularity is an issue.
- Despite availability of medicines (including anti hypertensives and antidiabetics) in the HWCs, these medicines are not being used largely due to low awareness among community, lack of proper guidance from State and District level to the service providers and CHOs.
- Only 5 tests are available out of 7 at some of the visited HWCs.
- At HWCs Jaitsar & Rautula, map is displayed which is showing the location of the nearest referral centres for the information of the patients. In addition to this, the referral calls are made by the CHO to the higher centres in case they refer a case.
- Sub-optimal uptake of services is noted which can be due to low community awareness about HWCs.

Tamil Nadu

- 1374 (PHCs) & 316 (UPHCs) out of 1384 and 320 targets are operational respectively. 470 out of 985 (target) SHCs are operational as HWCs.
- State has deputed an additional ANM, who has done a 6 months training under State University, at SHC and who is responsible for NCD services at the SHC level.
- Population enumeration is done by Women Health Volunteers (WHVs) and ASHAs (Tribal). The WHVs are paid Rs. 3100/ month.
- Performance Based Incentive is not yet started by the State.
- An additional Staff Nurse for NCDs is deputed at PHCs. These SNs maintain follow up registers of the patients. They are also trained for VIA.
- RMNCH+A activities are ensured by the 1st VHN in the SC-HWCs, while 2nd VHN delivers NCD related services and OPD.
- NCD screening (including Cervical, Breast & Oral Cancer) and referral systems are in place. Patient Support groups are present.
- Hypertensive and diabetic patients are referred to PHC-HWC for first 3 months. After the 3rd month the patient receives medicines from SC-HWC.
- Detailed records are maintained of all NCD patients. Patients are followed up from PHC and SHC.
- Home based palliative care is provided by 1 SN/ block in 14 District. Mobile Palliative care has begun in 130 blocks as a pilot.
- Mental Health counselling services are available through toll free no. 104.
- Strong linkages are present with tertiary care facilities.
- Yoga training is being given to pregnant women through trained VHN.

- Awareness about HWC in community islow.
- Performance based incentives are not initiated by the state
- One tab and laptop is available at HWC for data entry. Data is being uploaded in state developed application. Daily data entry is not done in National AB-HWC portal in all facilities.
- Tele consultation is not started at any of the HWCs.

Uttar Pradesh

- Block saturation is followed wherein all PHCs of a block are selected. Further, SHCs are selected based on: i) their accessibility, ii) if functioning in a government building, iii) availability of water and electricity.
- All districts covered under universal screening of NCDs have been included; state has planned to transform 75% of SHCs in aspirational districts by July 2020. Similarly, all the PHCs and UPHC having at-least one MBBS doctor in-place are being transformed as HWCs.
- Shortage of MBBS doctors in some of the HWC-PHCs is one of the key challenges.
- A twelve-member Community Processes division is looking after HWC implementation in the state.

At divisional level, ten Regional Managers (out of 12 sanctioned post) are looking after CPHC programme. At district level, state has received approval of one HWC cum CP assistant and hiring process has begun. The implementation of CPHC is being supported by development partners including Piramal, TSU BMGF, UNICEF, WISH Foundation, Jhpiego. Piramal Foundation is supporting implementation in 5 districts, TSU BMGF in 2 districts, UNICEF in 1 district, WISH Foundation in few facilities and Jhpiego assists in CHO training. CPHC team works in collaboration with district and state NUHM, NCD and other program teams. These teams form part of the review meetings and formulations of guidelines.

- The Primary Health care team at the SHC-HWC comprises of a Community Health Officer supported by Multi-Purpose Health Worker Female (MPREGNANT WOMEN-F) and ASHAs. However, an additional MPREGNANT WOMEN-M or MPREGNANT WOMEN- F is found to be missing at most of the SHC- HWCs. State plans to revive and deploy MPREGNANT WOMEN- M cadre at the SHCs. The Primary Health Care Team at PHCs is as per the guidelines.
- The Program Study Centre at College of Nursing in Meerut district is state of the art. An alternate strategy of the state, in addition to the IGNOU CPCH course is to roll out a virtual CPCH course through Regional Health and Family Welfare Training Centres (RHFWTCs) in collaboration with King George Medical University. This is an innovative model of the state optimizing resource utilization.
- High attrition rate of the Community Health Officers (CHOs) has been noted as a challenge due to better opportunities in regular government jobs or more lucrative positions. To address this, the state is planning to create a regular cadre of CHOs
- After the upgradation of the facilities as HWCs, there is a significant increase in number of OPD Cases.
- Screening of HT, DM, Oral and Breast cancer has been rolled out.

- Availability of Medicines and Diagnostics issatisfactory at the Sub Centre - HWCs. Most of the HWCs observed had adequate buffer stock of medications and a streamlined inventory mechanism. However only limited diagnostic services are available at PHC/UPHC- HWCs. Both the SHC- HWCs and PHC/UPHC-HWCs are offering the same number of diagnostic tests (7-8).
- Patients at the SHC- HWCs reported availability of medicines of Hypertension and Diabetes and are satisfied with the dispensation mechanism. Elderly patients are happy with reduction in travel time and effort to the PHCs from where they used to get medicines earlier.
- Understanding of continuum of care is weak among all Health functionaries as follows ups post referrals are poor
- Tele Consultation has been initiated in PGI, BHU, KGMU, MLB Jahnsi, BRD- Gorakhpur medical colleges. CDAC is initiating a pilot with KGMC as hubs and 5 UPHC- HWC Lucknow and 5 PHC of Meerut as spokes. Tele Consultation started in 9 HWCs of Sharvasti and Fatehpur with support from Wish Foundation.
- Community awareness of Ayushman Bharat, especially the CPHC part is average.
- To address the shortage of yoga trainers, state has engaged University of Ajodhya to facilitate and certify Yoga training for CHOs and other staff.
- Infrastructure is adequate as per guidelines in all the facilities visited.
- Issues related to distribution of performance-based incentive for CHOs areobserved. CHOs have not received incentives since last 6 months, especially in Bahraich district.
- CPHC-NCD app and HWC portal is being used to feed information. However, the use of NCD app is low.

Uttarakhand

- Upgradation is being conducted based on feasibility and is largely random without linking with other respective referral units as per the guidelines.
- Working hours of facility are generally 8 am -2 pm.
- External branding of the facilities had been completed. Adequate space is available to provide the required services, assigned for that health facility.
- In most instances there is provision of an additional room for examining patient in private that implied that there is consideration of Respectful maternity care.
- Antihypertensive and anti-diabetic medicines are available.
- 128 tablets have been distributed to CHOs in August. NCD app uploaded on the tablet given to CHO.
- Daily reporting from the facilities on the HWC portal on number of patients visiting the facilities, medicines dispensed and referrals made.

TOR 2: REPRODUCTIVE, MATERNAL, NEW-BORN, CHILD, AND ADOLESCENT HEALTH (RMNCH+A)

National Overview

RMNCH+A is a flagship program of NHM, launched by MOHFW in 2013 that is built upon the continuum of care concept and encompasses all interventions aimed at improving reproductive, maternal, newborn, child and adolescent health under a broad umbrella.Since the launch of CRM in the year 2007, a plethora of changes have been observed in the delivery of various services under RMNCH+A. Remarkable improvement has been noticed in infrastructure, availability of medicines, diagnostic facilities and competent technical resources along with an assured network of ambulances. As a result, the footfall for seeking services has increased in all RMNCH+A programs. However, there is a scope for further improving the quality of services being delivered.

Institutional birth has increased from 38.7% (NFHS 3, 2005-06)to 78.9% (NFHS 4, 2015-16). The percentage of mothers who had antenatal check-up in the first trimester rose from 43.95 % to 58.6 % in the same year. Similarly, TFR has come down from 2.7 to 2.2. Immunization coverage has increased from 78.2 to 91.2%.The total unmet need has decreased from 13.9% to 12.9 %. Exclusive breastfeeding practices rose from 46.4 % to 54.9%. The number of Adolescent Counseling services has increased considerably. An improvement in the range and access to the services has led to a reduction in mortality and morbidity.

The 13th CRM visit also revealed an overallimprovement under the RMNCH+A program in all the states and one of the major contributing factorsis the continuous support from healthcare system particularly infrastructure, HR, Drugs, diagnostics etc. States have made special efforts to improve the quality of RMNCH+A services, as reflected by the field findings on initiatives like Respectful Maternity Care services such as privacy and birth companion (PrasavSakhi in Bihar, Rajasthan and MP) during labor, better monitoring systems for tracking high-risk cases (Techno + in Gujarat) and availability of SBA trained staff at delivery points.Similarly, several other initiatives like PPIUCD, Injectable contraceptives, POSHAN Abhiyan, Augmented screening under RBSK, DEICs, WIFS Program, expanded peer group and counsellors at AFH clinics are some of the steps taken by the states in improving the quality of various services under RMNCH+A.

This TOR covers the detailed findings of the 16 CRM states - best practices and key focusareas for actions- in the areas of Maternal Health, Family Planning, Newborn Health, Child Health, and Adolescent Health.

National Overview: Maternal Health

Achieving the MDG goal for MMR is one of the important milestones in the journey of reducing maternal mortality and morbidity. The 13th CRM

observed state's continuous support for undertaking various maternal health initiatives. All these efforts led to further decline of MMR from 130 per 1 lakh live births (SRS 2014-2016) to 122 per 1 lakh live births (SRS 2015-2017) which is a decline of 6.2%. With this rate of decline India is on track to achieve the Sustainable Development Goal (SDG) target of reducing MMR to less than 70 per 1 lakh live births by 2025. Out of the 16 CRM states visited, TN has already achieved SDG. Moreover, 5 CRM states namely Tamil Nadu, Jharkhand, Uttarakhand, Andhra Pradesh, Gujarat, and Maharashtra have already achieved the National Health Policy target (MMR of 1/1000 live births) well ahead of the 2020 timeline.

The field findings further revealed good progress in institutional delivery and ANC coverage and detection of HRP cases etc. Good infrastructure, SBA trained service providers, availability of free medicines and diagnostics across the states helped in better uptake of maternal health services. Initiatives like JSY, JSSK, PMSMA, DAKSHTA, Skill Labs and free referral transport have also contributed significantly to this growth.

However, some of the areas of concern are pockets of high home deliveries in NE states and Uttarakhand. Jharkhand and Uttarakhand also reported high OOPE on Ante-Natal and Post-Natal Care either due to user fee or non-availability of services that acted as a deterrent for institutional deliveries. Operationalization of FRUs to increase access and availability of comprehensive obstetric care is also however found sub-optimally functional in almost all the states visited and need priority attention by the states.

While the overall progress has undoubtedly been impressive, systematic efforts need to be made to

eliminate disparities in maternal health outcomes across the country with a focus on improving the quality of services. Newer initiatives like LaQshya, POSHAN Abhiyan, and SUMAN (Surakshit Matritva Aashwasan) has been adopted by all the states which will help to ensure that all pregnant women receive quality maternal care with respect and dignity.

Key Findings

Antenatal Care: Coverage& Quality

- Rise in percentage of pregnant women undergoing ANC check-ups, especially with the launch of PMSMA scheme is seen in many states but4 ANC check-ups remains weak.
- All the states reported good IEC for community awareness and involvement of ASHAs in the mobilization of pregnant women and Maintaining ANC records.
- Quality of ANC care in terms of the range of services provided, management of HRPs, counselling about diet & family planning, etc. remains an issue to be tackled in almost all the states. Identification of high risk pregnancies and line listing is limited mainly to anaemia detection. States like Gujarat have addressed the issue with the help of an IT platform for tracking high-risk pregnant women. Other states also need to use IT platforms like RCH portal, MCTS etc.
- PMSMA is implemented in all the states but the quality of service provision remains an issue. The participation of private doctors/ hospital volunteers remains low in most of the states. However, states like Delhi took a special initiative in which *"Nimantran Patrika"* is distributed by ASHAs at the doorstep of the missed out or left out pregnant womenbefore 9th of each month to ensure increased ANC coverage.
- IFA tablets are available and being provided to pregnant women, but due to poor counselling and lack of proper follow up, the consumption of IFA and Calcium tablets by the pregnant women is foundto be low.

Delivery care: Experience & Services

- Labour rooms at all levels are found well equipped and organized with 24*7 water supplies, power backup, and separate toilets, especially in Andhra Pradesh, Uttar Pradesh, Madhya Pradesh, Odisha and Tamil Nadu.
- The percentage of institutional deliveries has increased in recent years in most of the states visited. However, some states also reported a high home delivery rate like Uttarakhand, Meghalaya, Nagaland and Jharkhand. Such deliveries are mostly conducted by non-SBA trained staff, often leading to high MMR in the region.
- Novel Initiatives like "MaaGruha" are found functional in Odisha, wherein the facility provides accommodation and medical care to pregnant women from tribal and inaccessible areas, one week before EDD. Similarly, in Andhra Pradesh a birth waiting hostel in remote facilities of Aarku valley is functional.
- Birth companion and respectful maternity care in labour room is observed in states like TN and Gujarat. States like Rajasthan, Bihar, and MP have implemented initiatives like "PrasavSakhi" and "Care companion program" to allow birth companion during labor and childbirth in the facilities.
- Although RMC during delivery care has improved in many statesit is not yet being properly practiced in other maternity care services like ANC, PNC, etc.
- However inclusion of RMC for LaQshya certification is bringing positive changes in improving respect and dignity while delivering services to pregnant women.
- High rate of caesarean sections is observed in some states like Andhra Pradesh and Tamil Nadu which is a matter of concern. In facilities visited, nearly 50% are prime gravida and major indications for C-section included PIH, Anaemia and CPD.

Orientation and Training

- The knowledge, attitude, and skills of nurses are found satisfactory with respect to Partograph

use, Oxytocin dosage, Case sheets filling, AMTSL, Essential new-born care etc. Quality filling of Partograph, however still remains an issue overall.

- Most of the labor room staff is found trained in SBA or DAKSHTA in almost all states except in the districts visited for the states of Bihar, Uttarakhand, Jharkhand, and Tamil Nadu.
- MCP cards are available at most of the facilities but the recording of information and its use by service providers remains an issue across all the states. Though, district and block level orientation for filling of new MCP card has been undertaken by the states, limited knowledge is observed in the technical understanding for the parameters like a foetal lie, pelvic grips, cervical dilation, the descent of head, Growth monitoring, ECD etc in almost all the states visited.

Benefits & Entitlements

- Free diet and free medicine are available at all CRM visited states. In states like Odisha, almost zero OOPE is incurred in the stay of a pregnant woman for delivery at the healthcare facility.
- Free referral and drop back services of beneficiaries are not assured and remains an issue in most of the states especially Uttarakhand, Bihar, MP, and Mizoram. However, states like Andhra Pradesh and Gujarat have taken special initiatives like *TalliBidda Express* and *Khilkhilahat Express* to provide referral transport.
- Beneficiaries in certain pockets have reported increased Out Of Pocket Expenditure (OOPE) on ANCs mainly on USGs and Transport. USG services are available at DH level only in the public facilities of many states.

Reporting & Reviewing: MDR

- Proper reporting and reviewing of maternal deaths is an issue in most of the states (Except Gujarat, Tamil Nadu, and Delhi). State like Gujarat has established a robust system for reporting and review of maternal death audits.

Others/Administrative

- Lack of proper Blood storage or Blood bank facilities is one of the major bottlenecks observed in many states in operationalizing the FRUs.
- Mandatory 48hrs stay post-deliveryis not seen in almost any of the states visited, making it difficult to track the mothers and the new-born in this critical period.

Recommendations

- Line listing of every pregnant women, identification, management and follow-up of High-Risk Pregnant (HRP) women need to be ensured at all levels of healthcare facilities.
- Time-bound action plan for the establishment of hybrid HDU/ICU at the District hospital level and operationalizing FRU for assured CEmONC services needs to be prioritized.
- Orientation on Respectful Maternity Care is universally required. Staff working in DH/CHC in the states can be sent to visit other hospitals for learning best practices under MCH.

- Peri-conception care courses and midwifery courses should be rolled out on priority.
- Uptake and utilization of the latest GoI forms, formats, registers, etc. is required.
- All the key staff (MOs, SN, ANM) needs to be trained in CEmONC, SBA, NSSK &Dakshata. Accelerating NSSK training of SNs, ANMs and refresher training for ANMs and ASHAs on essential newborn care/ home-based newborn care is recommended.
- Establishment of skill labs need to be scaled up across the states with priority to Aspirational and High priority districts.
- Protocols at LR and other places should be pasted at eye levels. The IEC/BCC material must be printed in local/regional language for easy understanding and practice.
- There is a need to develop a definite plan for integrated IEC and communication activities to create awareness on the importance of early registration of pregnancy and ANC and also generate demand for institutional deliveries at the community level.
- Videos developed and shared by the Ministry can be utilized for better awareness amongst service providers and beneficiaries.
- Non-rotational posting of staff nurses to be implemented for ensuring the presence of skilled nurses in the labor room. Also, HR to be deployed rationally at delivery points for effective service delivery.
- USG facilities to be made available below DH level available to reduce OOPEs on the same. More advocacy and recognition are required to involve private practitioners in the PMSMA.
- Capacity building of service providers for regular reporting and review of MDSR/ CDR. District Collectors to be sensitized for conducting review and improving inter-sectoral coordination and convergence/integration.

State Specific Findings

Andhra Pradesh

- **Well functional RMNCH+A services** with almost all women, 3-4 ANCs, all basic diagnostic tests, consuming IFA & Calcium and incurring nil OOPE on ANCs at Public facilities is seen. Even MMUs are involved in providing ANCs.
- Almost all functional FRUs are also conducting caesarean sections. Blood Storage and Blood banks are functional in almost all the FRUs visited.
- **TalliBidda Express**-Drop back (from hospital to home) facility for mothers after delivery in government hospitals. This service is coordinated by 102 call centres which operate

24X7. However, facility for pickup from home to hospital in the state is weak.

- **Maternal lifeline centre**- A centre has been established at KGH medical college for analysing the maternal deaths to further decrease the MMR and suggesting critical steps to be taken.
- Availability of birth waiting hostel in remote facilities of Aarku valley, a feeder ambulance for receiving pregnant women from hard to reach areas, privacy and provision of Birth companion at all the delivery points are other good practices observed in the state.
- **Referrals from lower level institutions are being made without admitting pregnant women, cases mostly being-** severe anaemia, PIH and prolonged labour which is a matter of concern.

Bihar

- Well-equipped LR, separate triage area for labour case and use of colour-coded band (Red, yellow & green) seen at the DH level in districts visited. Also, practices such as prasavsakhi (birth companion) and provision of maternal kits (gowns & other items) are seen in many facilities.
- Almost all the PHCs are found to be providing 24*7 services with greater focus on RCH component however there is a need for increasing the awareness towards the JSSK scheme.
- Identification and management of HRPs is weak, needing urgent attention. Also, low screening of HIV & Syphilis in pregnant women and inadequately functioning PMSMA reflected gaps in ANC services in the state.
- Delayed/unavailability of ambulance services for referral/transportation, non-availability of blood services and early discharges following delivery complicated quality of care being delivered to high risk pregnant women, mothers & new-borns.
- Out of 130 functional FRUs, only 36 FRUs are fulfilling the FRU's conditionality. Lack of specialists and non-availability of BSU are major bottlenecks found in operationalizing FRU.
- Non-functional MCH wings are seen, although 11 MCH wings are sanctioned in 2012-13, construction of only one MCH wing has been completed.

Chhattisgarh

- Awareness and demand generation regarding Maternal & Immunization services in the community is found to be good. Though, HR Shortage hampered delivery of quality RMNCH+A services.
- Labour rooms are found to be well organized and clean with toilet facilities nearby. Standard protocols are followed in general, but knowledge of Partograph use and its analysis needs to be improved among the LR staff.
- ANMs are often found to be untrained in SBA, Daksh, Dakshta, NSSK, FP methods etc.
- Tracking and referral system of HRPs and complications during labour is found to be inadequate.

- Placenta is being disposed off by sending it back to the pregnant women's home in spite of having deep burial pit in the facility.
- Other issues such as lack of OGTT and Syphilis testing, stock out of basic drugs such as Calcium (stocked out since April 2019), Poor quality of RCH registersare seen that needs attention.

Delhi

- As a State initiative, **"Nimantran Patrika"**is distributed by ASHAs at the door step of beneficiaries before 9th of each month- to the missed out, left out and resistant pregnant women to increase ANC coverage.
- Screening of ANC cases is being done and line listing of High-Risk Pregnancies (HRPs) is being maintained by ANMs/ASHAs.
- JSSK is partially being implemented in both the districts. Free diagnostics such as Ultrasound, ECG etc. and referral transport is not being provided. OOPE reported to the extent of Rs 1000-3000per normal delivery, in urban slums at Todapur, New Delhi.
- Few Tertiary care institutions have switched to their own MCP cards and do not accept the NHM MCP card. This leads to duplication of work by staff and sometimes incomplete entries during re-entering of patient details/clinical findings occur at the hospitals.

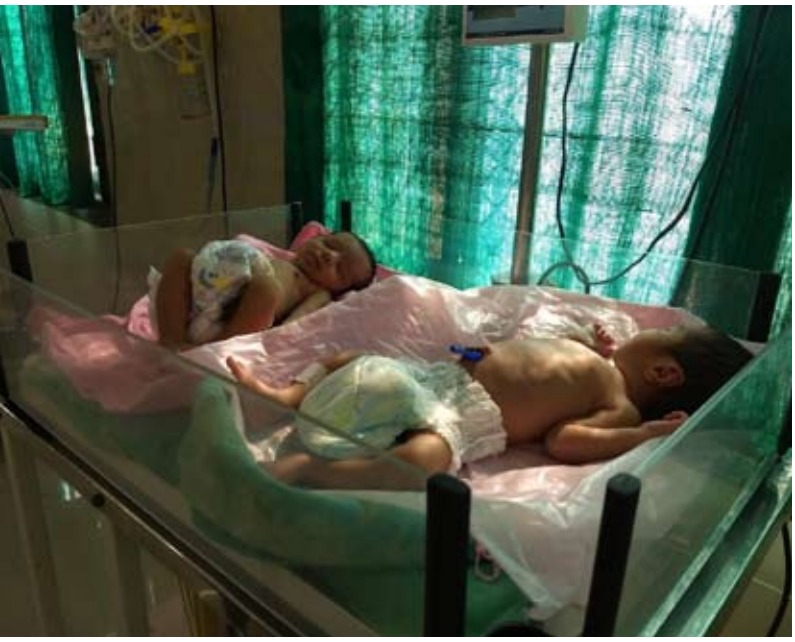
Gujarat

- In both districts, over 90% of the pregnant women are registered for ANC services and over 80% ANCs are registered during first trimester. The state has launched 'Techno+' application for tracking of pregnant women especially the HRPs by the field staff.
- The labour rooms visited across the districts are well maintained with availability of SBA trained medical and para-medical staff. Supplies like pregnancy test kits, IFA, antibiotics, oxytocin and calcium areavailable at all levels.
- Over 60% of FRUs are conducting adequate C-sections following availability of all the necessary human resources and infrastructure.

- **Khilkhilahat Express-** Free transport system is available for bringing and dropping back the pregnant women to and from the health facility.
- The state has established a robust system for reporting and review of maternal death audits and every year more than 80% of maternal deaths are getting reported within 24 hours of death.
- Birth companions are allowed in LRs across the facilities but they are not provided with counselling about dos and don'ts inside LR, PNC ward and for care after discharge, or are provided with masks and head caps inside the LR.
- General upkeep is found to be poor at SDH, Dahod leading to high mosquitos in PNC ward andthelabourroom.Rustedequipmentarebeing used in labour room in SDH-DevgarhBaria.
- Peripheral delivery points are not found using uniform registers for labour room data. Also, Partographs are not found properly filled in many facilities.

Jharkhand

- HRPs are being identified but their tracking to ensure provision of appropriate and timely care is missing. There are pockets with high home delivery rate due to cultural and accessibility issues.
- Labour rooms across both districts are well maintained, with availability of all trays, well displayed LR protocols, colour coded bins for BMW management, New born care corner, digital fetoscope, baby weighing scale, fridge and attached toilet.
- The MAMTA Vahan program is decentralised at the block & district level. Also, the number of Mamta Vahan has been reduced from 2581 (2016-17) to 1803 (2018-19), which needs urgent attention.
- Very low full ANC coverage is seen despite PMSMA being done across all the facilities. Initiatives such as Respectful Maternity care and Safe Delivery app are not yet rolled out in the state.
- Poor availability of USG services below DH level, poor referral linkages, non- availability of blood in Blood Banks or non-functional BSUs are some of the factors responsible for high OOPE and poor maternal health indicators in the state.



Madhya Pradesh

- Programs like **Care companion, Roshini clinics** and Aanchal corner are well maintained and functional in the health facilities visited.
- **Mukhya Mantri Shramik Seva (Prasuti Sahayata) Yojana** has been rolled out in the state to provide compensation for the wage loss to registered labourers for up to two live births.
- To enhance quality of ANC check-ups, all ANMs have been provided with Fetal Doppler. However, gaps such as suboptimal screening of pregnant women for HIV & Syphilis are seen.
- MDR and CDR processes are not functioning as per the protocol. Components of RMC- birth companion, privacy etc. is still missing from the labour room.
- Most of the complicated cases or high risk cases arereferred to DH from below level facilities such as CHC-FRU.

Manipur

- Many good initiatives (Delivery kit and JSSK Kit distribution) has been launched to increase institutional as well as cash less deliveries and decrease out of pocket expenditure (OOPE).
- PMSMA is being implemented and good IEC material i.e. posters, banners regarding the same are displayed in the facilities visited. As part of PMSMA, the State had initiated a scheme “Mirongbising GiKhudol” (meaning gift for the pregnant women) to provide ANC services to women in remote areas, where there is lack of specialists, by volunteer doctors from other areas.
- Labour rooms are well equipped with availability of trained SN or OBGY doctors having adequate skills. Most of the protocols for care around delivery are being followed in the district, but some need training on delayed cord clamping and AMTSL.
- ASHAs are playing an important role in motivating pregnant women for institutional deliveries.

- Community awareness about diet during pregnancy/lactation, free transportation facility (102) for delivery, JSY & JSSK entitlements is good. But OOPE on transportation of pregnant womendoes exist.
- Line-listing of pregnant women for severe anaemia and High-Risk Pregnancy is available.
- Regional good practices are followed in the state- e.g. family, friends, relatives organize gatherings and invite the pregnant women in their family for special lunches or dinners. During such gatherings the mother is advised or taught about child birth lessons, what to expect, what signs to be checked for or inform elders regarding delivery etc.
- Even though MCP cards are available, there is lack of supervision at all levels on importance of MCP cards, on recording services, tracking defaulters, correct entries in MCP cards and use of MCP cards as an important IEC tool.
- Blood Bank (BB) at DH and Blood Storage Units (BSU) at CHC are not functional in the district.

Meghalaya

- ANC services are being given under PMSMA. PHCs are providing 24*7 services and conducting normal deliveries.
- Under Community Action for Health, Public hearing or Jan Samwad is being held to discuss various health related issues including review of maternal deaths, denial of health services, basic amenities at Sub Centres etc.
- Well maintained labour rooms with well displayed protocols, clean attached toilets areseen across all the facilities visited. All the necessary equipment, new MCP cards are available.
- FRU Services is being provided only by District Hospital in West Garo Hills. However, in RiBhoi, even District hospital/CHC is unable to provide emergency obstetric care and sick new-born care, and for the same services people have to either travel to Shillong or Guwahati.
- Specialists at Nongpoh, DH are doing GDMO duty. Only one C-section is performed there in the last year despite availability of necessary HR, the reasons for which needs to be understood.
- ANMOL/RCH portal is not found to be functioning. Services are hampered due to extreme delays in repairs of critical equipment. Supply of drugs and consumables is Push driven, and beneficiaries are asked to procure medicines from outside.

Mizoram

- Labor room of Civil Hospital Aizawl is well organized. SBA/Dakshta trained staff are posted in most of the labor room. Also, Essential drugs and commodities are available at all LRs.
- HIV screening of pregnant women during ANC is being done at PHC level & above.
- State has initiated Midwifery initiative and elected 3 Midwifery trainers.
- Referral transport services for delivery are not available in the District and found to be managed by the beneficiaries or family members, which lead to high out of pocket expenses. Also, there is no ambulance at DH, Mamit (recently received one ambulance donated by TATA Trust).
- Availability of blood banks and blood storage units below district level remains a serious limitation in establishing CEmONC services and making FRUs functional.
- Documentation of delivery, High Risk Pregnancies and other services is poor throughout the facilities except Civil Hospital Aizawl.
- Provision of PMSMA services are limited to District Hospital and POC services not given. Poor Quality of ANC services is a concern in the state. Also 1st trimester ANC registration is low.

Nagaland

- In Phek district, the LRs are well maintained with proper asepsis management and display of protocols. Also ANC & PNC wards are in good condition, but the mandatory 7 trays are missing.
- CHOs are given Dakshata training recently and are found conducting deliveries at SCs and had

satisfactory knowledge about maternal and new born care.

- Regular VHND sessions are conducted at the AWCs and SCs.
- MCH clinics have been setup in the facilities (PHC and above) run by ANM/ staff nurses for ANC cases but are providing only TT, Clinical check-ups etc. These clinics need to be used more efficiently for quality ANCs.
- The healthcare providers (ANMs, Staff Nurses and MOs) are not aware of the latest INAP, KMC, LBW, Dakshata, LaQshya protocols.
- Line listing of pregnant women with severe anaemia is not being maintained in any facility visited by the team. Also, all four ANCs percentage is very low. Hb is checked only in 1st ANC visit.
- High preference for home delivery seen- about 57% registered pregnant women delivered at home and that too by non-SBA trained provider. Reasons being high OOPEs (about 3-4k per institutional delivery on drugs, diagnostics, referral transport), preference of home environment and poor road connectivity.

Odisha

- Districts visited have well placed maternal health services, higher rate of institutional delivery, implementation of JSSK/JSY, maintenance of Partograph and adherence to labour protocols.
- State has ensured committed transport facilities in terms of Delivery Van, Bike ambulance, Auto ambulance and stretchers in hard to reach and inaccessible areas.
- Special initiative called “MaaGruha”is found across both the districts in remote-inaccessible areas. The facility provides accommodation and medical care to pregnant women one week prior to EDD.
- Labour rooms are well organized and the staff working there are well oriented (Technical support from UNICEF in this regard is worth mentioning).
- Documentation needs strengthening: as the high risk pregnancies are not highlighted in the registers (PMSMA/ Labour room) in Jashipur and Rainragpur in Mayurbhanj.
- No out of pocket expense under JSSK is reported in either of the districts.

Rajasthan

- To promote respectful maternity care across the hospitals, the state has implemented an initiative called “PrasavSakhi” to allow birth companion during labor and childbirth in the facilities.
- The State reports almost 100% ANC registration but full ANC coverage is only 62%. Apart from PMSMA, the state is trying to improve the ANC coverage with the help of other schemes like Prasuti Niyojan Diwas and Surakshit Matritva Diwas.
- SCs & HWCs visited are also providing delivery services to the community and had also maintained complete line listing of pregnant women, high risk pregnancies, home deliveries, immunization due list, sick new-borns, maternal and child deaths.
- The infrastructure for labour rooms is good across facilities but delivery care is sub optimal at sub district level facilities in Churu.
- Lack of specialists & BSUs at FRUs and lack of 24X7 functional laboratory services in the hospital are major bottleneck in providing emergency obstetric care services such as emergency C-sections. It also contributed to high OOPEs in the state.
- DHs are overloaded, leading to outflow of patients to tertiary hospitals in Gujarat and Bikaner.
- Despite a strong IV Iron Sucrose initiative for anaemia control in the state, less than 50% conversion from first dose to fourth dose is seen in the facilities. High prevalence of Anaemia seen in both the districts and in the state overall.

Tamil Nadu

- Every Tuesday is designated as ANC Day and check-ups conducted as per guidelines in both the districts; further follow-up on 9th of every month (PMSMA) for high risk case management is done at GH level and DH-HQ level.
- Majority of the pregnant women are registered within the 1st trimester in both the districts through the very well developed Pregnancy and Infant Cohort Monitoring and Evaluation (PICME) software of the State.
- All labour room protocols are being followed- Adequate delivery trays, Partographs, Display of protocols etc. Skills of the Staff nurses with respect to the delivery care are found to be adequate.
- Respectful maternity care is observed in both the districts with privacy of the women maintained with curtains between two tables and allowing the birth companion in labour rooms.
- No OOPE observed or reported on delivery care and child birth in both the districts. Free Drugs, Diagnostic, transport and food are provided to the ANC beneficiary and women in post-partum phase, in both the districts. 85% deliveries are conducted at Government Institutions in Villupuram validating the quality of services in the public institutions of the state.
- State has also developed a very comprehensive Maternal Death Review System.
- Higher C-Section rate is reported across CEmONC centres and DHQ in both districts.
- Good community awareness about importance of ANCs, early and EBF, 108 Ambulance services is noticed.

Uttar Pradesh

- The state has well established 108 and 102 ambulance services and they are being utilised for pickup and drop of pregnant women and mothers post-delivery respectively.
- For Rapid activation of FRUs through CEmONC-LSAS trained doctors, state has adopted "Buddy-Buddy Model" for activation of CHC FRU. In Meerut, Buddy- Buddy model observed in CHC Mawana is seen working well,
- Gestational Diabetes test is not being done in Meerut district hospital which is an essential service provision for a district hospital.
- ASHAs accompany pregnant women for delivery to public hospitals but cases of referral to private hospitals by health workers are also noticed.
- High rate of home delivery (approx. 42%) is reported in Bahraich. Due to lack of SBA trained service providers, most of these deliveries go unattended leading to high MMR. Prepositioning of Misoprostol by ASHAs is absent in the district.
- Two CHC-FRUs both in Bahraich and Meerut are found conducting elective C-Section. However, the blood storage units (BSUs) there are non-functional. During the 8th CRM visit in 2014, the BSUs are reported as non-functional in Meerut districts, which is still the same.

- Orientation regarding filling the Partographs & MCP card is required especially with respect to components related to growth monitoring and ECD.
- ANC service quality is suboptimal; no line listing of HRPs is being done.
- 24*7 delivery services and C-section isnot being provided at the CHC level due to either shortage of specialists or overburdening of existing facility as seen in DWH, Meerut.
- **Condition of LLR Medical College, Meerut is very poor-** no boundary walls, no security arrangements and compromised cleanliness are observed, compromising service delivery at the facility.

Uttarakhand

- The initiative of displaying new-born male and female child board at the entrance of LR (GuddaGudia Board) has been symbolic in creating awareness regarding sex discrimination practices.
- Pregnant women and eligible couples in community are aware of the need for seeking care during pregnancy. Knowledge pertaining to ANC, PNC and HBNC among ANMs and ASHAs is extraordinary.
- ANC is being done as part of PMSMA on 9th of every month. ASHAs are routinely accompanying pregnant women for their deliveries.
- High Risk Pregnancies are being identified and line listed in both the districts but management needs improvement. All posted staff nurses are trained in SBA and NSSK.
- 108 ambulance services are available but the drop back facility is not being provided due to non-functioning of KKS *(Khushion Ki Sawari)*, causing OOPE for the patients. Urine pregnancy test (UPT) is also chargeable. Pregnant women bear non-medical costs (travel costs up to INR 1000) for getting the free compulsory USG prescribed once during the ANC period.
- Due to these OOPEs, a high proportion of home deliveries by unskilled attendants are noticed. Deliveries are being done by untrained ANMs at sub-centre level as well.
- Community is aware of the availability of health facilities around but is not satisfied with the quality of services rendered therein e.g. inadequate drug availability.
- Awareness regarding danger signs among the mothers needs to be improved.

National Overview: Reproductive Health

Family planning program has shown positive progress in almost all the states visited due to various policy decisions like FP 2020, Mission ParivarVikas and other population stabilization programs. Family Planning programme in Indiahas undergone transformation by improving the range and reach of contraceptive options at all levels and reduce the unmet need of family planning in the country.In all the states access and availability of newer contraceptives-Antara and Chhaya is observed. The states showing spacing between the births have lower MMR and IMR.

Despite these best efforts, the prevalence rate of contraceptive use has shown only marginal increase in the CRM visited states. Infact, certain contraceptive options such as Male Sterilization rates have shown decline in most of the states visited.

Acceptance for the family planning methods varied widely throughout the country. Post-Partum Intrauterine Contraceptive Device (PPIUCD) acceptance rate is 11 % (HMIS 2018-19) in Bihar against the National benchmark of 25%. In addition, use of contraceptives varied from 25.4% to more than 70% across CRM states. Frequency of female sterilization is much more common than male sterilization in all CRM states reflecting the skewed acceptance rate among males and females in the country. Improving male participation remains critical to increasing the contraceptive coverage, as does the monitoring of complications, failures and deaths following sterilization operation.

Awareness regarding injectable contraceptives is lacking in most of the states. Though aware of the importance of small family size, community lacks knowledge regarding different methods or options available for family planning and birth spacing. Proper counseling services are needed to ensure optimal awareness among the community members, especially the beneficiaries for choosing proper family planning methods. Most importantly, ASHA orientation should be done via monthly meetings on newer contraceptives like Antara and Chhaya in order to generate demand for these contraceptives from the field.

States need to devise strategies to increase acceptance and expand the bouquet of choices of contraceptive options available at every level of healthcare facility to promote family planning and ensure good reproductive health of the community.

Key Findings

Awareness and Availability

- Good awareness regarding the need and various methods of family planning is found in most of the CRM states visited. Also, preference of terminal methods over spacing methods is a common observation.

- IEC materials regarding FP are well displayed in the community in Delhi, Tamil Nadu, Meghalaya and Uttrakhand. In Delhi, awareness generation activities on FP and birth spacing methods e.g. Health talks, FGDs, NukkadNataks are held regularly in the community.
- Family planning services are provided at all levels of health facilities in almost all the states but instances of stock outs of basic contraceptives and commodities are seen as well.
- Uptake of injectable contraceptives is improving in most of the states. However, their continuous usage and availability is less than satisfactory in many states, especially in the MPV states of Jharkhand,Chhattisgarh, Rajasthan and Uttar Pradesh.
- Inadequate counselling and orientation on the benefits and side-effects of injectable hampers its uses in most of the state leading to increased dropout rate.

Service Delivery

- PPIUCD insertion rate is satisfactory in Delhi, Tamil Nadu, Uttarakhand, Andhra Pradesh and Rajasthan.
- The sterilization servicesare available on FDSbasis at SDH/DH level in almost all CRM states.
- Coverage of traditional contraceptives such as Condoms, OCP,and Male& Female Sterilization has shown a declining trend in many states such as Tamil Nadu and UP. Condom boxes are not found in place in many states visited.

Special Initiatives

- Gujarat has rolled out Family Planning Logistics Management Information System (FP-LMIS) very well up to PHC level and currently all its indents and supplies of contraceptives are taking place through FP-LMIS.
- Special initiatives seen in FP like colour coding of eligible couples in ASHA registers, male widowers manned by counsellors for NSV counselling and IEC strengthening through mass media campaigns (LED displays, Metro Train and platforms, Auto Rickshaw wraps) are seen in Delhi. Also, the state has enrolled AYUSH doctors for FP counselling, which is a good step towards addressing FP concerns in the state.

Orientation & Training

- Training and orientation of ASHAs and ANMs on family planning services is good in almost all the CRM states except for Meghalaya, Manipur, and Gujarat. Acceptance for family planning methods and sterilization is more in females as compared to their male counterparts. Jharkhand & Rajasthan showed least acceptance for male sterilization.

Recommendations

- Proper updating and maintenance of RCH register including eligible couples register and FP records is needed.
- Eligible couple from RCH register /portal to be updated and utilized for offering basket of all contraceptive services with counseling to promote informed decision making by couple.
- ASHA orientation should be organized via monthly meetings on newer contraceptives like Antara and Chhaya in order to generate demand for these contraceptives in the field.
- Basic counseling training module to be developed and service providers at the facility should be trained in family planning counseling.
- Religious leaders and churches maybe involved for advocacy of family planning services.
- Supply of FP drugs, IUCDs, Newer contraceptives & use of LMIS software to be encouraged.
- Proper planning, monitoring and follow up are required while implementing the family planning services at the community level.
- Good rapport and interdepartmental coordination is required for dissemination of IEC on family planning methods and schemes. District Health society can act as a good platform for the same.
- Community awareness on gender sensitization over the preference for male child needs to be augmented.
- Quality and access to MTP and CAC services needs to be improved

State Specific Findings

Andhra Pradesh

- Poor use of family planning methods seen. IUD are not inserted at the sub-center level, even though they are being supplied to the sub centres.
- Injectable contraceptives have been recently introduced and awareness is currently weak.
- MTP services are not been provided in any of the facility visited including FRUs. Non availability of Mifepristone in the facilities. MVA

tray is being maintained but without MVA; D&C is the preferred method.

Bihar

- Dedicated Family Planning Counselling Corners with CCTV monitoring are available up to APHC level. Fixed Day sterilization (FDS) services are provided at PHCs.
- Injectable contraceptive (Antara) & Weekly Pills (Chhaya) have been introduced and show good uptake by the community, but high dropout rates of Antara is observed. Also, acceptance rate for PPIUCD has increased.
- Activities under Mission Parivar Vikas (MPV) Promotional interventions (Saarthi, Saas Bahu Sammelan, Nayi Pehal Kit) are being carried out. FP-LMIS is also rolled out to ensure supply of FP commodities.
- Pre-registration mechanism of Eligible Couple is occurring only during Special Drive, not on monthly basis. Also, follow up & tracking mechanism for clients is not there.

Chhattisgarh

- FP Services being offered at all level facilities. However, they lack focus in terms of availability of drugs, commodities, service quality &counselling leading to failures, e.g. removal rate of IUCD is very high in Chattisgarh. MTP is being done at DH & CHC of both districts visited.
- Mitanins have knowledge on basket of choice of contraceptives but lack clarity in client selection. Accountability of distribution of FP materials is often left only with the Mitanins and not with the facility.
- Usage and availability of newer contraceptives is less. Even OCPs and Condoms are found missing at places. FP-LMIS reporting is also non satisfactory.
- Male sterilization rate is very poor. NSV being done at only one CHC (Mohla) Rajnandgaon.

Delhi

- Special initiatives seen in FP like colour coding of eligible couples in ASHA registers, male widowers manned by counsellors for NSV counselling and IEC strengthening through mass media campaigns (LED displays, Metro Train and platforms, Auto Rickshaw wraps) and at DM offices.
- AYUSH doctors have been involved in counselling of patients to cover the unmet need of FP.
- IEC and awareness generation activities like Health Talks, FGDs, Nukkad Nataks, Munadi, etc. are held every fortnight.
- Both districts have shown great rise in the use of contraceptives, especially IUCD and PPIUCD and newer contraceptives like Injection Antara. For PPIUCD, the clients are referred to DH and Maternity Centers. High dropout rates of Inj. MPA noted.

Gujarat

- The state has rolled out FP-LMIS very well up to PHC level.
- Training of staff up to ANM level on newer contraceptives like *Antara* and *Chhaya* has been done but not of ASHAs leading to lower uptake of these contraceptives in the state.
- Despite availability of trained HR to provide regular sterilization services, none of the facilities except DH are providing these services.

- Service providers don't explain entire basket of choice to the clients but only limited methods like Sterilization &PPIUCD. In fact, the providers decide the best contraceptive method for the client based on his or her background, rather than counselling the clients to make an informed choice.

Jharkhand

- Availability of Condom boxes, Injectable contraceptives under MPV, is found to be good.
- The knowledge on injectable contraceptives has improved in the community. Male sterilization and PPIUCD rates are also extremely low in the state.
- In Gumla, both at the block and district level, OC pills distribution is reported to be more than 250% - 300% which points towards poor quality data.
- Comprehensive Abortion Care Services are available only at selected facilities and there are no safe abortion services at the sub district level in both districts.

Madhya Pradesh

- Availability of FP commodities including Antara, Chhaya, IUCD and condoms seen at all levels.
- A dedicated family planning counsellor is present at DH Chhindwara and had required skills for counseling. Uptake of PPIUCD at DH Chhindwara is a good 35-40%.
- FDS for CAC services is not available, and also the standard formats and documents required for CAC are not available at high case load facilities (CHC Sausar and Khandwa).
- Poor maintenance of record & availability of registers seen like Eligible couple register, FP registers etc. FP-LMIS has been rolled out well in the state.
- Also there is lack of awareness regarding newer contraceptives amongst service providers as well as beneficiaries. Poor f/u and counselling about them lead to high dropout rates of these.

Manipur

- Ensuring spacing at birth scheme (ESB scheme) is implemented in the district FP commodities e.g. Condoms, OCPs, ECPs, and Chhaya are made available in all the health facilities and home delivery of contraceptives at the door step is provided by ASHAs in the district.
- The Comprehensive Abortion Care (CAC) services are available only at DH level and not below due to lack of trained MTP provider.
- FP services especially female sterilization functional in camp mode at DH only. IUCD insertions conducted in DH, CHC Chakpikarong and PHC Komlathabi in the district.
- There is lack of knowledge about newer contraceptives (injectable) among ASHAs and ANMs as training has not been conducted till sub-center level. FPLMIS is also not implemented yet.
- PPIUCD services are available only at DH. Proper counselling before PPIUCD and regular follow up are missing, resulting in high expulsion and removal rate.

Meghalaya

Oral Contraceptive Pills, Condoms and IUCD 380 A are available in all Facilities. FP-LMIS implementation has been initiated.

- Uptake of Injectable contraceptives under Antara program is good (WGH). However, Antara cards are not available. All FP Choices are available except Chhaya and condom boxes.
- Sterilization services not being provided in CHC even in FDS mode in West Garo Hills. Sterilization records not complete, and District Indemnity Sub-Committee is not constituted.
- PPIUCD acceptance rate are very low across facilities. ASHAs arenot receiving PPIUCD incentive.
- Comprehensive Abortion Care (CAC) available only in MCH hospital Tura in WGH, while in Ri-Bhoi, they are not available even at District Hospital.

Mizoram

- IUCD trained staff are posted at Sub-Centre level. However, availability of contraceptives at SC level is a major concern. Even ASHAs did not have adequate FP commodities.
- Most of the ANMs in both the districts are trained in IUCD insertion and are performing the procedures in peripheral facilities. However records of f/u & removal cases are not maintained.
- Fixed day approach (sterilization) is not being followed throughout the District.
- Post-Partum Family planning services (Sterilization & PPIUCD) are limited to the District Hospital with poor footfall for the same. Also, CAC services are available at DH only.
- New Contraceptives as well as IEC/BCC for FP are limited to the District Hospital only.

Nagaland

- Documentation and record keeping including registers for eligible couple, sterilization registers, IUCD/PPIUCD insertion registers etc. are adequately maintained.
- FDS are provided at DH level for 1-2 days only over the year. IEC/BCC activities are not in place in any of the facilities visited. Poor supply chain mechanism, partly due to poor road connectivity, resulted in regular stock outs of commodities such as Nirodh, Mala-N, Cu-380A, Cu-375.
- The block level trainings are not completed in the districts. Front-Line Workers lacked clarity on the dosage, side effects, management of missing pills etc. for oral contraceptives.
- Counselling on family planning methods, basket of choices available and new contraceptives is not being done by ANMs/ASHAs.
- Implementation of PPIUCD, PAIUCD and male sterilization services is very poor.
- Condom boxesare not available as children misuse the condoms for ballooning.
- MTP services, upto 12 weeks, are only available at CHC and DH. Moreover, post abortion family planning services are restricted to DH only.

Odisha

- Pregnancy testing kits are available across all the facilities in both the districts. PPIUCD and in few cases PP ligation is seen well promoted.
- Nearly 40 percent of all institutional births are provided PPIUCD in both the districts and uptake of newer contraceptives i.e. Antara and Chhaya has shown good progress in the state.
- Integrated counsellingcentresare available at the DH, Kandhamal and DH, Mayurbhanj.

Rajasthan

- In both the districts, full basket of choice, including modern methods is available. The state has consistently performed well in PPIUCD insertions as well as in Antara injections.
- Sirohi district is one of the better performing districts in family planning indicators in the state. However, district has very low acceptance for male sterilization.
- Churu has reported high expulsion rates for PPIUCD indicating need for refresher trainings and ensuring 6 weeks follow up for PPIUCD insertions. Sterilization services are provided on fixed days at selected facilities (CHC Taranagar and Sahawa).

- Awareness of the community regarding FP services offered is not found satisfactory.

Tamil Nadu

- FP static sterilization services available at all secondary and tertiary level facilities with adequate number of trained staff. FP commodities are available at all the facilities except at few PHCs.
- PPIUCD insertion is available at Block PHC level and above, indicating its increasing uptake.
- Good uptake of new FP commodities such as Chhaya and Antara isobserved in Virudhunagar whereas coverage of traditional contraceptives such as Condoms, OCP, and Male & Female Sterilization has shown decline in both the districts.
- Counselling for family planning methods for the high risk mothers (high order birth) is found to be sub-optimal in both the districts with low engagement of VHNs for FP Services.
- Comprehensive Abortion Care Facilities available at CeMONC and DHQ in both the districts. Delay of PPIUCD beneficiary payment is observed in Virudhunagar District.

Uttar Pradesh

- Availability of various contraceptives, condom boxes, IUCDs, PPIUCDs, Antara and Sterilization at facilities is observed. However, irregular supply and inadequate stock of all contraceptives, especially newer contraceptive such as Antara and Chhaya is an issue.
- Toll free number for follow up 18001033044 is found being utilized in Meerut, which may be scaled up.
- CAC services are available only at DH not at the CHC level. Majority of CAC servicesare reported to be provided till 10 weeks of pregnancy.
- MPV and basket of choice of contraceptivesare available in Meerut, however in Bahraich, awareness, availability and implementation of MPV is very poor. *SaasBahuSammelan* and distribution of *Nayipahel* kit isnot happening in Bahraich.
- FP service delivery is sub-optimal across all the facilities with very low coverage of PPIUCD, IUCD and Sterilization. The services for PAIUCH are not available at the CHC level.
- Fixed day services are not available in-spite of availability of trained manpower for sterilization services in Bahraich.

Uttarakhand

- Good awareness & acceptance of various family planning methods isseen. Condoms and female sterilization are most commonly used and preferred methods.
- The IEC material regarding family planning is well displayed.
- The abortion care facility under CAC program is available at SDH and DH level.
- PPIUCD and 'Antara' administration training is not in place. However, PPIUCD is happening in the facilities.

- Family planning counsellor is not available in most of the facilities. The awareness level for modern contraceptives is found to be adequate and beneficiaries desired injectable contraceptives as FP option but its limited knowledge and slow roll out is limiting its uptake.
- The sterilization services are available on fixed day approach at SDH and DH level however the consent form, Post-operative instruction card, medical record checklists and sterilization certificate is not as per GOI format.

National Overview: Neonatal Health

The newborn and child health are the two key pillars of the Reproductive, maternal, newborn, child and adolescent health (RMNCH+A) strategic approach, 2013. Infant Mortality Rate in India has shown a steady decline from 42 per 1000 live births in 2012 to 33 per 1000 live births in 2017 (SRS 2017). Similarly, Neonatal Mortality rate has declined significantly from 31(SRS 2011) to 23(SRS 2017). Apart from initiatives by GOI, to improve neonatal and child health indicators, states have also taken noticeable efforts in achieving these results, as observed during the CRM visit.

Apart from improved infrastructure to provide critical care services to the newborns& infants- 844 SNCUs, 2421 NBSUs and 20336 NBCCs established across the country [MIS report till 30 Sept, 2019] as compared to 794 SNCUs, 2329 NBSUs and 18570 NBCCs registered last year, enhanced community awareness about early and exclusive breast-feeding practices, complimentary feeding and KMC is also witnessed.

However, some key focus areas such as HBNC, follow up of discharged cases from SNCUs and other critical care units like NICUs/PICUs and HR trained in neonatal resuscitation need attention in almost all states. For instance, community interaction revealed poor knowledge of danger signs among mothers and untimely HBNC visits by ASHAs. Also, critical care units like PICUs are either found overburdened- more than 1 patient per bed or non-functional. In fact, in the state

of Jharkhand, only 1 PICU is functional and it is in RIMS, Ranchi. Early initiation and exclusive breastfeeding remain weak in most of the states visited.

States need to take cognizance of these gaps urgently and take appropriate measures to ensure zero preventable deaths of new-born in order to realize the ultimate Sustainable Development Goal (SDG) for neonatal health i.e. to reduce neonatal mortality to at least 12 per 1,000 live births by 2030.

Key Findings

Breastfeeding: Early & Exclusive

- Overall, community awareness about early and exclusive breastfeeding is found

to be satisfactory. DASTAK Program for breastfeeding and diarrhoea control and establishment of Aanchal Corners for facilitating breastfeeding at public places like bus stands etc. in Madhya Pradesh are few of the noteworthy initiatives to promote breastfeeding in the community.

- However Initiation of breastfeeding within 1 hour is found to be adequately practiced in only some states visited viz. Mizoram, MP, and Odisha. The same is delayed even in private sector as reported by the community.

Kangaroo Mother Care (KMC)

- KMC services varied across states. Well established KMC corners are seen in Bihar and Delhi. In States like Chhattisgarh, Jharkhand, MP, Odisha, TN, Meghalaya and Uttarakhand, KMC is practiced as an essential component of care for Low Birth Weight babies in health facilities, whereas it seemed to be a new practice in Uttar Pradesh.

- KMC advocacy at community level and its services at facility level need further strengthening throughout the country.

Birth dose Vaccination

- Birth Dose is being given in many states like Gujarat, Madhya Pradesh, Manipur, Mizoram and Odisha. Non administration of birth dose after delivery due to lack of cold chain in Sub-centres of Chhattisgarh and updates of its administration in MCP cards are few gaps found in the visit.
- Some states such as Nagaland and Odisha practiced administering birth dose vaccine by clubbing few new-born at common immunization site.

Home Based New Born Care

- Home-based new-born care program is running sub-optimally in most of the states visited. Although the HBNC visits are being undertaken by the ASHAs, the timing and number of visits is not as per the guideline, impacting desired neonatal health outcomes from the program.
- Capacity building of ASHAs in HBNC is required in many states like Bihar, AP, Delhi, Rajasthan, MP, Mizoram and Nagaland. Lack of adequate mentoring & supervisory support by ASHA facilitator / block or district community mobilizer/ANM/District Nodal officers, as reported in Delhi, led to poor detection of LBW or SAM cases by ASHAs during the visits.
- Logistics like incomplete HBNC kit as reported in Bihar and Nagaland and old HBNC Forms as found in Delhi need to be improved.

New Born Care Corner

- Functional New Born Care Corner (NBCC) is found established at all delivery points in most of the states however, placement of the corner, availability of Radiant Warmer and provision of safe electrical supply are few areas of concerns.
- Gaps such as use of lamp in place of radiant warmer in Manipur, non-availability of warmers in Nagaland and lack of awareness regarding

the protocol of using radiant warmer in Mizoram, Gujarat and about new-born resuscitation in Andhra Pradesh are identified.

New Born Stabilization Unit (NBSU)

- Many states had established NBSU services at the facilities but the utilization rate varied across the country. NBSU is functioning well in Manipur, Uttar Pradesh and Tamil Nadu, whereas the functionality of the same is found to be compromised in many states like Jharkhand, Bihar, Madhya Pradesh, Mizoram, Odisha, Andhra Pradesh and Nagaland because of lack of adequate space and training among hospital staff. It is also found that follow-up of the discharged cases is not being done.

Special New born Care Unit (SNCU)

- Special New born Care Units (SNCU) are established in most of the states. While SNCU in Chhindwara is awarded the best SNCU in Madhya Pradesh, a State of the art SNCU is built at Civil Hospital Aizawl, East of Mizoram. The SNCU in Meghalaya is associated with step down nursery and Kangaroo Mother Care Facility.
- Online reporting of SNCU is reported to be in place in Jharkhand, Tamil Nadu, Uttar Pradesh and Uttarakhand. Functionality of SNCUs is being supported by external agencies like EKAM Foundation in Chhattisgarh and USAID in Uttarakhand.
- Follow-up of SNCU discharged new-born needs improvement in many states like Madhya Pradesh, Bihar, Odisha, Rajasthan and Uttar Pradesh.

Recommendations

- Awareness about the benefits of early and exclusive breastfeeding practices needs to be propagated both to the service provider and to the community.
- Service delivery for HBNC by ASHAs, especially number and timings of visits &counselling of mothers about danger signs, diet etc. needs to be strengthened by provision of refresher training to the service providers& regular mentoring by ANM/MO/District officers.
- Regular follow-up of pre-term, LBWs and facility discharged new-born along with coordination with the health facilities.
- KMC practice for low birth babies needs to be propagated.
- Functional NBCC with in-built radiant warmer should be made available in all labour rooms with safe electric supply.
- Capacity building of the medical doctors, nursing and other staff about the protocols and guidelines to utilize NBSU should be done.
- SNCU should be strengthened by - Developing SNCUs as per GoI guidelines and norms.

State Specific Findings

Andhra Pradesh

- New-born care corners (NBCC) are established in all the facilities visited in both the districts except in Area Hospital, Velinduvela, but knowledge of New-born resuscitation among staff members is weak.
- Almost all new-borns received BCG vaccine but Hepatitis B birth dose and Zero OPV doses are

missed out in some areas as well as in Private hospitals(as reported by community).

- None of the Radiant warmer in the health facility visited in Kadapa district had MCB to prevent short circuit. In PHC Mundunur & Area Hospital Velinduvela, warmers are even found connected with an extension cord of 5 Amp.
- Home based new-born care is being done on a regular basis by ASHAS in Vishakhapattnam district. But, weighing of new-born, assessment of new-born about breast feeding, screening for any danger signs etc. are not found in the field. Also, many mothers reported not being aware of the ASHA visits for HBNC and thus lacked knowledge about diet, danger signs in new-born etc.
- Linkages of RBSK, SNCUs, NRCs with DEICS are weak.
- Very high antibiotics usage in SNCUs is seen. Swab culture testing in not done in some SNCUs.
- NBSU also need to be made functional. At few places, though NBSU are functional, due to lack of training and confidence, paediatricians did not use them.
- FBNC (Facility Based Neonatal Care), F-IMNCI (Facility based- Integrated Management of Neonatal and Childhood Illness) training is not given to the hospital staff.

Bihar

- Total 43 SNCUs are functional in the state. A system has been developed in all the SNCUs for facility and community follow up of SNCU discharged babies via whatsApp group which has all the district officials, BCMs and SNCU data operators.
- Six DHs (DH Purnea, DH Sitamarhi, DH Saran, Sheohar, DH Supaul, DH Vaishali and two Medical Colleges (NMCH Patna & ANMMCH, Gaya) declared as 'Bottle feeding free hospitals"
- State had established 10 Bedded Kangaroo Mother Care (KMC) units in 10 districts and 4-8 bedded KMC units in 11 districts indicating satisfactory KMC practice in the state. Also, 185 breastfeeding corners are established in different health facilities across the State to promote breastfeeding and maintain privacy.
- Counselling, Breast feeding Support and PNC to Mothers and New-born through MAMATA initiatives and a separate Kangaroo Mother Care (KMC) area are present at all levels of HCFs.
- Home Based Neonatal Care kit is not available with ASHAs. New-born Stabilization Units are non-functional at block PHCs & RH level.
- Functionality of NBSUs and SNCUs in the state needs supervision as SNCU's mortality rate is reported to be 14% which is higher than National average, though successful discharge rate from SNCU is reported to be 65%.

Chhattisgarh

- SNCU at District Medical hospital is well maintained, all essential components like oxygen, drugs, consumables & records are found in order. HR selection, appointment and trainings are done through EKAM Foundation.
- KMC rooms are functional at CHC & DH, but overall this practice needs strengthening. Similarly, NBCCs are there in some facilities visited, but their utilization is very poor.
- Identification and follow-up of low birth weight and high risk new born is poor in the state.

Delhi

- Comprehensive New-born Screening Programmeis started in the state with a target to cover at least 1.5 lakh births per year.
- National Comprehensive Lactation Management Centre supported by Norway India Partnership Initiative (NIPI) had been started as a pilot project at LHMC for providing mother's milk for premature and sick babies admitted in the Neonatal ward.
- Records are maintained in individual case sheet which is more extensive than SNCU case

sheet record of GoI, which is a good practice seen.

- HBNC isnot being effectively conducted to identify Low Birth Weight (LBW) and sick neonates and HBNC forms are randomly filled by ASHAs.

Gujarat

- Establishment of Breastfeeding corner at public places like bus stand, involvement of RBSK teams for identification, referral and follow-up of SAM children is a good initiative by the state.
- All the facilities visited had a functional NBCC inside the delivery room but is not properly positioned. Also, most of the facilities are found keeping all the new-borns in warmer regardless of indication, indicating the need to train the staff for protocols regarding NBCC and Warmer.
- Early and exclusive breastfeeding is found to be promoted by providers and practiced by mothers. New born are provided with birth dose of immunization.
- SNCU is found to be overcrowded and with about >1 baby per bed, a finding from DH Dahod. Mothers are allowed inside SNCU and are involved in care of new born.
- There is no 'in-born and out-born' demarcation in SNCU which is necessary for better infection prevention. Follow-up of SNCU/ NBSU babies is found to be a weak and needs strengthening.
- Referrals are done for new born admitted to NBSU across all visited facilities and main reason for referral is Low Birth Weight. Refer in, refer out register is not available for NBSU.
- Standard and uniform record keeping formats and registers are not available with the facilities visited. Foot print of the new born is not recorded in all the facilities

Jharkhand

- The home-based new-born care program is monitored through the Sahiya-Sangi portal. Every Sahiya is getting an auto generated code for every baby to be covered under HBNC and their kits are replenished during the meeting with ANM in HSC on third Friday of every month.
- Presently 19 SNCUs are functional in the state. However, all 24 districts still do not have SNCU. The second tier of new-born care services through NBSUs is not available in the state.
- SNCU admissions for Asphyxia / HIE are 31% which clearly suggests poor quality intrapartum care. Also, SNCUs had a very high referral rate (20%). This suggested that many critically sick and small babies did not receive appropriate treatment in the SNCUs and either got admitted in the NICUs in the tertiary care facilities, private NICUs or went home untreated.
- Thus, overall New born care services need to be strengthened in the state as the state doesn't have data regarding SNCUs run by NHM, also the number of beds in existing SNCUs are less as compared to the delivery load responsible for high referral rate of SNCU, overcrowding of NICUs and poor NMR and IMR in the state.

Madhya Pradesh

- DASTAK Program is a good initiative step by the state to increase awareness regarding breastfeeding practices and diarrhoea control.
- Children are breast fed within 1 hour along with birth dose vaccination in the facilities.
- Overall good new born care with HBNC visits done by ASHAs, KMC provided at both the DH of the districts visited, functional NBCC corners at all delivery points.
- Sick Neo-natal Care Unit (SNCU) is well equipped with trained manpower. But some loopholes do exist in new born care in MP as the overall cure rate of SNCU in MP is only 13%. Also, lack of follow up of new-borns discharged from SNCU from DH seen.
- No proper management of new-born complications at lower facilities and all the complicated cases are refereed to district hospital level leading to over burden at DH.

Most of the cases coming in DH are pre-term, pre mature and LBW babies.

Manipur

- Functional NBCCs and radiant warmers are present in the labour rooms in the district. A well-functioning NBSU with sufficient number of trained staff in the district is also available.
- SNCU and NRC are not found in the visited districts and demotivation in the team due to delayed payment of DEIC staff is observed.
- At some places, Radiant warmer/Open care system are found lying elsewhere and unused. State to distribute these equipment to all sanctioned delivery points to ensure their use and adequate new-born care at all the facilities. e.g. PHC Oinem is found using Lamp in absence of a warmer.

Meghalaya

Functional SNCU with good occupancy, Stepdown nursery, and Kangaroo Mother Care Facility is in place in West Garo Hills. No SNCU isavailable in RiBhoi hospital, leading to high referral rate to Shillong.

- The SNCU in District hospital is catering to 21 babies with 15 beds. Out of 20 Staff Nurses in SNCU only 2 aretrained in FBNC; and it provided services to 1,920 babies per year whereas SNCU of other health facility handled only 98 inborn babies over the same period.
- Incorrect strength of Vitamin K1 being procured by the state (10 mg/ml).

Mizoram

- Birth dose vaccinations are given at all delivery points. Breastfeeding initiated within an hour of birth in the facilities.
- State of the art SNCU is established at Civil Hospital Aizawl and has developed strong mechanisms for follow up of SNCU discharged babies.
- A WhatsApp group is created between the DEO at the SNCU, Civil Hospital, Aizawl and the ASHAs in the district wherein ASHAs share the status of the baby post follow-up.
- A Special Clinic for New-born& SNCU Follow up launched on 9th January, 2017. The clinic operates on all working days after the Paediatrician finishes the SNCU ward round. All babies who are born at Civil Hospital, Aizawl due for follow up within 48-72 hours after discharge and Sick newborn babies (in-born) babies upto the age of one month are expected to attend the clinic.
- However, no SNCU is available in DH, Mamit.
- NBCC at delivery points (below the district level facility) are poorly managed and mostly non-functional. Staff is not aware about how to operate the Radiant Warmer (Mamit District).
- HBNC visits are not done on regular basis in Mamit District mostly due to hard to reach areas and poor road connectivity to the community. Also, for the visits done, hardly any referral of sick or LBW new-bornis in place.
- Capacity building of doctors and nurses in ENBC and resuscitation at PHC & CHC is required.

Nagaland

- Early initiation of breast feeding and EBF for initial 6 months found in both the districts visited.
- To prevent vaccine istage, clubbing few new-born at one session site is observed.
- Ninety eight percent of New-born areweighed at birth. The “0” dose OPV coverage is 70% and Birth dose hepatitis B coverage is 68%. The vaccination at birth is poor; this could be improved by coordinating with the nearest ILR point.
- There is an urgent need to strengthen NBSU and NBCC services. Gaps such as absence of NBCC or Radiant warmer at some facilities or lack of training to use them wherever equipment/ infrastructure is present are observed.
- HBNC visits are not regular. Many mothers complained that visits arenot done after the

child birth. Knowledge of ASHAs about the danger signs of new-born, care of LBW or Pre-term babies is poor. ASHA drug kit is not being replenished regularly and poor road connectivity is a big hurdle in performing home visits and referral.

Odisha

- In the hard to reach areas of Odisha it is observed that birth dose is given collectively to a group of new-borns and not individually at the time of birth, irrespective of open vial policy.
- Follow up of babies discharged from SNCUs needs improvement. This list of SNCU may be taken up under 'Mo Sarkar' initiative to accelerate reduction in neonatal mortality.

Rajasthan

- Delay isobserved in initiation of Breast feeding in the LR.
- SNCU beds are not as per delivery load in facilities. Follow up of the low birth babies and SNCU discharged babies is not being done as per the guidelines of HBNC.

Tamil Nadu

- Essential new born care services (NBSU or NBCC as per GoI guideline) are available at all visited delivery points. State has 73 functional SNCUs all reporting through an online platform.
- Neonatal ambulance for transporting the emergency cases of neonates is available in the state.
- Block wise analysis of cause of Infant Deaths is in practice in Villupuram.
- Tele Imaging new initiative (since August 2019) for Retinopathy of Prematurity with Arvind Eye Hospital, Madurai at NICU DH in Virudhunagar (MoU)
- VHNs carried out HBNC visits and screening the mother and new-borns in Villupurum whereas community linkages for mother and new-born in Virudhunagar are sub-optimal.

Uttar Pradesh

- Home Based New-born Care visits are undertaken by ASHA but LBW and SNCU discharge follow-up needs strengthening in district Meerut.
- NBCC with well-functioning radiant warmer are established at all delivery points visited.
- The MCH wing of DH, Bahraich has a well maintained 14 bedded SNCU with trained staff. High percentage of in-born admissions due to neonatal asphyxia and irrational use of antibiotics are observed. Also, no blood culture facility is available at DH of both districts visited.

- Over the last 6 months, 6 neonates are identified with congenital malformation in SNCU of one of the MCH wings. However, no linkages between SNCU and DEIC manager at DH are observed for ensuring tertiary care management of these neonates.
- Still birth reporting and surveillance needs strengthening- for e.g. 25 fresh stillbirths and 41 macerated stillbirths occurred between 21st August to 20th Sept 2019 at MCH Wing, Bahraich. However, no stillbirth reporting forms are being filled neither isthe staff aware of stillbirth surveillance mechanism.

Uttarakhand

- SNCU at CRW hospital is a Family participatory care unit which is being supported by USAID. Delivery points have well-functioning NBCC.
- KMC is observed as an inherent component of care of LBWs in health facilities.
- HBNC visits being undertaken and supervised by ASHAs. But, the coverage is only 41% for the HBNC visits (Completing 7 home visits) in the state.

National Overview: Child Health

Under 5 child mortality has reduced from 69 (RGI2008)to 37 (SRS 2017) due to improved full immunization coverage and timely management of childhood illnesses particularly ARI, Diarrhea, sepsis etc. at the health facility. However, community awareness on use of ORS, Zinc, HBNC visits and timely consultation with health care providers for various illness of their children remains a weak area.

As per NFHS IV, 62% percent of the children aged 12-23 months are fully immunized (BCG, measles, and 3 doses each of polio and DPT). During the CRM visits, it is observed that initiatives like IMI 2.0and other initiatives by the states (e.g. Model Immunization Center in Bihar) have contributed significantly in scaling up full immunization in the community. However, capacity building regarding Cold chain management, Open vial policy, Adverse

Effect Following Immunization (AEFI) management etc. is needed at every level of health system.

During CRM visits, it is also observed that Home based Young child care (HBYC) programme has not been rolled in many states. Growth monitoring at community level and follow-up of malnourished children is an area of concern as well. Though the screening for birth defects under RBSK has improved, the facility linkages with NRC, DEICs etc. are found weak in all the states visited and need to be strengthened to ensure desired health outcomes. The lack of optimal HR, infrastructure, referral transport and specialists are reported to be the major reasons for non-functioning of DEIC in most of the states.

'Poshan Abhiyan' to improve nutritional outcomes for children, pregnant women and lactating

mothers is also found weakly implemented. Though regular Community Based Events are being carried out in states like Bihar, Rajasthan and Manipur, the status and functioning of Anganwadi is inadequate everywhere with lack of basic amenities like cooking fuel, electricity, toilets etc. THR and SNPs supply is also found erratic leading to poor nutritional statuses of the beneficiaries.

Key Findings

Home based Young Child Care Programme (HBYC)

- HBYC programme has been initiated in Manipur and Tamil Nadu, whereas it is under process of implementation in many states like Bihar, Mizoram and Madhya Pradesh.
- Home visits under HBYC though started in Manipur and Tamil Nadu, HBYC cards, job aids and weighing machines are yet to be provided in these states.
- In states like Uttar Pradesh and Delhi, the programme still needs initiation.

Infant & Young Child Feeding (IYCF) & Mothers Absolute Affection (MAA)

- The IYCF programme has been initiated in all the states. However, awareness about complimentary infant & young feeding practices in the community is found to be unsatisfactory and varied across most states. ASHAs and Community are practicing IYCF in Nagaland and Delhi.

Growth Monitoring

- Growth monitoring and reporting is found good in Tamil Nadu and Uttar Pradesh.
- Challenges in the growth monitoring are reported in many states viz. procurement and availability of growth monitoring devices as seen in Manipur, Bihar and Rajasthan, filling growth monitoring sections in MCP Card or ICDS-CAS mobile app due to difficulty in understanding English language in the card/app is reported in Manipur.

Immunization

- Immunization coverage is found to be improved in many states. Special initiatives taken by states have helped achieve nearly 85-90% immunization coverage in those states such as **'Model immunization corner'** in Bihar and **'Tikakaran Nimantran Patrika' in Delhi**.
- In Madhya Pradesh, coordination with rural development programs like Gram swaraj and Extended Gram Swaraj Abhiyan has helped increase the immunization coverage.
- Maintenance of cold chain is proper in almost all the states visited except in Andhra Pradesh, Jharkhand and Madhya Pradesh where it needs further strengthening.
- Electronic Vaccine Intelligence Network (eVIN) is found in place in states like Chhattisgarh, Gujarat, Jharkhand, Odisha and Manipur.
- Open vial Policy is institutionalized in Gujarat, Meghalaya and Manipur. Alternate Vaccine Delivery is in place in Chhattisgarh, Gujarat, Uttar Pradesh and Manipur.
- Adverse Effect Following Immunization (AEFI) Kits are found updated in Chhattisgarh, Gujarat, Jharkhand, Manipur and Nagaland.
- Newer vaccines like Rota Virus are incorporated in immunization schedule of states like Jharkhand, Delhi, Madhya Pradesh and Odisha. Along with Rota Virus vaccine, Inactivated Polio Vaccine (IPV) and Pneumococcal Conjugate vaccine (PCV) are also there in the immunization schedule of Madhya Pradesh.

Rashtriya Bal Suraksha Karyakram (RBSK)

- RBSK screening for all the 4Ds in the new-born is taking place in almost all the states but linkage with higher health facilities are missing in most of the states.
- In Delhi, under 'Chacha Nehru School Health Yojana', medical care is being provided to all paediatric patients for all medical and surgical illnesses.

- As a good practice, adolescent clients for depression, substance abuse and common RH problems are also screened under RBSK in Gujarat.

GHC (DEIC)

- Though DEICs are established in many states visited, they are found functional only in few states like Madhya Pradesh, Meghalaya, Uttar Pradesh and Uttarakhand.
- In states like Andhra Pradesh, Bihar and Manipur, DEIC has been established but not yet functional due to poor infrastructure, non-availability/shortage of Human Resources, lack of DEIC equipment and inadequate training of the available staff members.

Nutritional Rehabilitation Centre (NRC)

- NRC is found functioning well in Gujarat and Odisha. However, overall involvement of mothers in management of child at NRCs, building capacity regarding feeding practices for the child etc. is found to be deficient everywhere.
- In Tamil Nadu and Uttar Pradesh, monetary incentives for hospital admissions into NRC are being given which had increased the utilization of NRC.
- Some NRCs are aided with some external agencies e.g. Bihar and Jharkhand.
- Children are being discharged after 15 days irrespective of weight gain in many states.
- Field linkages for referral and community follow up of discharge cases are found sparse in all the states. Record & documentation need to be strengthened at all the NRCs visited.

Child Death Review (CDR)

- In Gujarat, Odisha and Bihar, child death reporting and its facility-based review are being conducted. However, the review of child death and community level death audits is not taking place satisfactorily in almost all the states.

POSHAN Abhiyan

- Community based events like Upari Aahar Abhyas Diis (UAAD), Annaprashan Diis/God-bharaihave strengthened the Complimentary Feeding Practices in the states as noticed in Bihar, Manipur, Rajasthan etc.
- **Malnutrition Treatment Centres** (CKP) being managed by MSF (Medicine Sans Frontiers) i.e. Doctors without borders is a good practice observed in Jharkhand.

- VHSNDs areregularly being organized at Anganwadi Centres but service delivery in Anganwadi centres is suboptimal due to poor infrastructure and lack of basic amenities such as electricity, clean fuel and water supply. Supply of THR and HCMs is also erratic.
- Gaps are found in the universalization of SNP and training of ASHAs on Early Childhood Care and Education (ECCE) in the states like Bihar and Uttar Pradesh.

Recommendations

- Immediate measures need to be taken to scale up Home based Young child care in all the states.
- Capacity building of AWW/ASHA for Infant and young child feeding (IYCF) and Mother's Absolute Affection (MAA) to be done with regular monitoring by ANM/Medical officer or District nodal officer.
- Assured procurement of GMDs, induction training of AWWs/ANMs/ASHAs to use them and reporting of the growth monitoring data both in MCP card and in ICDS-CAS need to be ensured. Mothers should also be oriented about the various sections of MCP card and its importance.
- Capacity building of ANM, ASHA, etc. regarding all the component of immunization starting from cold chain maintenance, open vial policy, AVD, EVIN and Storage of vaccines to be done.
- RBSK Screening and its linkage to DEIC and NRC need strengthening. Adequate follow-up of screened and referred children needs to be ensured.
- SAM/MAM children need to be monitored both in the facilities and in the communities.
- Child death reporting and review to be strengthened across the country.
- Poshan Abhiyan which involves coordination of PRI, Health workers and the community should be strengthened and utilized to disseminate information regarding various other health programs, family planning, adolescent health etc.

State Specific Findings

Andhra Pradesh

- Awareness about importance of breastfeeding and immunization is found adequate among the community, ASHAs and ANMs. Almost all new-borns received BCG vaccine
- Excellent District Early Intervention centre (DEIC) and Nutrition rehabilitation center (NRC) seen in the state.
- Cold chain is well maintained and vaccines are arranged as per the protocols in the facilities visited. Temperature charts are maintained well. Open vial policy is not being implemented yet.
- RBSK Screening of 4Ds in the community is found adequate but its linkage with the tertiary level facility is weak.
- Data available with ANM is not updated. State may be recommended to reintroduce ANMOL.

Bihar

- Immunization, AVD and Cold Chain Maintenance is functional. HBYC and MAA training has been conducted in 24 batches of 635 ASHAs. DM also held meetings with private schools to improve their participation in National Deworming Program.
- About 770+ Mobile Health Teams (MHT) comprising of AYUSH doctors, ANMs, Pharmacists are working under RBSK. A hospital coordinator is deployed at tertiary healthcare institution to ensure proper f/u and treatment of the referred cases.
- State has rolled-out Model Immunization Corner for increasing immunization coverage. Weight measurement, Blood pressure measurement, distribution of IFA tablets, contraceptives and counselling etc. are the additional services provided by these corners to the population.
- Average Bed Occupancy Rate (BOR) in NRC is 56.9% and average successful discharge with target weight gain rate/ Cure rate is 73% in 38 functional NRCs. All four follow

ups are conducted for 52.7% of the children discharged from NRCs.

- Poshan Abhiyan- Upari Aahar Abhyas Diis (UAAD), Annaprashan Diis/God-bharai has strengthened the Complimentary Feeding Practices in the State.
- THR & HCMs are provided to the beneficiaries under Anganwadi Services Scheme, but the quality of food is compromised. Also logistics like examination table, curtain stands and footstep to support and maintain the privacy of pregnant women during ANC are not available at the AWCs. Lack of electricity, running water and cooking fuel are other issues observed.
- Expired adrenaline injections are found in AEFI Kit at DH & Blood Bank. No investigation of AEFI Deaths is being done and AEFI Kit is not available with field level vaccinators. State has collaborated with AIIMS Patna as an AEFI Technical Collaborative Centre, to address these concerns.
- Out of 9 approved DEICs, only 4 are partially functional at Muzaffarpur, Bhagalpur, Gaya and Saharsa. Also at DEIC, Bhagalpur, only few cases of cleft lip and clubbed foot are being managed as equipment as per DEIC guideline and HR are not available.

Chhattisgarh

- Immunization services are found to be good in the state. eVIN, AVD are functional with updated AEFI Kits.
- **NRC**: Regular visits are not done by the doctors. Irrespective of weight gain, the patients are discharged after 15 days. No DEICs found in the state.
- **RBSK:** Total 12 teams are working in Korba and 21 teams in Rajnandgaon.
- No Child death reporting or review is observed in the state.

Delhi

- State has a very good initiative to control diarrhoea through establishment of 955 Zinc-

ORS corners across facilities and ORS packet distribution in 9 lakh houses in 2019.

- "Essential Childhood Immunization" Programme has been initiated at more than 600 health facilities.
- BRIDGE {Boosting Routine Immunization Demand Generation} training to improve IPC skills of front-line workers is nearing completion in most of the districts.
- Tikakaran Nimantran Patrikais introduced for informing parents of children due for immunization by ASHA worker a day prior to immunization session.
- Family planning counselling at the time of vaccination is also done as a good practice.
- RBSK is not functional. However, a state scheme called "Chacha Nehru School Health Yojana"is functional under which medical care for all paediatric related medical and surgical illnesses is provisioned.

Gujarat

- The state has established TECHO+ for reporting and review of new born deaths.
- All the facilities visited had functional ILR, E-vin and deep Freezer with designated staff responsible for maintaining the temperature and log books. Staff handling the cold chain is well versed with the vaccine storage protocols. There is a system of transporting the vaccines to nearby facility in case of longer power cuts or failure.
- Micro plan for MamtaDiisis available and TECHO is used to generate workplan as well as list of pregnant women and children for immunization.
- State has partnered with *Amul co-op.* in Anand for supply of specially designed THR for ANCs and adolescent girls. Supply chain upto end users has been well established throughout the state.
- Well-functioning RBSK programme with inclusion of screening of adolescent clients for depression, substance abuse and common RH problems is found to be a good practice.
- For nutrition rehabilitation, three tier approach is adopted. At district level, NRC is established at DH while at taluka level 11 CMTCs are established. At community, C-MAM caters to cases of SAM. Cure rate among NRC beneficiaries, this FY, however is 31% (decreased over last 2 years), hence capacity building of the mothers to prevent malnutrition at home is felt urgent.
- Many AWCs operate from rented buildings or AWC worker's houses; especially in tribal and remote blocks. Basic amenities like functional toilets, hand ishing stations are not available in some centres. Weighing scale is not available in AWCs visited in Dahod district.

Jharkhand

- A unique model of effective linkage between facility and community-based management of malnutrition in the form of Malnutrition Treatment Centres (CKP) being managed by MSF (Medicines Sans Frontieres) i.e. Doctors without borders is found in the state. The state has 96 Malnutrition Centres with 1175 beds and a bed occupancy rate of 60%.
- Reporting of child deaths as well as reviews is very poor in Jharkhand. Last year 192 child deaths are reported in Gumla and 298 child deaths in West Singhbhum, however only a negligible number of deaths are reviewed.
- RBSK Screening is limited to information collection and basic anthropometry readings without record keeping. DEIC is not available in the state.
- No PICU in the state except at RMIS, Ranchiis available.
- Cold Chain at all levels is well maintained with all Deep Freezers and ILRs connected through EVIN. Temp log books well maintained. However, AEFI awareness is poor.

Madhya Pradesh

- Mission Indradhanush is implemented under Gram Swaraj Abhiyan (GSA) and Extended Gram Swaraj Abhiyan (EGSA) (404 villages covered under GSA and 8 districts covered under EGSA). During the six phases of Mission Indradhanush, 25.68 lakh children and 7.51 lakh pregnant women are vaccinated including GSA and EGSA.
- State is urged to initiate HBYC training for ASHAs/ASHA Facilitators/ANMs at the earliest and ensure physical copies of HBYC training resource material.
- Cold chain is not maintained properly at delivery points. AVD plan needs to be revised. Presently, number of AVD persons very less.
- Vaccine stock registers and temperature of ILR and deep freezer are not updated regularly at CHC Mundi. AEFI cases are not being detected.
- Detailed RI micro-plan is not available at the district and block levels.
- There are no DEIC units in both the districts visited. RBSK screening for visible birth defects in new-borns during home visits by ASHAs

(using revised MCP card) and prompt referral to District Early Intervention Centre (DEIC) need to be ensured in the state to reduce IMR & U5MR.

Manipur

- Immunization services are really good with regular meetings. AVD, Open vial policy, eVIN is in place and supportive supervision is being provided by UNDP.
- Zinc tablet and ORS at periphery level for diarrhoea management is observed in the state. The birth dose among new-born within 24 hours of birth is being administered at health facilities visited.
- 2 RBSK mobile health teams (MHTs) are in place for screening but follow up of referred cases is poor leading to no information of the quality of services provided and OOPE incurred, if any. Significant delay in payments of RBSK staff at DEIC at Bishnupur district are also noticed.
- Awareness regarding availability of free of cost transport facilities for the sick child up to the age of 5 years is missing in the community.
- Poshan Abhiyan- AWs are either running in the house of AWWs and those that are not, are in dilapidated state with no toilet and cooking facilities. Sub-standard Growth monitoring isobserved due to lack of equipment such as infantometer, weighing scale and stadiometer.
- Issues of lack of supply of kerosene, THR, or other supplementary nutrition items to AWs for many months is observed, impacting provision of HCMs or THR to the beneficiaries registered.
- Training for ASHAs and HBYC home visits started this year, however no HBYC cards, job aid and weighing machines are provided until the visits.

Meghalaya

- Vaccines are available & properly stored, open vial policy is followed, AEFI kit is available.
- Cold chain is maintained in facilities visited. But, poor electricity supply and power back up is found in district RiBhoi, impacting cold chain.
- Functional DEICis present in MCH hospital (West Garo Hills) with proper utilization. Screening of children and adolescents is conducted under the program by trained teams.
- Only 3-4 bedded NRC seen in both districts. Also, due to paucity of funds to provide meals, children are discharged before full treatment.
- Awareness and Counselling on Child growth, Breastfeeding, nutrition being done by AWWs and ASHAs.
- AWCs lack separate room for examination of pregnant women and proper seating arrangements and toilet facilities for beneficiaries and children (West Garo Hills and Jaramani- RiBhoi). 100% procurement of GMDs (Growth Monitoring Device) used by AWWs isseen.
- In-spite of having well established health system, immunization coverage is found to be low. State can try utilization of the HAAT Bazar for delivery of Immunization and other health services.
- RI Micro planning is not available as per guidelines at some instances. Left out & drop out tracking needs to be strengthened to improve full immunization coverage in district.

Mizoram

- All ASHAs (i.e., 69 ASHAs), health workers at Sub Center, and 15 Anganwadi Workers under Mamit District received training under HBYC.
- RBSK screenings at the field level are as per the micro plan in both the districts; however birth screenings have not been initiated adequately.
- Immunization, cold chain, alternative vaccine delivery arrangements, training in AEFI and training are in place in both the districts.
- POSHAN Abhiyanis running well with no vacancies. CBEs are conducted regularly like inviting women in the first-second trimester of pregnancy, Annaprashan Diis, Suposhan Diis etc.
- The AWCs are well maintained with hygienic kitchen, baby friendly toilets, well displayed IEC and availability of ECD kits. GMDs such

as weighing scale, stadiometer etc. are also available.

- The AWWs are well versed with the ICDS CAS software on their phone and could easily monitor the nutritional status of the child using GMDs for recording and reporting.
- VHSND is regularly celebrated at the AWC (every month). Counselling of pregnant and lactating mothers on Nutrition, complementary feeding and Health Promotion is done by the AWW.
- The hot cooked meal (majorly chana, dal-bhaat, khichadi, potato, egg) and take-home ration (rice, mater-chana, red- masoor) is made available to the beneficiaries.
- The mothers are visiting the AWC regularly (almost daily) and are aware about the concept of growth monitoring of the child.
- The AWW maintained good rapport with the community and also informed the parents about the status of child nutrition (whether the child is malnourished).

Nagaland

- The focus of child health seems to be only on immunization – even when the child is coming to the MCH clinic, there is no follow up on the child's growth.
- Fever followed by vaccination is found to be a major concern among tribal communities leading to missed out children from vaccination. To avoid the missed outs, ASHAs and ANMs announce the date of vaccination and other events in the community through mic and churches one day before and on the morning of the scheduled days. But missed out children are not being followed.
- RBSK team is not available in all the blocks, only one RBSK team is in place for 3 blocks. Lack of coordination seems to be a major issue as the monthly tour plan prepared by the RBSK team is shared with the state officials, CMO, CDPO and school inspectors but local health centres (PHCs and SCs) are not at all aware about the visit of MHT in their respective areas. Most of the referred cases are not visiting the facilities.
- Screening of SAM/MAM children is not being done by RBSK as well as AWWs. State has only one NRC at Kohima.
- Growth monitoring of children isnot done by Anganwadi Workers (AWWs). Data is not being updated on ICDS-CAS mobile application, as it is in English and difficult to understand.
- Issues related to AWW training, timely distribution of THR, quality of food being served and poor infrastructure of AW are seen.

Odisha

- Child deaths are being reviewed however, autopsy quality needs improvement. Action taken based on CDR should be monitored at the highest level and be on the dashboard of CM and HS.
- Growth monitoring in the community needs follow- up for weight gain.
- School health programs are being addressed through RBSK teams and Mobile health units. In Kandhamal, each block has one mobile health unit, through state initiative, visiting each school twice a month. However, in Mayurbhanj it is being done in collaboration with RBSK team.

Rajasthan

- Most of the AWWs have been trained in use of ICDS-CAS, growth monitoring devices. But shortage of GMDs is seen, leading to poor distinction between SAM and Underweight children.
- THRs/ HCMs are being provided by Self-help groups. However, the supply of SNP is erratic in some blocks, e.g. in the Taranagar block THR had not been supplied since the past 7-8 months.
- Regular visits to the schools have been conducted by the RBSK team for regular health check-ups but there is a waiting list for CHD surgeries.

- Data validation is required in the State as IMI is planned in 32/33 districts but the full immunization in RI is 80%.
- Community Based Events like Annaprashan and Godbharai are being organized per month by the AWWs in all the Anganwadis visited.
- None of the AnganwadiCenter had functional toilets, kitchens, cooking fuel, electricity or drinking water neither it had any place to maintain the privacy of women during the examination at the time of Maternal and Child Health Day (MCHN/VHSND).

Tamil Nadu

- Separate Male and Female RBSK teams arefound active in the field and conducting screening of children at AWCs and Schools.
- Hygiene Kit consisting of Hand Towel, Soap, Comb and Baby Nail Cutter are provided to all AWCs every year. The kit is procured through Tamil Nadu Medical Service Corporation.
- Both districts have well established PREM (Paediatric Resuscitation & Emergency Management Unit) at DHQ and staff is also aware about clinical/ treatment protocols. KMC / Breastfeeding ward is operational at DHQ in both the districts
- Open vial policy is in place in Villupurum. No Vaccine stock-out observed in both the districts.
- Poshan Abhiyan- Procurement of Smart phone and GMD done. Community Based Event (CBE) and VHSNDs are regularly being conducted and ILA training has been completed for 1-16 Modules at State Resource Group (SRG) and District Resource Group (DRG) level.
- Biannual deworming of the beneficiaries in the community done through the AWWs with the Support of VHNs in the field level for reduction of anaemia prevalence.
- Eggs arebeing provided to beneficiaries. Also, Double Fortified Salt, Palmolein oil fortified with Vitamin A & D is supplied to AWCs. Also, Health check-ups are performed periodically by PHC medical officer at AWCs.
- DEIC isnot fully functional at Virudhunagar, gaps observed in terms of required trained staff, shortage of equipment is seen. No Digital Weighing Scale observed in any of the facilities visited in Virudhunagar.
- Still birth/Infant deaths/Child deaths records are neither maintained nor reported.
- AWCs infrastructure varies in the state ranging from very well equipped centres to one with no electricity or proper infrastructure. Also, components of ECD in the MCP cardare not explained to the mothers, Growth monitoring is not being done in the MCP card.

Uttar Pradesh

- EDL drugs for new-born and child health is available across all facilities.
- The coordination of efforts between ICDS, PRI and Health frontline worker on field in UP is much appreciated. The ANM and ASHA are aware about growth monitoring chart, NRC services, SAM and MAM children.
- Overall immunization servicesare good- All vaccines are available during session, RI micro plan is in place, 4 key messages after vaccination are given and functional Alternate Vaccine Delivery (AVD) is in place. AEFI kit is available with the ANMs at the vaccination site visited.
- RBSK Mobile Health Team doctors are well versed with screening protocol and are conducting regular screening visits to schools and AWCs. Mobile application is used for filling up screening data with photographs of children identified with any of the 4Ds.
- Good quality of care is observed in the NRC, with good follow up rate. However, the Bed Occupancy rate is low.
- KMC and Breastfeeding roomis functional at CHC Nanpara, CHC Motipur and MCH wing Bahraich & Meerut. Most mothers are seen initiating breastfeeding within 1st hour of birth.
- Poshan Abhiyan- Apart from conducting 2 CBEs under Poshan Abhiyan, the state is conducting three more CBEs every month. However, the

incentives to AWWs for the same are not being paid in time in Bahraich, rather the AWWs are asked to pay the expenses from their pockets and get it reimbursed later. Mainly 'Annaprashan' and 'God Bharai' are conducted. Also, the Block and District workforce for Poshan Abhiyaan are still not in position.

- Enumeration on CAS portal of the families eligible for THR is very slow and Aadhar linked, leading to many families or children not getting THR in both districts.
- Identification and management of children with health condition requiring tertiary care management is very low under RBSK. DEIC is not established in either of the districts.
- Low immunization coverage isseen in the state- vacant positions of ASHAs being main reason.

Uttarakhand

- There is an NRC at Mela Hospital (District hospital) but has poor infrastructure. It is observed that despite high number of SAM/ MAM cases in the state, the community referrals to NRC are low since duration of stay of 14 days for mothers is an issue.
- RBSK screening is found to be adequate but linkage with NRC and DEIC is found to be weak. Haridwar district has well-structured RBSK programme with 15 mobile health care teams. The programme has enrolled 1043 schools and around 1.6 lakh children are covered under it.
- The immunization coverage is found to be satisfactory. Cold chain is maintained in the districts visited.
- Community referral to NRC is found to be extremely low.

National Overview: Adolescent Health

Adolescents form an important link in the chain for continuum of care. Healthy adolescents are not only the future parents but also a major contributors to the growth of the country. Thus, their overall good health remains an important focus under the RMNCH+A program. Every state reported various initiatives to meet the health care needs of the adolescents such as WIFS (Weekly Iron Folic Supplementation), AFHC (Adolescent Family Health Clinics) and Peer Education Program.

Currently in the country there are 7495 Adolescent Friendly Health Clinics (AFHCs), 39.6 million adolescents are covered under WIFS program, there is a fleet of 2,20,000 Peer Educators.

The Percentage of out of school adolescent girls aged 10-19 years provided with 4 Iron and Folic Acid (IFA) tablets at Anganwadi Centre has increased from 12.10% (2018) to 21.36 % (2019). Similar increase is seen in case of boys.

However, approach of the states for a well functional Adolescent health programme as envisaged under the RMNCH+A strategy remains inadequate. The Adolescent Friendly Health Clinics (AFHCs), though are functional in some states, are mostly underutilized owing to lack of adolescent friendly environment and community awareness.

Supplementation of Weekly Iron Folic Acid (WIFS) in schools has gathered pace in many states. But, lack of interdepartmental coordination between Health, Education and WCD resulted in poor reporting under WIFS program**.** Menstrual Hygiene Scheme has also been implemented since 2011. Many of the states visited by CRM have showed the implementation of the program. However, poor quality of sanitary napkins and its skewed distribution under Menstrual Hygiene Scheme is another consistent finding from the field visits.

Awareness of the community and even grass root health workers like ANM and ASHAs to promote healthy lifestyle and discuss about reproductive and sexual health remains low both in priority and knowledge. Some community and even health workers still feel taboo and moral stigmas to discuss and educate the adolescent about the reproductive health. However, the launch of Peer group and educators initiatives has helped break these barriers in most of the states.

The states must take active measures to address the healthcare concerns of its adolescent sub-group and generate higher community awareness via IEC / BCC activities; celebration of Adolescent Health Day at village level on fixed days, capacity building of PEs and strengthening linkages with Anganwadi centres, schools and other facilities.

Key Findings

Community Awareness

- Awareness and knowledge amongst adolescents about common health problems e.g. nutrition, healthy lifestyle, age of marriage, menstrual problems, acne, teenage pregnancy & associated risks, emotional & psychological issues is suboptimal in most of the states visited except Delhi.
- Substance abuse among adolescents is reported in few states like Uttarakhand, Mizoram, Manipur and Meghalaya.
- Despite good number of PEs in the field, the knowledge about GOI's or State's initiatives for adolescents such as AFHCs or the bouquet of services offered therein is poor in the community and hence, wherever present, these clinics are highly underutilized.

Service Delivery

- **Adolescent Friendly Health Services**-AFHCs are operational in Bihar, Delhi, Gujarat, Jharkhand, Meghalaya, and Tamil Nadu. Delhi is providing AFHS under the name of DISHA clinics which provides AFHS every Tuesday between 2 – 4 PM.
- **WIFS**- In states like Jharkhand, Manipur, Tamil Nadu, Meghalaya, Rajasthan and Uttar Pradesh Weekly Iron Folic Supplementation are provided to adolescents every month in the community or in the school via either ANM/ASHA or School teachers. Deworming activities are found functional in Rajasthan and Tamil Nadu.
- State funded program (Kishori Suraksha Yojana) has been implemented in Uttar Pradesh but the scope is limited to only school going children leaving a large population uncovered and hence, limiting their knowledge and skills on menstrual hygiene management. Tamil Nadu also has its own state run scheme in place for all adolescent girls.
- Sanitary napkins are being distributed in many states visited except Jharkhand, Manipur and Nagaland, but the quality of the napkins is a concern everywhere as reported by the adolescent girls. Menstrual Hygiene schemeis not functional in Chhattisgarh& Jharkhand.

IEC/BCC Activities

- Some states have launched initiatives to address adolescent health issues of anaemia or Menstrual Hygiene. For example- **Delhi has launched Udaan- "UDAAN"**- a Menstrual Hygiene Scheme for out of school Adolescent girls to promote menstrual hygiene. It also conducts **Test, Teach and Treat (T3 camps)** for detection of anaemia in schools and colleges. Similarly, Meghalaya has launched innovative initiatives like Quiz, Zumba, Brand ambassador and Road shows as the medium of spreading awareness regarding adolescent health.
- In Jharkhand, **Ekjut Foundation and Centre for Catalytic for Change (C3)** is found doing excellent work in creating awareness on RKSK in the community.

Recommendations

- States should focus on creating awareness in the community through robust and frequent IEC/BCC activities regarding Adolescent Health Care needs and services available in AFHCs.

- States should strengthen their referral networks in promptly providing AFHS and decreasing potential barriers in availing these services at end users level.
- States should take steps for training of manpower and delineate clear roles and responsibilities for the staff members for effective implementation of RKSK at facility level.
- Record keeping of services provided in facility and outreach needs to be improved.
- Flipcharts and specific area wise counselling points need to be made available at all the health facilities.
- States should ensure that the service delivery of AFHCs is available for every adolescent.
- Parents needs to be involved as stakeholders in the implementation of RKSK. Counsellors can also be used to inform and counsel parents during outreach activities.
- Institutional and community sensitization on gender, respect and dignity to the women, gender based violence, gender sensitive toilets, washrooms, security cameras in the institution and schools, sensitization of the teachers and the staff are some of the recommended steps to curb the cases of sexual violence.

State Specific Findings

Bihar

- Weekly Iron and Folic acid Supplementation (WIFS) Programme islaunched in the State in January 2019. All 38 districts are being covered under WIFS Programme.
- 206 AFHC are functional in the State. Peer Education Program is being implemented in 69 Blocks of 10 RKSK districts. The state selected total 17270 PEs, from which 13766 PEs are trained.
- AFHC is found non-functional in both the districts visited. The enrolment of Adolescent girls in the AWCs also needs immediate action to improve adolescent health status in the state.

Chhattisgarh

- Adolescent health activities have rolled out of RKSK in terms of AFHC establishment, Peer Educator identification and selection, Peer group training are not seen at any level.
- Awareness and programme implementation of Menstrual Hygiene is not seen.

Delhi

- Total 17 DISHA clinics established in North East& North West district.
- “UDAAN”- Menstrual Hygiene Scheme is implemented for out of school Adolescent girls to promote menstrual hygiene. Line listing of all such adolescent girls is maintained by the AWW and ASHA. The scheme provides sanitary napkins at six rupees per packet through ASHAs.
- Special initiatives in form of Test, Teach and Treat (T3 camps) have been taken up for detection of anaemia in schools and colleges.
- AFHC Clinics awareness is poor in the community and clinics are not functioning well either.

Gujarat

- Facilities have trained medical and paramedical staff on adolescent friendly health services.
- Surat is a non PE district. However, it still has adolescent clinics established at facilities up to CHC level.
- In PE districts, Peer Educators are selected and trained but do not have necessary skills to conduct village level sessions with other adolescents. State lacks an established support system for mentoring the PE post training, which is critical.

Jharkhand

- Awareness and knowledge at the community level regarding WIFS and Albendazole is found to be good.

- Ekjut Foundation and Centre for Catalytic for Change (C3) are doing excellent work in creating awareness on RKSK in the community as seen in West Singhbhum district.
- The AFHCs have been set up across majority of the DHs and CHCs. The clinics are well maintained, with prominent display of IEC material, proper seating arrangement, clean drinking water and necessary equipment and supplies.
- The menstrual hygiene program has taken a back seat in the state. Adolescent girls reported incurring OOPE in travelling to the clinics and purchasing drugs prescribed there.
- Training of peer educators is lacking in West Singhbhum and only 25% of peer educators have been trained. Referral linkages, especially to the de-addiction centresare missing.
- AHDs are organized quarterly- contraceptives are distributed on AHDs but not sanitary pads.

Madhya Pradesh

- Weekly AFHCs are established at higher centres with referral to medical colleges of Jabalpur.
- ANMs are found providing counselling sessions to adolescent girls on VHNDs on Nutrition and adolescent related concerns. But overall, adolescent health program needs more focus in the state.

Manipur

- Drug de-addiction treatment centers are functional in some CHCs in view of high rate of substance abuse in the state.
- School going Adolescent boys and girls are getting weekly IFA tablets by their class teachers in their School, but private schools and out of school girls are not covered under the scheme.
- AFHC are underutilized in the state. Also, free supply of Sanitary Napkins to Adolescent Girls is not being done.

Meghalaya

- Innovative activities like Quiz, Zumba, Brand ambassador and Road shows organized in state for creating awareness among community regarding adolescent health issues. PEs are in place too.
- Weekly Iron Folic Acid Supplementation is being implemented in schools and AWCs.
- AFHC with a motivated counsellor is functional in CHC Selsella (West Garo Hills).

Mizoram

- AFHC Counsellors are posted in DHs in both the District and CHC Kawrthath at Mamit District. District RKSK Coordinator is in place in Mamit District.
- IFA tablets are given to the Adolescents at school under the WIFS.
- District has selected PEs but Adolescent Health component at community level is found to be lacking. The role of the PE and ASHA in community mobilization for adolescent health has been negligible.

Nagaland

- The concept of adolescent health is absent at the community level. No PEs are seen, nor are any Adolescent Health Day at VHND reported by the ANM / ASHA or by the community.
- Menstrual hygiene is not discussed because of stigma. Sanitary napkins supply is not initiated at district level.
- Rise in HIV+ cases amongst adolescent girls is a concern.

Rajasthan

- WIFS- IFA tablets are given to adolescents every Monday of month. Sessions by ANM, ASHA and even RBSK team are conducted with the adolescents on anaemia, its symptoms, importance of deworming and family planning.

- ARSH clinics, counselling corners or health check-up points for adolescents are not observed in any of the HCFs visited. Sanitary napkins are provided in the school but areof poor quality.
- Early marriages are common and all the adolescents wanted to get married by the age of 23-24 years. Few adolescent girls are even found engaged and are to get married by 18 years of age.

Tamil Nadu

- Adolescent girls and boys are aware about the importance of nutrition, physical exercise and menstrual health issues.
- Three packs of Sanitary napkins are being regularly provided to adolescent girls once in two months in Villupuram District whereas in Virudhunagar district it is distributed through a vending machine for school going girls and through AWW for out of school girls.
- WIFS is found operational in the School and at AWC and covered even out of school and private school going girls in both the districts.
- Virudhunagar (a PE district) has not selected and trained Peer educators.
- Adolescent Friendly Health Clinics are grossly under-utilized in both the districts (client load < 50 per month). Equipment and commodity is found in place however family planning commodities are not displayed properly.
- No standardized printed registers for WIFS and AFHC areavailable.

Uttar Pradesh

- Peer educators programme has been rolled out in 25 HPDs. State has established 348 AFHCs, out of which 92 are at DH and 256 at CHC with dedicated AH counsellors at majority of the places.
- WIFS programme is well implemented at school and at AWC level. Records are properly maintained, however, AWC is catering only to the out of schoolgirls between the age group of 10-14 yrs.
- State is implementing MHS programme (Kishori Suraksha Yojana) from state budget under which- only schools going adolescent girls are currently being covered leaving out of school girls and limiting their knowledge and skills on menstrual hygiene Management.
- Quarterly Adolescent Health Days are being conducted at SC level along with Peer educators, adolescents and caregiver participation. Thematic calendar is in place for conducting AHD.
- Poor linkages between community and facility based adolescent health services is observed. In spite of huge number of PEs in the field, the client load at AFHCs still remains a challenge.
- It is observed that counsellors lack skills and confidence to talk on the issue such as reproductive and sexual health, mental health and sexual abuse.

Uttarakhand

- RKSK unit is in place in most of the facilities. 7 AFHC are operational in District Haridwar.
- PE training is also taking place in the community but the adolescent girls are not aware of menstrual hygiene, safe sexual practices, HIV-AIDS.
- Sanitary napkins supply is erratic and are of the poor quality.
- Adolescent boys are indulged in substance abuse, which leads to high level of associated crime like theft, domestic violence etc.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व्यक्तियों की Sugar & B.P
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TOR 3
NON-COMMUNICABLE DISEASE CONTROL PROGRAMME

National Overview: National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) is launched in 2010 in 100 districts across 21 states with an objective to prevent and control major Non Communicable Diseases. The programme is scaled up in a phase-wise manner and now covers all the districts across the country. The focus of NPCDCS is to enable opportunistic screening for common Non-Communicable Diseases at District Hospital and Community Health Centres level, through the setting up of NCD clinics. The prevalence of Hypertension ans blood sugar has been varying across the country, highlighting the necessity of service delivery for NCDs. Prevalence of hypertension ranges from 4.2% (Chhattisgarh) to 23.1% (Nagaland) in males and from 5.9% (Chhattisgarh) to 16.0% (Nagaland) in females. Prevalence of high blood sugar ranges from 5.7% (Rajasthan) to 10.7% (Odisha) in males and from 3.5% (Rajasthan) to 8.6% (Mizoram) in females.1

However to expand the services and bring them closer to the community, Universal Screening of common Non-Communicable Diseases is launched in the year 2016 which included the screening of individuals of 30 years and above age group for five common Non-Communicable Diseases (NCDs) i.e. Hypertension, Diabetes, Cancers of the oral cavity, cervix and breast. The key components of this initiative include population enumeration, assessment of risk factors, mobilizing communities for screening at sub centres/Primary health centres in rural and urban areas, health promotion, initiation of treatment at a Primary Health Centre, and follow up at household level to ensure treatment compliance.

Universal screening of common NCDs has been envisioned as a step to expand the range of services to be delivered under Comprehensive Primary Health Care, and envisages that risk assessment, screening, early detection, referral and follow up for common NCDs amongst all women and men aged 30 years and above; is to be included in the service to be delivered as a part of CPHC.

Under NPCDCS, “NCD clinics” are established at CHC and District Hospital to provide comprehensive care of patients referred by lower health care facilities as well as of those reporting directly. Here the examination of individuals is conducted for ruling out complications or advanced stages of common NCDs. Screening, diagnosis and management (including diet counselling, lifestyle management) are key services provided at this level.

This section summarizes the CRM findings from the states visited during thirteenth CRM in October

1 Source: NFHS-4

2019, with regards to rolling out of Universal screening of common NCDs and overall status of NPCCDS.

Key Findings

Human Resources and Capacity Building

- Human Resource shortfall is reported across the states, where absence of NCD clinic manpower is adversely impacting the service delivery at the secondary level of health care facilities. In states like Andhra Pradesh, Gujarat and Odisha, adequate manpower is reported at the NCDs clinics but is being either underutilized or are deployed to other NHM initiatives, thus hampering the functions of NCD clinics.
- The National Guidelines on Prevention, Screening and Control of common Non-Communicable Diseases strongly emphasizes the need to provide information and training to four cadre of Health workforce i.e. ASHA, MPREGNANT WOMEN/ANM, Staff Nurses and Medical Officers. It helps them acquire the skills, knowledge and attitude to make them competent to undertake activities related to Universal Screening of common NCDs.
- Most of the states reported that training on NCDs is completed for the health care workforce in the districts visited during thirteenth CRM; however, in states like Uttar Pradesh, Nagaland and Madhya Pradesh, the health workers are not trained as per the training guidelines, and the training duration is shortened thus leading to content overload. Bihar reported completion of training of District Nodal Officers on NCDs, and is yet to initiate the training of sub district health workforce including ASHAs and MPREGNANT WOMEN/ANMs. It is observed that ASHAs and MPREGNANT WOMENs are trained separately on NCDs and there is no joint training planned at the district level. The field findings also indicate a need of refresher training for frontline workforce on recording and reporting formats including CBAC.
- Whereas the training on NCD module is either completed or planned and in progress in the states, Tamil Nadu and Odisha have also initiated training of the health care service providers i.e. Staff Nurses and ANMs/ MPREGNANT WOMENs(F) on Visual Inspection using Acetic Acid (VIA) to be used for Cervical Cancer Screening. However, the training duration is not as per the national norms of ten days; and is condensed to a shorter duration, for eg. In Odisha it is a six days training.
- One key issue emerged during the CRM with regards to training is posting of trained resources to other departments, which not only is draining the resources, but also limits capacity of the trained personnel to contribute to the system utilizing the upgraded skills. In addition, it also needs additional efforts from the system to train new personnel again and thus resulting in loss of resources in training and handholding.

Health Promotion and Community Mobilization

- Promoting healthy behaviours to effect lifestyle behaviour changes, is critical for prevention and control of chronic disease conditions like Non-Communicable Diseases. Health promotion is an integral part of the Universal Screening of common NCDs, and enabling community to take control over their health and adopt healthy life style is one of the key roles of front-line workers and service providers across the levels of health care.
- The health promotion does not only include the display of IEC messages across the facilities, but majorly involves community mobilization. Community mobilization is a key strategy to generate demand for health care services within the community and also help individuals to identify their own health care needs and respond to it.
- The state findings indicate a need to focus more on community awareness and designing the community's efforts more effectively in order to achieve desired health outcomes.
- Information, Education and Communication (IEC) is a proven effective tool for bringing positive changes in community's behaviour and attitude towards healthy life style practices and health care seeking behaviour. It defines the need of the population, and plays a pivotal role in generating awareness and promoting healthy life style.
- In Tamil Nadu, Rajasthan, Nagaland, Madhya Pradesh and Delhi, CRM teams observed that the IEC material is adequately present and well displayed at the facilities. From community's perception, IEC material with more pictorial representation is identified as more useful and preferred over text heavy posters. In Uttar Pradesh, IEC material is well displayed at the district level facilities, but not at the facilities below. Teams' observations have reflected that posters are displayed across the facilities in most of the states, whereas in Andhra Pradesh and Bihar limited IEC is reported and hardly any posters are observed. Overall findings from state indicates a need to focus on strengthening

of IEC activities. Looking at the extent to which IEC can effectively enhance community's knowledge, states like Jharkhand which at present do not have adequate IEC activities may integrate this component in existing NCD programme.

- Community awareness is a crucial aspect of preventative healthcare, and improves the attitude of the community towards health care services which is much needed for prevention and control of NCDs. In most of the states visited, community did not know about the NCDs and its associated risk factors. Only in states like Tamil Nadu and Delhi, awareness regarding Hypertension and Diabetes is high; however, awareness regarding Cancers is more in Urban areas than rural areas. The awareness regarding NCD diseases conditions is limited to Hypertension and Diabetes, and in states of Uttarakhand, Rajasthan and Nagaland community is unaware of the other NCD services being provided at the health care facilities. In these states, it is observed that individuals did not know where to avail services related to NCDs other than Hypertension and Diabetes, and are seeking care from private health care facilities/ providers. In Tamil Nadu, AYUSH integration is observed where Yoga and Naturopathy life style clinic located within the DH premises are providing yoga exercises for diabetics and hypertension patients specifically.

- Preventive and promotive care plays a crucial role in improving the health status and quality of life in individuals, and also addresses the issues of Out Of Pocket Expenditure thus reducing the cost an individual would spend on medical treatment. To ensure this, the health promotional activities should be undertaken at the community level as a continuous process, with a focus on enabling the community to adapt a healthy lifestyle.

Population enumeration and screening

- The first step in the process is the active enumeration of the population which would also list existing NCD conditions and exposure to risk factors among individuals which can be utilized to prioritize health interventions.
- ASHAs would first complete a Community Based Assessment Checklist (CBAC) for all individuals of age group thirty years and above. This form is intended to capture the information on the exposure an individual has to NCD associated risk factors and based on the questions each individual is allocated a score. The scoring is not a point of elimination but a means to highlight risk factors. In order to compensate ASHAs to undertake tasks to support prevention, screening and control of NCDs, an incentive of Rs. 10/person is defined under the Universal Screening of common NCDs for filling the CBAC and mobilizing the individual for NCD screening.
- Population enumeration has been initiated in most of the states, however not much has been reported on line listing of the target population and status of family folders. All the states reported of CBAC completion

being done by ASHAs, except for Nagaland and Delhi. In Nagaland, it is observed that MPREGNANT WOMEN-F are mostly involved in filling CBAC forms where ASHAs are not able to read or write. CBAC completion is not being done in the community universally; and it is observed that in some facilities individuals are assessed and scored for their risk factors only when they came to the health facilities to get screened.

- In Andhra Pradesh, incomplete CBAC forms are observed, flagging the need for sustained training. The field findings also indicate a need to build the capacity of front line workers to understand that the CBAC is not only for risk assessment but also helps in emphasizing certain aspect of causations, prevention and prioritization for NCDs. Most of the states have reported population based screening which is currently limited to Hypertension and Diabetes. Madhya Pradesh is currently undertaking the NCD screening in a campaign mode and male MPREGNANT WOMENs are designated as Community NCD worker by State and are involved in screening of the target population. Delhi, at present is providing routine screening and basic treatment for NCDs across facilities, but Population Based Screening (PBS) for NCDs is not being reported. Uttar Pradesh also reported population based screening in initial phases in both the districts visited during CRM. Andhra Pradesh showcased a good practices, where in urban slum areas MePMA workers in Mahila Arogya Samitis are involved actively in screening of women for NCDs and encouraging women to get screened for NCDs at Urban Health Care facilities.
- Where mostly states have not initiated Cervical Cancer screening, states like Andhra Pradesh, Tamil Nadu have reported of screening being undertaken at the health facilities using VIA. In Gujarat, the cervical cancer screening is done at the level of CHC and above using PAP smear, and it is observed that symptom based diagnosis for breast and cervical cancer is being considered to be screening. Madhya Pradesh also reported screening for cancer at the secondary level i.e. District Hospitals.

Medicines and Diagnostics

- The credibility of the Universal Screening initiative for NCDs rests on the availability of essential medicine and diagnostics for the NCDs across the health care facilities.
- Availability of antihypertensive and antidiabetic medicines is reported in most states like Andhra Pradesh, Delhi, Gujarat, Nagaland, Uttarakhand and Uttar Pradesh. In Andhra Pradesh, Nagaland, Uttar Pradesh and Uttarakhand, anti-hypertensives and anti-diabetic medicines are also available up to the level of Health and Wellness centre – SHC/PHC/CHC.
- The duration of dispensing of medicines vary, where most of the states are currently dispensing the NCD medicines for a period of 5-10 days. However, in Delhi the medicines are being provided to NCD patients for a period of one month. In Gujarat, it is observed that prescription practices of antihypertensive

are neither uniform throughout facilities nor according to guidelines at many places.

- A key factor contributing to the impoverishing effect of out-of-pocket expenditure for healthcare is expenditure on medicines. To avoid patient hardship and to ensure treatment compliance, it is advisable that medicines are being dispensed for a month period, to avoid multiple trips of the patient to the health facility. Places where the medicine for NCDs are being dispensed for 5-10 days made NCD patients visit repeatedly to the facility to collect medicines. In such scenario non-compliance to treatment is observed amongst patients, especially in far flung areas.
- Diagnosis is a crucial part of NCD screening and requires adequate equipment, consumables and skilled staff to be present at appropriate levels. It is to be noted that demand for diagnostics would increase with programme as more number of individuals being screened would also increase.
- It is observed that in some states individuals being screened for hypertension are not getting screened for diabetes due to non-availability of gluco-strips at the facilities. Supply of consumables is not streamlined especially in procurement and supply of gluco-strips. In Chhattisgarh, the glucometers are found with inaccurate readings and thus effecting the screening exercise. Calibration of equipment is not being reported by all the facilities.

Referral and Follow up

- Continuum of care is essential for Non-Communicable Diseases' management and control; however, referral and follow up mechanism is found weak across the states. None of the states reported on back referral of identified NCD patients undergoing treatment at higher health care facilities. Field level observations highlighted that the follow up mechanism needs to be defined across the level of Health Care facilities. Patients being screened at primary level are being referred to either CHC or DH, but there is no mechanism to follow up on these identified NCD cases. Referral cards/diaries which also act as a tool for follow up, are either not observed or not used properly for strengthening follow up mechanism. In most of the districts, follow up of identified NCD patients for hypertension and diabetes are not driven by health workers at the primary level or from facilities, but self-driven by patients.
- Lack of follow up mechanisms for positively diagnosed cases has emerged a critical challenge, and in absence of records for identified cases it is difficult for the service providers to follow up for treatment compliance.

Recommendations

- States should expedite the training for all cadres on a priority basis. For states, where ASHAs and MPREGNANT WOMENs training has not been completed yet, states should ensure the joint training of ASHAs and ANM/MPREGNANT WOMENs of respective SHCs on the fifth day of ASHA training.
- For states, where the training for front-line functionaries has been conducted for a shorter duration, a refresher should be planned, with main focus on health promotion, reporting & recording, and follow up mechanism.
- More focus on health promotion to be given during the capacity building of front-line workers and service providers across the level of health care facilities.
- State and district should ensure that the trained personnel are being utilized for NCD services and not being deployed to other departments, thus avoiding the draining of system's resources.
- Role and responsibilities of ASHAs and ANM/MPREGNANT WOMENs in health promotional activities to be discussed during monthly meetings by the block level officials.
- Involvement of community based platforms like VHSNC/MAS/PRI/ULBs to be ensured for health promotion and screening activities.

- State needs to develop IEC material specific to the programme guidelines and disseminate at the primary health care facilities.
- Diagnostics availability to be ensured at SHC, PHCs and also at secondary care facilities to maintain continuum of care after screening.
- Availability of medicines to be ensured across levels of facilities especially SHCs to reduce out of pocket expenditure. Clear guidelines to be communicated to block level officials and service providers regarding medicine prescription and dispensation.
- Prescription audit is recommended to check on prescription of outside and irrational medicines.
- States should also strengthen reporting and recording mechanism to ensure the follow up of positively diagnosed individuals.

State Specific Findings

Andhra Pradesh

- Community awareness on NCD and services available at the primary level health care facilities is low.
- NCD services are limited to Hypertension and Diabetes.
- CBAC forms are being filled by ASHA. However, incomplete CBAC forms are observed flagging the need for refresher training with a focus on reporting and recoding formats.
- Regular Health checkups & field visits by Medical Officers for NCDs is in place, so increasing number of cases of Diabetes, Hypertension and Oral Cancers is being identified.

Bihar

- NCD screening is limited to Hypertension and Diabetes.
- Under Ayushman Bharat, NCD Nodal Officers have been appointed in each district and their orientations have been completed by NPCDCS Master Trainers
- Training on NCDs for ASHAs and MPREGNANT WOMEN (F/M) has been reported low in the state and needs to be expedited.
- Anti-hypertensive and Anti diabetic medicines like Metformin, Glimepiride, Atenolol, Telmisartan, Propanolol, etc. are available at secondary care facilities and primary care facilities (APHCs & UPHCs) upgraded to HWCs.
- Counselling for dietary modifications and lifestyle changes is being given at DH, Begusarai.

Chhattisgarh

- Universal screening of NCDs has been rolled out in the state and also fixed day clinics are reported to be conducted in Korba district.
- Quality of glucometer needs to be authenticated before procurement/supply as it is observed that in one of the HWC, the glucometer used is giving random readings on the higher side.
- Follow up mechanism for referred patients is not yet fully functional and needs to be strengthened.

Delhi

- Community awareness on NCDs and associated risk factors is observed, however is low in certain urban slum pockets.

- Universal screening of common NCDs has not been rolled out in the state and CBAC forms are not being filled by ASHAs.

Gujarat

- Universal screening for HT and Diabetes is undertaken in HWC catchment areas, including completion of CBAC forms by ASHAs. NCD clinics are established at DH, SDH and CHC levels. Screening for HT and Diabetes are available to all -attending health centres-over 30 years of age.
- District NCD cell is established with a program officer and other staff in place to manage NCD control programs in both districts visited. Similarly physiotherapist, laboratory technician, data entry operator (at DH) and staff nurses (CHCs) are posted to run NCD clinics
- Linkages of NCD clinics with HWCs has been established particularly for screening for HT/ DM and provision of counselling for tobacco cessation.
- Inadequate patient counselling regarding hypertension and diabetes is notably an area of concern across the facilities.
- Prescription practices of antihypertensive are neither uniform throughout facilities nor according to guidelines at many places. Patient tracking for follow up is yet to be institutionalised.

Jharkhand

- CBAC forms are being filled in the community, but the individuals are directly refereed to CHC to get screened for NCDs.
- NCD clinic at Gumla DH is functioning collocated in male OPD, while in West Singhbhum, its functional in main OPD and is headed by a dentist. Inadequate HR is reported in the NCD clinics.
- Medicines available at the NCD clinics at DH are limited to Telmisartan and Metformin. At CHC NCD clinics, shortage of NCD medicines is reported.
- In urban areas, no fixed day NCD clinic services are available at UPHCs, however, in West Singhbhum, MO is providing counselling on diet and nutrition.

Madhya Pradesh

- Currently the Universal Screening of common NCDs is being rolled out in a campaign mode in state. Population enumeration and screening has been initiated in the districts. Male MPREGNANT WOMENs have been designated as Community NCD workers and are involved actively in screening activities.
- NCD screening is limited to Hypertension and Diabetes, while women are being encouraged for self-breast examination in the community.
- Referral and follow up mechanism needs to be strengthened.
- Reporting and recording needs to be improved across the facilities.
- IEC material is well displayed across the facilities.
- NCD clinics at DH are functioning better, while CHC NCD clinic needs to be strengthened to provide better reporting on NCD services.

Manipur

- NCD screening has is limited to Hypertension and Diabetes in aspirational districts. However, in other districts, NCD screening including cervical cancer screening using VIA is being done at selected DH and CHCs, and at PHC its being done by MOs during weekly visits.

Meghalaya

- NCD screening at present is limited to Hypertension and Diabetes.
- Follow up of identified NCD patients is not being done.

Mizoram

- At community level, the universal screening of NCD's has started and ASHAs are filling CBAC. However, follow up activities are not being

undertaken for individuals identified or referred or those under treatment for NCDs.

- Community awareness activities are reported poor.

Nagaland

- Universal Screening of common NCDs is being rolled out across the facilities and screening activities are being undertaken for Hypertension and Diabetes. ASHAs along with MPREGNANT WOMEN-F are doing the population enumeration in their catchment area.
- MPREGNANT WOMEN-F are mostly involved in filling CBAC forms where ASHAs are not able to read or write. CBAC completion is not being done in the community universally; and it is observed that in some facilities it is done only for those visiting the facilities.
- Filled forms are being entered into the NCD module of CPHC application by the CHOs; however, operational issues regarding software are reported across the HWCs.
- Currently screening facilities are being undertaken only for Hypertension and Diabetes. Despite of consumables available at the HWC for oral cancer screening, none of the CHOs reported of screening being undertaken by them. Breast and Cervical cancer screening are yet to be initiated across the facilities.
- At HWCs it is observed that people screened for HT are not always screened for DM as well, and the reason varied across HWCs from patient's unwillingness to unavailability of gluco-strips at the facility.
- Anti-hypertensives and anti-diabetic medicines are available across the primary and secondary level health facilities.
- At the CHC and DH level, there is a functional NCD clinic where screening is undertaken for HT and DM. The CHC clinic is running under the supervision of a staff nurse; while at DH there is a team of epidemiologist, staff nurse and counsellor.
- Record maintenance and follow up activities are not found strong at any level of health facilities.
- The medicine for NCDs are being dispensed for 5-10 days depending on type of facility, thus making NCD patients visit repeatedly to the facility to collect medicines. In such scenario non-compliance to treatment is observed amongst patients, especially in far flung areas.

Odisha

- District NCD cell and NCD clinics have been established with an HR including an epidemiologist and a finance-cum logistic consultant.
- Universal screening of common NCDs has not been implemented across all districts in the state, and training of service providers including frontline workers is underway.
- In selected districts, state has initiated six day training of Staff Nurses and MPREGNANT WOMEN (F)/ANM on VIA for cervical cancer screening.
- Adequate anti-diabetes and antihypertensive medicine are available at all levels.
- The State has rolled out Hub and Spoke model for the timely treatment of cardiovascular diseases.

Rajasthan

- Community awareness is low in both the districts visited, and community lacked information regarding NCD services available at the public health facilities.
- IEC material is displayed at the facilities.
- CBAC forms are being filled by ASHAs. However, over all coverage of screening is low in the state.
- Functionality of NCD clinics is variable and though the NCDs clinics are available at CHCs and above in the districts visited, they are largely unutilized.

- Although medicines for NCDs are available at the HWCs, but are not being dispensed below the level of CHCs.

Tamil Nadu

- Community awareness on Diabetes and Hypertension is high in community. However, awareness on cancers and associated risk factors is higher in the urban as compared to rural areas.
- IEC material and NCD protocols are well displayed at the facilities.
- CBAC forms are being filled in the community and CBAC screening has been initiated.
- Women Health Volunteers (WHV) attached to CHCs are also involved in screening at village level to identify patients, who then received medicines regularly from the CHC.
- Dedicated NCD corners are available at facilities, managed by a staff nurse where screening activities are undertaken.
- NCD screening protocols and IEC materials are well displayed. VIA positives are referred to the DH and follow up services are being done by the HWCs.
- Follow up services are provided by frontline workers. Lifestyle and diet counselling is provided only to patients visiting facility.

Uttar Pradesh

- Awareness of community on Non-Communicable Diseases and associated risk factors is observed to be low.
- Population enumeration, filling up of CBAC by ASHA's and screening of individuals is very minimal in both the districts.
- District NCD clinic are operational in both districts at District Hospital. However, shortage of manpower is reported in both the districts against sanctioned manpower under NPCDCS program. Dedicated CHC NCD clinic has not been established in any of the CHC's visited in both the districts. No issues related to availability of drugs and equipment's has been observed in both the districts.

- Fixed days for NCD is not observed in any of the facilities visited, counselling on lifestyle and diet takes place sporadically and not in a structured way. Display of IEC materials are observed in district hospitals and not in facilities at block and below.
- Follow up mechanism is yet to be established in the community and at the facility level.
- ASHAs are trained on NCD module for a shorter duration.

Uttarakhand

- ASHAs, MPREGNANT WOMEN/ANMs and CHOs have been trained to under activities under Universal Screening of common NCDs; however, the training on VIA is yet to start.
- Screening of NCDs is limited to Hypertension, diabetes and Oral Cancer.
- Screening activities are being undertaken at HWC/non HWC – SHCs, and suspected individuals are being referred to PHCs for confirmatory diagnosis. For individuals diagnosed with NCDs and under treatment, the records are maintained at DH itself.
- Medicines for NCDs are not available at SHC level.
- NCD clinics are only limited till District Hospital.

- Community awareness on NCDs is low, and patients seek care from private service providers, thus incurring a high OOPE on medicines and treatment.

National Overview: National Oral Health Programme (NOHP)

Government of India launched NOHP to provide integrated, comprehensive oral health care in the existing health care facilities with the objective to improve the determinants of oral health, to reduce morbidity from oral diseases, to integrate oral health promotion and preventive services with general health care system, and to encourage Promotion of Public Private Partnerships (PPP) model for achieving better oral health. The Organizational Structure of the NOHP constitutes of a National Oral Health Cell comprising of Technical and Administrative personnel, a State Oral Health Cell (SOHC) which works in liaising with the State NCD cell existing for other NCD programs, and a District Oral Health Cell.

Key Findings

- Community level awareness regarding National Health Oral program is low in most of the states, and individuals not being aware of the services available at the health facilities, are visiting the private dentists and incurring a high OOPE on treatment. In is observed that the oral health services being provided under RBSK is known in community although.
- Disparity is seen in HR availability and logistics. In states like Meghalaya, Bihar, Odisha sufficient dental chairs are not available in accordance with the number of dentists.
- Health seeking behaviour in preference to access to public health facilities are low in states like Gujarat.
- IEC materials are well displayed in few states like Meghalaya, Tamil Nadu and Uttarakhand.
- NOHP services are functional at the DH level except in Bihar where the services are being compromised due to unavailability of dental chairs and in Uttarakhand where dental units are unutilized because of unavailability of dentist. In most of the states, service provision below the DH level is not adequate.
- Service delivery is compromised at secondary level health care facilities due to inadequate number of dental chairs against the dentists available in the dental units at CHC/SDH/DH.
- The dental services available in the most of the states are limited to oral prophylaxis, tooth extraction, routine filling, and RCT. Only Tamil Nadu reported of providing services related to dentures in the public health facilities.
- In Nagaland, due to unavailability of transport facilities, villagers avoided to come from far flung areas and preferred home remedies to relived dental pain and inflammation (if any). Also at DH and CHC level, the services are not free of cost and patients are being charged due to unavailability of logistics and consumables.

Recommendations

- The primary care services for oral health needs to be strengthened in all states.
- The mismatch between dentist and dental chair needs to be addressed in all states to ensure effective implementation of National Oral Health Program.
- Community awareness needs to be strengthened to improve the demand generation and thus optimizing the utilization of services at the public health facilities.
- Community outreach activities can be used to increase community awareness on preventive and promotive care.
- Efficient display of IEC material should be ensured across the health care facilities.
- States may ensure uninterrupted supply of logistics and supplies to the dental units, thus providing free of cost services to the patients and avoiding patient hardships.

State Specific Findings

Andhra Pradesh

- Low community awareness regarding the National Oral Health Programme.
- The programme is functioning well at the District Hospitals, but needs to be strengthened for service delivery at the primary level.

Bihar

- Dental care units established at the DH are non-functional due to unavailability of dental chairs.
- At the HWCs, Oral Health screening is being conducted on a weekly basis by a visiting dentist. However, there is no provision to undertake any dental procedure, thus limiting the activity to oral screening.

Chhattisgarh

- Korba district hospital has only one dental chair functioning for five dental units in the facility
- At the CHC level, the HR availability is satisfactory with availability of dentists in nine out of ten CHCs.
- There is a disparity in the working hours of regular and contractual Dentists, where the regular HR is providing services for six hours in six days a week; the total time for contractual HR in OPD is eight hours.

Delhi

- Maulana Azad Institute for Dental Sciences is organizing regular dental camps in the state.
- Routine oral health care services are providing which includes pain relief and treatment for oral ulcers. Patients with dental problems are referred to the health facilities.

Gujarat

- HR and logistics including dental chair are available at the level of SDH/DH. At CHC/ SDH/DH, key services delivered include basic dental procedures and root canal treatment. However, dentures are not provided at SDH and below.
- In rural and tribal areas, there are a lot more private dentists than in public health systems, thereby contributing to high OOPE of the community in dental treatment.

Jharkhand

- At community level a low service utilization is observed.
- Dental units are established at DH with adequate HR and equipment; however, limited service provision is observed and procedures like RCT and prosthetic devices like dentures are not available.
- CHC level dental units are not functional, where in one district there is unavailability of dentists; while in other district despite of HR availability, services available at SDH and CHC are limited due to non-availability of a dental chair.
- IEC services are lacking at the district level in both the districts.

Madhya Pradesh

- NOHP is not fully functional across the different level of Health care facilities.
- Low community awareness is observed for the programme and service provisions for oral health care.
- Unavailability of dental chairs is adversely impacting the utilization of services pertaining to the NOHP.

Manipur

- Dental units are available and reported functional at CHCs and DH level. However, the ratio of dental chairs to dentist is inadequate and there more dental surgeon than the dental chair.
- Services available at these dental units are limited to basic screening and tooth extraction.
- Visited facilities reported of unavailability of a separate autoclave dedicated for the dental units.

Meghalaya

- Service delivery is compromised at the facilities due to inadequate number of dental chairs against the dentists available in the visited facilities.
- IEC materials are well displayed at the visited facilities
- Support staff like dental hygienist/assistant is not in position at either of the facilities.
- There is a need to strengthen follow up mechanism for cases with precancerous lesions which are referred to higher centres for treatment.

Mizoram

- At state and district headquarter, skilled staff with equipped dental chairs and required logistics is available and providing the services under NOHP.
- At the Civil Hospital, RCT services are being provided but dentures are not being delivered, and thus patients are seeking care from private dentists for denture related services.
- At CHC/PHC, in absence of a dentist, Medical officers are undertaking the activities like oral health screening and tooth extraction.

Nagaland

- Due to high tobacco consumption and poor oral hygiene, dental problems are prevalent in the community, and the health care seeking behaviour of the community is poor due to unavailability of the oral health care services.
- At CHC level, dentist is available and it is the first point of care to oral health services. However, due to unavailability of logistics, the services are not free of cost and patients are being charged. Similarly at the DH, the services available are minimal and chargeable as the logistics and supplies is not regular.
- Due to unavailability of transport facilities, villagers avoided to come from far flung areas and preferred home remedies to relived dental pain and inflammation (if any).

Odisha

- ASHA and MPREGNANT WOMEN/ANM are trained under oral health screening programs for identifying and referring the suspected cases as well as mobilization of suspected/ positive cases of cancer to hospital.
- Community awareness on preventive care and availability of services is reported low.
- Dental services are limited to OPD prescription and extraction of tooth.
- At the dental units, the availability of dental chair is not as per the dentists positioned at the facility. Autoclaving/sterilization of equipment's, infection prevention protocols are completely lacking at the time of visit.
- At Badisahi CHC, oral health services are not available and individuals had to go to the district headquarters for seeking care for dental problems.
- In some of facilities visited, it is observed that dentists are also prescribing medicines for general illness.

Rajasthan

- Functional dental units at DH/SDH/CHC are present with dentists positioned at these facilities.
- Services being provided at these facilities include routine restoration, extraction, and RCT.

Tamil Nadu

- Community awareness on oral hygiene practices and services related to NOHP is poor.
- However, community is well aware of the services provided by the dental surgeon under school health programme (RBSK) in both the districts.
- Although the oral cancer screening is being done at the HWC level, other oral health care services are available at BPHC and higher level of health care facilities. Services are also being provided at DEIC by the dental surgeon under RBSK.
- Dental services available at these facilities include General dental checkup, restorations, extractions, scaling, removable/fixed partial dentures, operculectomy, frenectomy, RCT, and oral cancer screening which are being provided at in 6 block PHCs and DH in Virudunagar.
- IEC materials are displayed in the visited facilities.

Uttar Pradesh

- In Baharaich district, it is observed that community is unaware of availability of oral

health services at the health facilities and thus is availing oral health services from private facilities.

- In Meerut district, adequate manpower is in position in DH and high case load is also reported. Also, comprehensive range of services are offered including counselling regarding good oral health practices.
- In Baharaich DH, one dentist is in position, while two are visiting from the Medical colleges, and are providing services limited to tooth extraction and oral prophylaxis. Also, poor sterilization practices and ill maintenance of equipment is observed in the dental unit.
- No dental services are available at the visited CHCs and PHCs.
- Shortage of HR is observed at CHC/PHC, although dental hygienist post is created.
- Due to non-availability of services at block level, community is availing services from private clinics.
- In Meerut, dental camps are being organized and identified cases are referred to DH for treatment.

Uttarakhand

- Well displayed IEC material is reported across the facilities.
- Availability of dentist is reported at CHC/SDH. However, there is no dentist available at DH Rudrapur and thus the otherwise well-equipped dental unit is being underutilized.
- Infection prevention practices are followed at all visited facilities.

National Overview: National Tobacco Control Programme (NTCP)

Government of India launched the National Tobacco Control Programme (NTCP) in the year 2007-08, with the aim to (i) create awareness about the harmful effects of tobacco consumption, (ii) reduce the production and supply of tobacco products, (iii) ensure effective implementation of the provisions under "The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" (COTPA) (iv) help the people quit tobacco use, and (v) facilitate implementation of strategies for prevention and control of tobacco advocated by WHO Framework Convention of Tobacco Control.

NTCP is implemented through a three-tier structure, i.e. (i) National Tobacco Control Cell (NTCC) at Central level (ii) State Tobacco Control Cell (STCC) at State level & (iii) District Tobacco Control Cell (DTCC) at District level. There is also a provision of setting up Tobacco Cessation Services at the District level.

In addition, Tobacco Cessation Centres (TCCs) exist almost in every State/Union Territory apart from the hospitals providing cessation facilities. One who wants to quit tobacco may visit these Centres and take pharmacological therapy (if required).

The Ministry of Health and Family Welfare has also started National Tobacco Quit Line to provide tobacco cessation counselling services to the community through a toll-free number (1800-11-2356) and has launched a pan-India, "m-cessation" initiative to reach out to tobacco users who are willing to quit tobacco use and to support them towards successful quitting through text-messaging via mobile phones (on 011-22901701).

Key Findings

- High consumption of tobacco is reported in the state of Meghalaya and Nagaland. In most of the states, Community awareness on tobacco use and its health hazards is minimal.
- IEC materials and signages are well displayed at the facilities, however compliance to COTPA rules is not observed at all places.
- Most of the states reported of "no smoking" signboards being in place and well displayed at the health facilities. However, contact details of designated officer for reporting the violations is not mentioned in the signboards in all states.
- Tobacco Cessation Centres are established and functional in Gujarat, Jharkhand, Mizoram and Uttarakhand; while the Nicotine Replacement Therapy is reported available only in two state of Uttarakhand and Uttar Pradesh.

Recommendations

- States need to strengthen the intersectoral coordination activities and collaboration with PRI and NGOs can be done to generate community awareness and ensure compliance to COTPA rules.
- Service providers including frontline workforce may also be trained on COTPA to ensure effective implementation of the act.
- Implementation of COTPA needs to be strengthened and counselling for tobacco de-addiction needs to be initiated.
- State need to ensure availability of functional Tobacco Cessation Centre at district level and also to support the pharmacological therapy by ensuring regular supply for Nicotine Replacement Therapy.
- IEC materials can be used to increase the community level awareness
- Special emphasis may be given to increase awareness activities in schools and colleges.
- Standardized anti-tobacco signage could be displayed at the Health facilities and public places in the community. Community could be sensitized about the program and its implications.

State Specific Findings

Andhra Pradesh

- Under Tobacco Control Programme, all the health facilities are tobacco free, and staff is aware of signage on the front of the building.

Bihar

- NTCP implementation is observed partially in the state. Hoarding and pamphlets are available at the facilities to generate awareness in the community.
- In most of the places, "no smoking" signboards are in place and well displayed at the health facilities. However, contact details of designated officer for reporting the violations is not mentioned in the signboards.
- Facility staff is found unaware of the penalization process in case of non-compliance with the COTPA rules.
- De-addiction Centres previously functional in the DH Bhagalpur is converted into Dengue wards at present. Counselling activities for tobacco deaddiction are not being undertaken due to unavailability of Nicotine patches and gums.

Chhattisgarh

- Tobacco free premises are observed at the district level facilities. However, in one of the DH, smokers are observed in the DH premises.
- Well displayed IEC material in most of the facilities.
- Counselling and treatment facilities are available and being provided through psychiatric OPD of the Medical College in one of the district – i.e. Rajnandgaon.

Delhi

- Most of the facilities visited have tobacco free premises and signages are well displayed.
- Tobacco control initiatives such as counselling, health talks and IEC is available in both the visited districts.
- In one of the Maternity home visited, the screening for tobacco control is being done by the dentists.
- State has also taken an initiative to ban e-cigarettes.

Gujarat

- Tobacco Cessation Centre is established at DH and also a counsellor in positioned to support the activities. Services of Psychiatrist are available to beneficiaries visiting TCC. The counsellor also undertakes outreach activities and visits schools to undertake community based activities. Only a single counsellor provides counselling at DH and visits peripheral units.
- COTPA provisions are enforced and during last one year, and people have been penalized for non-compliance. Although, use of tobacco and spitting at public places is quite common in government offices, hospital premises, etc. and warrants more comprehensive efforts.
- Community awareness on tobacco use and its health hazards is minimal.
- There is progressive increase in number of individuals counseled during last 4 years including current year. The facilities also reported of a defined mechanism available to follow up with individuals visiting the Tobacco Cessation Centre.

Jharkhand

- The district teams are involved in organizing awareness camps in coordination with the school health programme. So far, 26 awareness camps are reported in the last four months in Gumla.
- At present 14 Tobacco Cessation Centres are functional in the state. However Nicotine Replacement Therapy is not being provided due to unavailability of medicines.
- People are being penalized for non-compliance with the COTPA rules. Standardized display of anti-tobacco signages are available at all facilities.
- None of the CHCs reported of NTCP components available and functional.

Madhya Pradesh

- Tobacco Cessation Centres are yet to be operationalized at the district level.
- Anti-tobacco signages are well displayed across the facilities and also penalization is being done for people violating the rules.
- No information on IEC activities being conducted or planned is available.

Manipur

- Districts have constituted an enforcement squad, and training of the law enforcers, health professionals and stakeholder have been completed.
- NGOs are organizing the awareness camps in collaboration with District NCD cell and so far 15 schools have been covered.
- Tobacco Cessation Centres have not been established at the DH and also Nicotine Replacement Therapy is not available. So far, no drive on compliance to anti-tobacco laws has been undertaken.

Meghalaya

- IEC is found well displayed across the facilities; however, mandatory warnings as per COTPA act could not be seen.
- ASHAs and AWWs are aware of NTCP requirements and undertake community level activities at their own level.
- Community awareness on ill effects of tobacco is low, and there is a rampant use of tobacco, especially in chewable form.

Mizoram

- All the health facilities have been declared as tobacco free and IEC is well displayed across the facilities.
- District Aizwal has reported of 80 awareness camps being organized in last year and is followed by 2000 tobacco users attending the Tobacco Cessation Clinics.
- In district Mamit, primary level health facilities did not report of conducting any awareness activities or providing services related to NTCP.

Nagaland

- State reports a high tobacco usage and is ranked seventh in the country in tobacco usage.
- IEC material is well displayed across the facilities and also facilities are labelled as tobacco free areas. However, service providers themselves are seen consuming chewable tobacco within the health facilities' premises.

Odisha

- Community awareness regarding harmful effects of Tobacco and COTPA is found very low.
- In Kandhamal, it is observed that the district hospital is not tobacco-free, and reflects the poor knowledge and awareness and sensitization of COTPA Act 2003 and its status of implementation at the district hospital.
- District tobacco consultant under NTCP programme is not recruited and hence, all the tobacco control activities apart from the IEC are affected.
- In Mayurbhanj, anti-tobacco IEC is displayed at health facilities but enforcement of COTPA is not followed. Tobacco de-addiction centre is functioning and counselling is also given to the patients but nicotine replacement therapy is not available.

Rajasthan

- IEC well displayed at the public places, health care facilities and school.
- However, the community and the health providers had no information about the 'Quit line'. During visits, vendors for tobacco products are not seen within 100 meters of schools.
- Outreach activities are not observed as per the guidelines.
- Follow up and penalization on violation of COTPA rules is not observed. In some facilities, the number of challans issued in FY 2019-20 is zero.

Tamil Nadu

- Community awareness on tobacco cessation is found low.
- School authorities are aware about ban of tobacco around school premises, and teachers are aware of fines being enforced for smoking in public places and awareness sessions being undertaken by RBSK teams.
- Increase in smokeless tobacco is observed. Tobacco cessation facilities, pharmacological treatment facilities are yet to be introduced as a health programme.
- Tobacco awareness generation activities done monthly on the third Friday by the RBSK teams.
- "Tobacco free facility" signage is not visible at the facilities visited. However, the contact details pertaining to the complaints are not provided on the signage as per the guidelines.
- A video regarding ill effects of tobacco runs in the facility during OPD hours.
- Common IEC activities reported include rallies by school children and distribution of hand bills in shops and public places.
- State has included COTPA in the monthly crime review meetings. There is a well-defined challan mechanism being set up and notified by the Competent Authority. Challans are issued by the Officer in triplicate with one copy to the person charged, one Treasury copy and the other for Fund Receipt.
- The Signage of "No Smoking Area- Smoking Here Is an Offence" is present at the entrance and inside most of the government building

premises, not seen in many of the health facilities visited.

Uttar Pradesh

- At community level ASHAs/ANM are involved in disseminating the information or counselling beneficiaries with regard to harmful effects of tobacco consumption.
- The services in DH is being offered through NCD clinic counsellor and mental health clinic staff. Dedicated Tobacco Cessation Centre is not available in Bahraich. However, Nicotine replacement therapy is observed to be available in DH, Bahraich.
- Facilities at block and below are offering service in this program through their existing staff. Facilities visited have displayed adequate IEC materials. Despite display of IEC materials and messages, it is observed people visiting facilities are consuming tobacco.
- Imposing strict fines are not observed in any facilities. People smoking inside hospital premises are being objected for not to do so, however fines are not imposed or collected within the hospital premises.
- In Meerut district, penalization for violating COTPA rules is observed at the Bus stop and RTO; however it is not reported at either of the health care facilities (PHC/CHC/DH).
- Awareness camps for tobacco cessation are conducted through mental health and NCD cell.

Uttarakhand

- The health care facilities are tobacco free an signages and IEC is well displayed.
- Awareness generation activities are being organized at the level of CHCs and tobacco cessation related information is also provided to individuals visiting Sub Centre level for any services.
- Tobacco Cessation Clinic and Nicotine Replacement Therapy is available at the DH level.
- Gram Panchayats are not empoared to take action against smoking in public places.

National Overview: National Mental Health Programme (NMHP)

The Government of India has launched the National Mental Health Programme (NMHP) in 1982, with the objectives to (i) ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of the population; (ii) encourage the application of mental health knowledge in general healthcare and in social development; and (iii) promote community participation in the mental health service development and to stimulate efforts towards self-help in the community.

Under this Programme, the Government is supporting implementation of the District Mental Health Programme (DMHP) in 517 districts of the country for detection, management and treatment of mental disorders/ illness. Further, The Mental Health Care Act 2017 is passed on 7 April 2017 and came into force from July 7, 2018. The law is described in its opening paragraph as "An Act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto. "This Act superseded the previously existing the Mental Health Act, 1987 that is passed on 22 May 1987. The Mental Healthcare Act, 2017 also provides that the appropriate Government shall take all measures to ensure that the Government Officials including police officers and other officers of the Government are given periodic sensitization and awareness training.

Key Findings

- NMHP has been partially implemented across the districts, where the services are available at the district level, but implementation at the sub district level and below is sub optimal.
- Central Mental Health Authority (CMHA) & State Mental Health Authority (SMHA) are meant for regulation & co-ordination of mental health services under the central & state governments respectively. Chhattisgarh and Jharkhand reported on constitution of SMHAs, and also district level review boards are being formed to strengthen the mental health services.
- Community awareness on Mental Health programme is reported low across the states. However, states like Delhi, and Manipur reported of undertaking activities to generate awareness in the community.
- Community had identified individuals with mental health conditions, which are either unattended or are incurring high OOPE due to lack of information on mental health related conditions and service available at the health care facilities.
- Outreach activities at present are reported from Chhattisgarh, Madhya Pradesh, Manipur and Uttar Pradesh, where state is undertaking fixed day clinics or conducting awareness sessions as a part of National Programme.
- Notable achievement is observed in form of functional District Counselling Centres at the DH level, and also suicide prevention helpline which is functional in most of the states.
- High incidence of alcohol consumption and substance abuse are reported in few states, however there are no deaddiction services reported to address these issues.
- Frontline workers are not yet actively involved in Mental Health related services, and few state reported their involvement in mobilizing the community for fixed day clinics. FLWs have not been oriented/trained on Mental Health related services so far.

Recommendations

- Strong IEC campaign is required to increase the awareness within the community on mental health conditions, and the services available in the health care facilities.
- State may strengthen the coordination activities at state and district level between Mental Health division and other divisions like NCD cell, Drug deaddiction centres, Tobacco control cell to improve the coverage and provision of services in a holistic approach.
- Linkages with Primary level facilities need to be developed to enable improved access to Mental Health services and facilitate continuum of care.
- State may strengthen the existing DCCs to also follow up on identified individuals seeking services at these centres, and develop linkages to enable primary level facilities to provide counselling services to these identified individuals in the community, thus reducing the patient hardship and OOPE incurred in travelling to higher level facilities.

State Specific Findings

Andhra Pradesh

- Mental health is reported well functional at the district level with adequate Human Resource in position; however, retention of qualified psychiatrists is a challenge faced by the districts.
- Good practices including de-addiction campaigns in coordination with the excise department are reported across the districts. Also at the level of HWC-SHCs, it is observed that ASHAs and CHO/MLHPs are actively involved in informal counselling of community on tobacco and alcohol deaddiction. However, in absence of deaddiction and tobacco cessation related activities, the counselling done at the primary level is not able to yield expected outcomes.

Bihar

- NMHP is found to be non-functional in the districts. Although state as already initiated the process for adopting the Mental Health Act 2017.

Chhattisgarh

- SMHA has been constituted and also district level boards have been created for each zone.
- Framing of rules under the Mental Health Act is under process and nominations of retired judges has been sought as the initial step.
- District Counselling Center (DCC) services are not available at the district level in the DH visited in Rajnandgaon.
- High prevalence of alcohol consumption reported in the community, and outreach activities related to deaddiction are sub optimal.

Delhi

- Community awareness reported for Mental Health conditions, and identified cases are referred to the higher centres.
- Counselling and management of mental health conditions is presently not being done at the level of UPHCs.
- Patients presenting any signs and symptoms are being referred to the tertiary level health care facilities.

Gujarat

- At the District Hospital and peripheral units, mental health clinics are functional and clinical psychologist, social worker and nurse is the key HR available.
- At the district level, a Psychiatrist is also positioned from the regular cadre, who also visits SDH and CHC during fixed day clinics.
- Psychotropic medicines are available at the DH level.
- However mental health program is yet to be functionalized in peripheral facilities.
- There are no awareness camps on suicide prevention being conducted in the state.

Jharkhand

- SMHA has been constituted and formation of mental health review boards is under process.
- A Suicide prevention helpline has been introduced and is functional in twelve identified districts in the state.
- The services for Mental Health Care varies in districts, where it is observe that in Gumla district there is a dedicated infrastructure and HR available, while in West Singhbhum the Mental Health services are not available at present.
- At the DH level in Gumla district, the HR available is one psychiatric social worker and a nursing attendant. A Psychiatrist is available on a weekly basis and visits DH on the fixed day i.e. Wednesday. A dedicated OPD and a 20 bedded ward is separately available for Mental Health services and is being utilized for counselling.

Madhya Pradesh

- At the DH level a designated District Counselling centre is present called “Man Kaksh”. HR available at DCC includes a Psychiatrist, Staff

Nurse, and 2 Psychiatrist from medical College (Asst. Prof & Senior Resident). There is no counsellor available at present.

- DH is procuring the medicines locally utilizing the existing funds and there is adequate stock available.
- Most common conditions being reported at the clinic are Anxiety disorder, depression, Psychosis and alcohol use disorder.
- A weekly OPD clinic at the CHCs are being conducted as an Outreach activity. The outreach clinics are planned in advance and the time table is pre informed to the frontline workers. ASHAs and MPREGNANT WOMEN/ANMs are actively involved in mobilization of identified and suspected cases to the clinics.
- Also learning sessions and seminars are being conducted in schools and colleges to generate co amongst the students.
- Details on the Suicide prevention helpline and linkage with the District counselling center is not available.
- At PHC level component of Mental health is yet to be introduced.

Manipur

- DMHP is reported from one district visited during CRM i.e. Bishnupur. DMHP is coordinated with the Drug treatment Centres under National AIDS Control Programme (NACP).
- HR shortfall is reported in DMHP and total HR available is one Psychiatrist and an attendant.
- Outreach activities are being undertaken on a regular basis. Training of the Health care service providers is conducted in the district and also a suicide prevention workshop is held to generate awareness in the community.
- Workshops on workplace stress management are also being conducted for Paramilitary personnel, Jail inmates and nursing students.
- Six mental health camps are organised in last Financial year.
- A dedicated suicide prevention helpline is not reported in the state.
- Counselling in school and colleges had not been started.

Meghalaya

- Limited facilities for diagnosis and treatment of Mental health is available in the state.
- Community is also accessing care on mental health conditions from the traditional healers.
- At the DH, rehabilitation/follow up or community based intervention for patients who have completed treatment is not being done at present.

Mizoram

- At state headquarter in the civil hospital, HR available is a psychiatrist and counsellors.
- At the DH level, counsellors are available and posted in the dedicated Mental health clinics.
- At the Sub district level and below, mental health services are not being provided at present.

Nagaland

- Mental Health related issues are found more common in adolescents and school going children in the community. With changing life style and increasing unemployment, young population sub groups are getting engaged in risk behaviours and thus affecting their well-being.
- Substance abuse is reported as a common issue by the community members. Tribal clashes, village level disputes are also reported as common cause of stress amongst the villagers.
- Services under NMHP are not found satisfactory within the districts. The services under these programmes are not being delivered at health care facilities below the DH level; except for availability of medicines for epilepsy at the PHC/CHC/DH level.

- Drug deaddiction related counselling services are being delivered by the Counsellor in both the districts. Psychiatrist is available in only Phek, while Kiphire had no dedicated NMHP HR positioned in the DH.

Odisha

- In both districts, Community is aware of the people suffering from mental health/ epilepsy (neurological health) but they did not have knowledge on where to seek advice for the care of people with mentally/neurological conditions.
- In Kandhamal district HR shortfall is reported and positions of Psychiatrist, Programme facilitator and Clinical psychologist is vacant.
- In Mayurbhanj district, a Psychiatrist is available and services are being delivered on a regular basis. At DEIC as well, a psychologist is available and is providing good services for management of learning disabilities.
- Integrated counselling centres are functional n both the districts but information on various areas of counselling on mental health is lacking.
- Suicide prevention helpline notification is not observed in either of the districts visited.
- Due to unavailability of dedicated HR and facilities, many of the identified cases in the community are either untreated or are seeking care from private providers and incurring high OOPE.
- A backlog in the utilization of the funds is noted.

Rajasthan

- Community awareness is poor and no IEC is reported across the facilities in the district.
- The implementation of the programs as per the guidelines is not observed below District Hospital level. The facilities have limited structural features to support disable patients. Also, the utilization of the services is sub-optimal.

Tamil Nadu

- High incidences of stress and suicidal tendencies among adolescents are mentioned by school teachers during the team's interaction in schools. Reasons mentioned are pressure to cope up with studies, high expectations from parents regarding studies, media exposure etc. Teachers though provide counselling , but felt inadequate to deal with these issues.
- Mental health services are available only at DH and above. There is a District Counselling centre which provides services as suicide prevention counselling, psychometric evaluation, De addiction, family counselling, stress management, personality and skill development.
- The concept of Emergency Care and Recovery Centre (ECRC) for the mentally unstable people lost in the community is developed well at Villupuram DH. These patients are supported at the DH and treated to be well enough to return to the society again as a contributing member.
- There are day specific clinics e.g. on Monday - Psychiatric OP, Tuesday - adolescent clinic, Wednesday - Child Psychiatric clinic, Thursday - Suicide prevention clinic, Friday - De addition clinic and Saturday - Geriatric Psychiatric clinic. However, IEC material at these facilities is not found satisfactory.

Uttar Pradesh

- Community lacks awareness of various services of mental health. Dissemination and awareness generation for mental health services by ASHA/ ANM is found to be very weak.
- Baharaich DH has a functional Mental health clinic and its functionality and skills of the available HR are well appreciated.. Epilepsy, substance abuse, common mental disorder, severe mental disorder cases are treated in DH. Both men and women are screened, treated and counselled for the mental health problems. Supply of medicines is found to be adequate.
- Mental Health Counselling is done in Man-Kaksh at district hospital. However, space is not

adequate to undertake counselling services. Mental Health clinics are also functional at the district level in both the districts.

- A dedicated suicide prevention Helpline is functional in the state.
- District Mental Team in Baharaich is also involved in outreach activities, conducting medical camps in facilities (CHC/PHC) and also in jails, and training of staff from CHC/PHC/ CHO/School teachers. However, in Meerut, minimal activities are initiated and reported in facilities at block level and below.
- Good coordinationis observed with NCD cell, elderly care and tobacco control team. Medical and awareness camps are conducted jointly for these three programs in the district.
- However, implementation of district mental health Programme at facilities in block and below in terms in terms of screening and identification is found to be weak.

Uttarakhand

- DH Rudrapur had a dedicated mental Health team had no specialist available. District Counselling Centre (DCC) is available at DH.
- Line listing of patients with diagnosis is maintained by the Psychiatrist at DH
- General lack of awareness on mental health issues, attached stigma, and availability of services is observed in the community.
- No IEC/ BCC materials on mental health programme is available in community and also in most of the facilities visited. Awareness and training of ASHA/ANM/MLPs at Sub Centers on mental health programme is lacking. Most of the MOs at the PHCs are not trained either.

National Overview: National Program for Control Of Blindness And Visual Impairment (NPCB&VI)

National Programme for Control of Blindness and Visual Impairment (NPCB&VI)is launched in 1976 with the goal of reducing the prevalence of blindness to 0.3% by 2020. Main objectives of the programme are to reduce avoidable blindness; develop and strengthen the strategy of NPCB for “Eye Health for All” and prevention of visual impairment; strengthening and up-gradation of Regional Institutes of Ophthalmology (RIOs) and partners like Medical College, DH/ SDH, Vision Centres, NGO Eye Hospitals; strengthening existing infrastructure facilities and developing additional human resources, enhance community awareness on preventive measures and expand research for prevention of blindness and visual impairment.

Key Findings

- In all the states, Cataract surgeries are being conducted however a backlog in the targets has been reported in Odisha, Mizoram, Manipur, Delhi and Jharkhand. Gujarat has effectively used NGO and private sector to address backlog of cataract surgeries in state.
- School eye screening camps and screening of eye problems is being conducted in all the states. In Delhi and Tamil Nadu, Diabetic Retinopathy Screening Camps are being organised. Distribution of free spectacles is found to be poor in few states.
- In Tamil Nadu, New initiative - Tele Imaging, has been introduced to screen babies for Retinopathy of Prematurity while another initiative - Tele V Care Centre is proposed in which Fundus Camera Images (using mobile phones) will be taken and sent Medical College for faster diagnosis. In Gujarat, a project to reduce blindness from Diabetic retinopathy has been started.
- In most of the state, community awareness about program is poor as people with eye problems are visiting private providers incurring out of pocket expenditure (OOPE), except in Nagaland where awareness is good as local churches are being used as a platform to spread awareness related to eye care and services available at the health care facilities.
- AndhraPradeshhaslaunchedDr.YSRKantivelugu Programme for providing comprehensive eye care at no cost to prevent cases of blindness

in the state. The main objective of this initiative is to provide comprehensive and sustainable Universal Eye Care to all the people in the state by conducting eye screening and provision of appropriate interventions like distribution of Spectacles, Surgeries in case of Cataract, Glaucoma, Retinopathy, corneal disorders etc in a Phased manner.

Recommendations

- District level team should know the burden of cataract, glaucoma and other major eye diseases which would help them to create a road map for identification and treatment.
- Operation Theatres (OT) at the DH/ SDH should be well equipped as per the norms. The position of ophthalmic Assistants should be filled at the block level facilities.
- Orientation of ASHAs and MPREGNANT WOMEN/ANMs in the program should be done and the performance of the programme needs to be regularly reviewed.
- Outreach camps should be planned with a view to create awareness among the community and expansion of eye care coverage.

State Specific Findings

Andhra Pradesh

- Andhra Pradesh has launched Dr. Y S R K antivelugu Programme for providing comprehensive eye care at no cost to prevent cases of blindness in the state. The main objective of this initiative is to provide comprehensive and sustainable Universal Eye Care to all the people in the state by conducting eye screening and provision of appropriate interventions like distribution of Spectacles, Surgeries in case of Cataract, Glaucoma, Retinopathy, corneal disorders etc in a Phased manner.

Bihar

- At the district level health facilities, adequate Human Resources and infrastructure is available; however, in DH Begusarai, the Eye OT is not functional due to unavailability of an Ophthalmologist. Also, no outreach activities are being carried out in the community.
- Screening for refractive errors, cataract, glaucoma and other eye problems is being carried out in the ophthalmology OPD. However, free spectacles are not being provided at present.
- At the higher facilities, cataract surgeries are being conducted on a weekly basis.

Chhattisgarh

- District Hospital Korba got an Eye ward sanctioned, which is yet not constructed.
- Linkages with RBSK are yet to be developed for screening of preschool children.
- Follow up of identified individuals needs to be strengthened.

Delhi

- At identified Health centres, state government has initiated Vision Centres in collaboration with the Community Ophthalmology Department of All India Institute of Medical Sciences.
- Screening for refractive errors, Cataract, Glaucoma is done by a team of Optometrists and technicians through fixed day clinics at various facilities on rotation basis.
- Once in a month Diabetic Retinopathy Camp is organised using the portable community ophthalmoscope, wherein all Diabetic and Hypertensive patients are screened for retinopathy and blindness and referred to AIIMS for management on priority.
- In remaining centres, cataract cases are referred to polyclinics in LBS Hospital and Guru Nanak Eye Hospital.
- At the district level, a functional Eye OT is observed; and Cataract /Visual impairment records are being maintained and updated timely.

Gujarat

- State has effectively used NGO and private sector to address backlog of cataract surgeries

in state. Functional eye OT is available at DH and SDH and cataract surgeries are performed there. In addition to this, one trust hospital and five private hospitals are identified for services under NPCB&VI particularly cataract surgeries.

- Currently there is no backlog of cataract surgeries in Surat district; whereas it has significantly decreased in Dahod district.
- 11 ophthalmic assistants are also deployed at taluka levels in Dahod. At village levels, ASHAs counsel for eye related conditions particularly cataract. Free glasses are also provided to beneficiaries at districts. ASHAs refer cases of suspected cataract.
- Ophthalmic assistant in CHC Fatepura is noted to be equipped with all functional machinery and lenses. Basic clinical services as detection of refractive error, screening for cataract, etc. are being provided efficiently at this level.
- In Surat district, an innovative project is undertaken to reduce blindness from Diabetic retinopathy by PHFI under agreement between Govt of Gujarat PHFI & Divyajyoti trust.

Jharkhand

- State is establishing an Eye bank, for which the equipment are being procured through state corporation fund.
- At the District Hospital, EYE OPD services are available and one Ophthalmologist is posted at the facility. Also, eye camps are being organized at the district level.
- At the level of CHC, an Optometrist is available in Gumla; however, it is reported in West Singhbhum that eye care facilities are not being provided at present.
- At the level of community, free spectacles are distributed under the NPCB & VI programme.

Madhya Pradesh

- At the District hospital there is an eye OT for cataract surgeries, reporting ut 50-60 cases per month are done on an average.
- At the District level, under the National Blindness Control Programme, against the target of 10800 cataract surgeries for 2019, only 2533 have been completed (23%). No glasses are distributed in the district. A total of 47 eye screening camps are conducted for 2019 -20.
- There are also PPP models in place where patients identified are transported to the partner hospitals for surgeries.
- None of the CHCs have a specialist. At CHC Mundi, as ophthalmic Assistant is posted. Is on a camp on the day of the visit.

Manipur

- Cataract Surgery is carried out in the two medical colleges Jawaharlal Nehru Institute of Medical Sciences (JNIMS) and Regional Institute of Medical Sciences (RIMS). One of the local hospital is a empanelled hospital which also carries out Cataract operations.
- However, the Cataract detection is reported inadequate with a back log of surgeries at the state level.
- Eye surgeons are available in the DHs of Bishnupur, Thoubal, Senapati, Churachandpur and Ukhrul; while in most of the DH, equipment and functional OTs are not available. The District Hospitals and below did not perform cataract surgeries.
- In the CHCs visited there is no fixed days services available with planned visits of Ophthalmologists.
- The health care facilities reported of Visual tests for refractory error and minor procedures being undertaken at the OPDs. The cataract and major eye illnesses are referred to RIMS, JNIMS and Shija Hospital
- Community awareness on service provision related to eye care is optimal, and individuals are seeking care at the health care facilities. However, the reporting is not satisfactory and village blind/visual impairment registers are not seen anywhere.

Meghalaya

- Human Resources shortfall is reported in the state where shortage of Ophthalmologists and near absence of optometrists is adversely impacting the service provision under the programme.
- Across the districts, The school children are school children getting screened, also, some have attended cataract operation under Govt./ NGO arranged Camps. Some of the children with reading problems end up accessing corrective measures from private sector. Children are getting Vitamin A through ASHAs & at AWC.

Mizoram

- At state headquarter, civil hospital has a functional OT for eyes surgeries, and over 2000 surgeries are reported in last year.
- Although reporting and recording of cases is being done as regularly; yet a three month backlog is being reported for cataract surgeries.
- At districts and block level, a ophthalmologists are in position at many facilities and are providing eye care services; however, facilities which lack skilled personnel are not able to provide services related to eye care.
- Medical Officers have taken an initiative and are conducting screening for students in school, although it is being done infrequently.

Nagaland

- Community reported of cataract and visual impairment as a common condition amongst elderly population subgroups. Due to village level screening camps being organized regularly in community and schools, cataract and refractive error conditions are know to the community.
- Villagers undergone cataract surgeries came up as a field champion and role models to build community's trust in blindness control services and acceptance of the screening camps in their village areas.
- Churches too are being used as a platform to spread awareness related to eye care and services available at the health care facilities.
- Pastors referred to eye screening camps as a brilliant initiative to reach to the community who otherwise would have not travelled to the CHC/DH to get screned for eye conditions.
- Facility level screening camps are also being organized at block and sub block level, however there is no follow up mechanism in place for identified cases in the community.

Odisha

- At Kandhamal, 20 bedded well maintained eye ward is available but with only two patients.
- There is lack of awareness about cataract, glaucoma, retinopathy and visual impairment in the community. Community in Badasahi village did know about cataract and availability of free operations and spectacles. But they are not aware about the other problems.
- During interaction people could not say about the availability of the services and lacked knowledge about timely care for eye ailments which can save from severe morbidity /blindness.
- Eye Surgeons are posted for routine emergencies and other routine work leading to their sub-optimal utilization for eye care.
- There are untreated cases of cataract identified in the visited community. Also a backlog of cataract surgeries is reported in the districts.
- Very few surgeries (3 per week cataract surgeries) are done in district hospital in Kandhamal and most of the surgeries being shown as an achievement which is done under the NGO program.
- OT is not fully equipped, and the infrastructure is old and roof leakage is identified at the time of the visit.

Rajasthan

- Community awareness about NPCB is poor in community, including those with eye problems

(cataract and others), and thus individuals are seeking care from private providers and are incurring OOPE in treatment.

- Ophthalmologists at DH /SDH sub optimally utilised. Both the DH Sirohi and DH, Churu SDH Sujangarh in Churu are equipped with eye OT and 1 Ophthalmologist.
- Although Eye Surgeons are performing surgeries, however due to unavailability of IOL and other equipment at SDH Sujangarh, their role is limited to the camps where the equipment and logistic support is provided by the NGO counterparts. In absence of adequate equipment, SDH is not reporting any surgeries and is reported as non-functional even with adequate HR available at this level.

Tamil Nadu

- Community members are aware of screening and the provision of glass especially under RBSK. However, there is a need to generate awareness amongst community members regarding availability of services for eye care including screening at the NPCB camps. Community level awareness on the services provision under the programme is poor.
- For age related vision problems and diabetic retinopathy treatment some of the members reported to have sought services from the private facilities.
- Fixed day screening is being done at BPHC on every Tuesday by an Ophthalmic Assistant, and the identified cases are referred to the GH. Also at APHCs, BPHCs and UPHCs, recently camps have been introduced exclusively for diabetic retinopathy.
- Under RBSK, screening in government and government aided schools is conducted, and spectacles are provided to children; and if needed children are referred to the higher center.
- BPL patients are provided free spectacles through the funds from the State Blindness Control Society.
- Records and Reports are found satisfactory across the facilities and registers are well maintained at DH including Eye OP for DM/HT screening register, Eye OP register, cataract Surgery record, Pterygium register, Glaucoma register, cataract follow up register.
- In FY2018-19, 494 schools covered ad 1,53,908 children are screened. Out of all children screened, 8,696 children are identified with refractive error and are provided with spectacles.
- TNMSC procures spectacles for schools, which takes 3-6 months to reach the beneficiary. However, the provision of free spectacles is missing those children who are out of school. Under NPCB, procurement is usually done locally.
- New Initiative Proposed: A Tele V Care Centre has been set up at Narikkudi BPHC, where the infrastructure and HR (an optician) is already available. Using Mobile phoes, a fundus camera image will be taken and sent to Madurai Medical College or Chennai Medical College. The results are expected to be available in 15 minutes.
- Tele Imaging: This is new initiative started by state in collaboration with Arvind Eye Hospital, Madurai. Babies < 25 weeks of age and sick babies will be screened for Retinopathy of Prematurity at the DH in Virudhunagar. The Mobile equipment is brought from Madurai on alternative weeks (one week in Virudhunagar and 1 week in Rajapalyam and placed at the NICU. Handholding/capacity building is currently being provided and it is proposed that once trained, the same would also be introduced at the GH.

Uttar Pradesh

- Beneficiaries from the community are usually referred to district hospital for all eye related surgeries. Optometrist at CHC conducts the eye check-up at the community and facility level.
- At the district level, adequate availability of HR is reported. Eye surgeon are available at the level of DH, while with in the district Optometrists are available. In Baharaich district alone, 13

Optometrists and 17 Optometrist through RBSK are available.

- DH is undertaking all major activities under the NPCB. Against the target of 17,881 surgeries in current FY 2019-20, 3,556 surgeries are reported conducted in Baharaich.
- A large number of surgeries have been undertaken at DH, Meerut in the current year (including Small-Incision Cataract Surgery (SICS), PHACO and minor surgeries).
- Eye care camps are not reported at district and below in either of the districts in current FY.

Uttarakhand

- Community awareness on vision impairment is found poor in the districts.
- Currently screening is being conducted at the schools and so far 12 out of 23 schools have been covered.
- Follow up mechanism needs to be strengthened as a present there is no follow up done for cataract cases and Visual impairment register is also not available at the facilities.
- Facilities are at higher level are well equipped and the following equipment are available - Perimeter, Tonometer, illuminated vision, Testing drum, Trial lends sets with frames, slit lamp, Snellen and nearer vision charts and battery operated torch.
- In US Nagar, individuals with eye problems (including cataract) are seeking care in the private sector and some would go to Nepal as is only 10 km from the village and the cost of treatment is low as compared to India. Screening camp in the village is carried out by NGO in 2018.

National Overview: National Program For Prevention & Control Of Deafness (NPPCD)

National Programme for Prevention and Control of Deafness (NPPCD) is launched in year 2006-07 and is currently operational in 384 districts. The key objectives of NPPCD are to prevent avoidable hearing loss on account of disease or injury, enable early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness, medically rehabilitate persons of all age groups, suffering with deafness, strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme and develop institutional capacity for ear care services by providing support for equipment and material and training personnel.

Key Findings

- In almost all the states, services are limited to the District Hospital (DH). The cases from facilities at block and below are referred to DH. In Nagaland, only Otitis Media cases are being treated at the DH, while for any other ear related conditions, patients are directly referred to Kohima or Dimapur.
- In Tamil Nadu, free hearing aids being provided under CMHIS (Chief Minister's Comprehensive Health Insurance Scheme) while in Uttar Pradesh it is provided by Divyank Kalyan Vibhag. In Uttarakhand and Mizoram hearing aids are not being supplied from State to the facilities.
- Linkage between NPPCD and RBSK programme for identification and referral of Congenital Deafness/ Hearing problems in neonates, infants/ Under five children is found in all states except Bihar, Chhattisgarh and Delhi where it is poor. Cochlear Implants are being carried out at Tamil Nadu and Gujarat.
- There is a lack of understanding of program among the frontline workers. Awareness among community, on problems related to hearing and knowledge regarding availability of services at the government facilities is poor.

Recommendations

- Orientation of field levels workers (ASHA, ANM etc.) along with the primary and secondary level facility staff on NPPCD is needed for early detection and timely referral of common Ear problems.

- Rational placement of Human Resource including audiologist to be ensured for early detection of hearing problems.
- Awareness camps may be conducted involving NGOs, SHGs etc. and referral linkages to DH must be improved for better access of the community. IEC campaigns are required to create awareness among the community members.
- Supply of essential consumables such as hearing aid needs to be streamlined in order to provide ensured services.

State Specific Findings

Andhra Pradesh

- There are no specific practices or activities are reported regarding National programme on prevention and control of deafness.

Bihar

- Screening for congenital deafness/ hearing problems in neonates, infants and under 5 children is not being conducted, as functionality of RBSK in the districts is sub optimal.

Chhattisgarh

- Linkage with RBSK not done for preschool children and a poor follow up is reported.

Delhi

- The findings varied across the health facilities. As part of the World Hearing Day Campaign, a hearing camp is organized by Polyclinic Basant Gaon in coordination with ENT Specialist in March 2019 for screening of patients. While LBS hospital reported of distributing hearing aids to the identified individuals with hearing loss conditions.
- Counselling sessions for hearing loss patients is not observed in any of the facility.
- Delhi Cantonment Hospital reported of facilities like soundproof rooms for ear testing by audiometrists.
- Brainstem-evoked Response Audiometry (BERA) is not reported being undertaken for screening of children in any of the facility.

Gujarat

- HR availability varied across districts where Dahod reported of audiologist, audiometric assistant and instructor being at position and ENT surgeon's position vacant at the DH; while ENT surgeons are available at DH Dahod and visiting CHCs irregularly than on fixed days.
- Hearing aids are being distributed under this program.
- Linkages with RBSK are established and referrals for cochlear implants are done to higher centres.

Jharkhand

- Community awareness on preventive care and risk factors associated with hearing loss is reported low.
- None of the districts have been approved for NPPCD.
- Deafness screening is not being undertaken in Gumla district under NPPCD or through RBSK. While in West Singhbhum- Deafness screening through RBSK is being undertaken and identified cases are referred to MGM medical College Tata Nagar.
- No collaborations observed with Department of Social justice regarding distribution of hearing aids.

Madhya Pradesh

- ENT specialists are only available at the DH level and there are no services at sub district level and below.

Meghalaya

- The community is not aware regarding the existence of National program for deafness, however, some elders reported having impaired hearing & are aware that, Govt. facility is available, but haven't accessed it yet.

- ASHA is knowledgeable & helpful to offer basic cares & other advices.
- Distribution of hearing aids is happening at West Garo Hills.
- Deafness related surgeries e.g. Myringoplasty, Tympanoplasty, Myringotomy, Stapedectomy Mastoidectomy etc. are not being done due to unavailability of trained personnel and unavailability of equipment.

Mizoram

- At state and district headquarter skilled staff and logistics are available for testing and treatment of hearing problems. At CHC and PHC level, skilled staff and services are not available.
- No hearing aids distributed so far as there is no stock available and supplied from the state authority.

Nagaland

- NPPCD implementation is not found satisfactory within the districts. The services under the programme are not being delivered at health care facilities below district level.
- For NPPCD, only Otitis Media cases are being treated at the DH, while for any other ear related conditions, patients are directly referred to Kohima or Dimapur.

Odisha

- Community awareness is low regarding services available at the health care facilities.
- At the DH level, an ENT specialist is available but the services are not available at the level below DH, except the screening activities being undertaken under RBSK.
- NPPCD programme activities have not yet been initiated and intervention of ear-related illness is limited.
- Hearing screening and provision of free hearing aids is working very well under RBSK program through DEIC.
- The recruitment of NPPCD support staff has not been done.
- There is backlog of fund utilization for the last three years indicating lack of any activities in this area.

Rajasthan

- Awareness regarding NPPCD is found low amongst frontline workers and the community members.
- The implementation of the programme is limited to secondary level, and services are limited to routine services available at the DH /SDH only.

Tamil Nadu

- Awareness among community especially among the elderly on problems related to hearing and availability of services at the government facilities is very low
- No relevant IEC material visible within community, while at DH, IEC material is well displayed.
- Services are provided at district level only. HR available at DH includes 4 Medical officers and 1 Audiologist.
- Free hearing aids being provided under CMHIS; a total of 62 hearing aids distributed between August 2018 and May 2019.
- It is reported that when a child birth is reported at PHC/CHC/DH with a family history of hearing problems, then such cases are directly referred to DH.
- Every Wednesday disability camps organized at DH. Outreach camp are often organized where screening for deafness is done
- Screening done under RBSK for children in schools and AWCs and further services are provided at DEIC.

Uttar Pradesh

- Community reported of seeking care from private health care service providers for ENT related conditions.
- Adequate HR is available at DH including ENT specialist and audiometrists.

- Audiometry room is available in Baharaich DH, but is not present in Meerut district.
- Provision of services for deafness at block and primary level is very weak, and the cases are all being referred to DH.
- In Bahraich district, hearing aids are being provided by Daivyank Kalyan Vibhag. While Meerut did not report of providing hearing aids to the identified cases.
- Coordination with RSBK is observed more strong in Bahraich as compared to Meerut district.
- Service providers at primary and secondary level has not been reoriented on the program.

Uttarakhand

- The ENT specialist and audiologist are available at the DH Rudrapur, and are aware of program provisions but no concrete activities have been initiated so far.
- No hearing aids are distributed in last 6 months. It is reported that a linkage between RBSK programme for identification of Congenital Deafness/ Hearing problems in neonates, infants/ U5 children has been developed and is functional.

National Overview: National Programme For Health Care Of Elderly (NPHCE)

National Programme for Health Care of Elderly (NPHCE)is launched in 2010 with an objective to provide dedicated health care facilities to the senior citizens (>60 year of age).

The programme aims to provide accessible, affordable, and high-quality long-term, comprehensive and dedicated care services to an ageing population; create a new “architecture” for Ageing; and build a framework to create an enabling environment for “a Society for all Ages”. It also promotes the concept of Active and Healthy Ageing. One of the objective of the programme is also to strengthen the coordination between various

departments i.e. National health Mission, AYUSH and Ministry of Social Justice and Empowerment.

Key Findings

- Most of the states do have a functional ten bedded elderly ward at the level of District Hospital. The states which do not have a dedicated elderly care ward are Gujarat, Meghalaya and selected districts of Madhya Pradesh and Jharkhand. In Nagaland a five bedded elderly ward is available but is not functional. Also in Bihar and Mizoram, ten bedded wards are in place but not functional due to unavailability of HR and administrative reasons respectively.
- Many states are also having a daily OPD for Elderly while Delhi, Manipur and Uttarakhand are also giving elderly care services through fixed day clinics at the facilities. Few states are also providing elderly care OPDs with the NCD clinic services at CHC and DH level.
- Delhi showcased a good practice at the health facilities to make it easy for the elderly to seek care. A provision of separate queue has been

kept in the OPD and at dispensing counters so that elderly would not have any difficulty. Also, OPD services are available exclusively for elderly onSundays to cater to the various difficulties faced during the weekday rush at the hospitals. Also in Nagaland and Odisha, a separate queue has been kept to prioritize the elderly.

- Rehabilitation services for elderly patients are available to a certain extent at district hospital level although dedicated services are not being provided. At CHC and below level ther is a gross deficiency in provision of physiotherapy services for elderly both institutional as well as home based.
- Community awareness on elderly care services is reported low from all the states, except in Nagaland where elderly population in the HWC catchment area is visiting HWCs regularly to get screened for NCDs and also household visits are being done by the CHOs.
- Human Resource shortfall is also reported from the states, and Jharkhand also reported of no district level nodal officers dedicated to NPHCE.
- Training of service providers is lacking across the districts, and field findings indicated a need for refresher training of those who had undergone orientation training at the time of joining.
- Tamil Nadu also reported Health insurance schemes like CMHIS and PMJAY have been merged to facilitate provision of a common insurance benefit for elderly; and also an Old age pension scheme of Rs. 1,000 per month is provided by the Department of Social Welfare.

Recommendations

- States should expedite the training and refresher trainings of the workforce on NPCE guidelines to better understand the needs of elderly and delivery quality of care.
- State may strengthen its capacity by making Elderly care wards functional at the district hospitals, and linking the elderly care clinics with the NCD clinics at the CHC and DH.
- Health care facilities should be made elderly friendly and provisions of hand rails and elderly friendly toilets should also be made available. A provision of separate queue in OPDs and diagnostics and at the medicine dispensing counters may be preferred to prioritize the elderly.
- Linkages of AYUSH should be done at the district level and those AYUSH doctors placed in remote areas should also be trained in elderly care.
- Physiotherapy units should be near to the elderly care ward or Physiotherapist should periodically visit the elderly ward and provide services. If these options are not possible then a support may be made available in the facility to facilitate the movement of the elderly patients to the unit.
- States need to operationalize rehabilitation/ physiotherapy services either dedicated or exiting in the system for all the elderly requiring such services, at DH level.
- At the CHC and below level, adequate rehabilitation services with preferably 2 days institutional and remaining in the form of outreach and or home base rehabilitation care needs to be established.
- Integrated consultation facility may be set-up, where multispecialty consultation happens at one place, and elderly need not to move from one place to another.

State Specific Findings

Andhra Pradesh

- A ten bedded elderly care ward is functional at the District Hospital.
- Elderly care services are reported minimal in the community, and home visits for bed ridden elderly and training of care givers has not yet initiated in the districts.

Bihar

- A ten bedded elderly care ward is reported at the District Hospital Begusarai, but is non-

functional due to unavailability of Human Resource.

- Limited services available at the Health facilities as not dedicated clinic defined for Elderly care.
- DH has physiotherapy services available for the elderly, but the service is available on paid basis per session wise.

Delhi

- A ten bedded elderly care ward and Physiotherapy unit is present and also a dedicated elderly care clinic is functional at the facility and running on a daily basis.
- Routine clinical services are available in all facilities in the state. State has prioritized elderly care and ensured a separate queue for elderly for consultation and also dispensing of medicines to make it easy for them to avail services at the health facility.
- Previously elderly are issued a senior citizen card to facilitate the bi annual screening of elderly population for Hypertension, Diabetes and Cataract. The card is maintained by ASHA. This has been discontinued in most of the facilities.
- Elderly care OPDs have been extended to Sundays, and also some facilities are provided fixed day services to elderly population on Saturdays.
- In New Delhi district, Delhi Cantonment Hospital is running a pain clinic under Anesthesia department. Physiotherapy and Yoga clinic services are also available at the facilities and being used by the elderly.

Gujarat

- A dedicated elderly care ward is not available at the DH in both the districts.
- As a part of general OPD, elderly care clinic is also conducted and elderly are given the preferences in queue.
- Although physiotherapy unit is available at the DH; however, due to unavailability of specialized equipment, it is not being used for elderly.
- None of the service providers had undergone training on Elderly Care.

Jharkhand

- No District Nodal Officer identified for NPHCE in both the districts.
- At the community level, Mobile Medical Units are being used for screening of elderly and also making medicines and diagnostic services available for both mobile as well as home bound elderly.
- 10 bedded geriatric ward is not available in both the district hospital; West Singhbum had a functional ten bedded elderly care ward at the DH, while Gumla did not have an elderly care clinic either separately or collocated with NCD clinic. Elderly care services are limited to District Hospital.
- No collaboration available with Department of Social Justice for distribution of supportive devices for elderly.
- No separate queues are available for the elderly. Dedicated physiotherapy services or preferential treatment at existing rehabilitation/ physiotherapy units not available at DH/CHC

Madhya Pradesh

- A ten bedded elderly care ward is functional at the DH in Chhindwara district.
- In Khandwa, NCD clinic at the DH is also functioning as Elderly clinic. NPHCE cards for elderly patients are being used in the clinic for following up with Elderly patients.
- No fixed day services for elderly reported in the state.

Manipur

- A ten bedded elderly care ward is functional at the DH in Bishnupur district and is being developed in the DH in Chandel district.
- Elderly care clinic is held weekly on a fixed day in the DH and free of cost OPD tickets and medicines are provided to the elderly population seeking care.

- Also a physiotherapist is engaged for elderly care, but in absence of equipment the services are currently not being provided.

Meghalaya

- Community awareness on elderly care services is really low, and elderly are seeking care from both public and private health care facilities.
- Elderly care ward is being developed at the CHC and DH in Ri Bhoi district.

Mizoram

- A ten bedded elderly care ward is present but not operational due to administrative issues.
- Civil hospital has a dedicated NPHCE clinic and physiotherapy services are also available.
- Services are not available at CHC and PHC; and trainings are yet to be done for elderly care services.

Nagaland

- Community awareness and care seeking behavior of elderly is more in the catchment area of HWCs as compared to the elderly in the non HWC areas.
- Elderly are visiting HWC regularly for Hypertension and Diabetes screening and treatment.
- A five bedded elderly care ward is available but is not operational at present. The elderly care services are limited to the districts and CHC NCD clinics. However, it is observed that CHOs at HWCs are doing household visits to houses with elderly on a routine basis.
- NCD clinics at CHC and DH are also delivering services for elderly, and a provision of separate queue has also been to prioritize the elder people.

Odisha

- A ten bedded elderly care ward is functional at the DH. Pulse oximeter, oxygen cylinder is available in elderly care ward.

- The elderly friendly queue system is observed in SDH Rairangpur and district level.
- In Kandhamal, One physician is also appointed who visit the ward regularly.
- At Badasahi CHC, regular camps are conducted to screen elderly patients and facilitate treatment.
- Linkages with the AYUSH department for wellness and quality care in geriatric patients are not observed in any of the facility visited. However, there is demand for AYUSH medicine and OPD panchakarma in visited HWC in the Mayurbhanj district. The CHO at HWC also demanded AYUSH medicine and set-up for OPD panchakarma.

Rajasthan

- Community awareness regarding NPHCE services is poor.

- Services are limited to district hospitals and utilization is reported suboptimal.

Tamil Nadu

- Community awareness regarding NPHCE services is poor.
- A ten bedded elderly care wards is functional at the DH. Daily OPD services are available and HR available includes 2 Medical Officers, 1 Physiotherapist, 2 Attendants. DH Virudhunagar also has a dedicated physiotherapist and a rehabilitation unit.
- Health insurance schemes like CMHIS and PMJAY have been merged to facilitate provision of a common insurance benefit for elderly; and also an Old age pension scheme of Rs. 1,000 per month is provided by the Department of Social Welfare.

Uttar Pradesh

- Community based interventions are reported minimal in the state.
- A ten bedded elderly care ward is functional at the DH, and a well-equipped physiotherapy unit is also operational in both the districts. No separate records are maintained for elderly cases.
- Human Resource shortfall is observed in both the districts. Also, service providers have not received any refresher training in last few years on NPHCE.
- Services below DH are limited, and only counselling is being done at CHC/HWC – PHC/SHC.
- No outreach activities reported for elderly care services.

Uttarakhand

- A ten bedded elderly care ward is available at the DH Rudrapur, and fixed day elderly care services are being provided at the SDH.

National Overview: National Programme For Palliative Care (NPPC)

Government of India launched National Programme for Palliative care (NPPC) in 2012 with a goal to ensure availability and accessibility of rational, quality pain relief and palliative care to the needy, as an integral part of Health Care at all levels, in alignment with the community requirements.

The key objectives of NPPC are to (i) improve the capacity of service providers to provide palliative care, (ii) refine the legal and regulatory systems and support implementation and ensure access and availability of opioids while maintaining measures for preventing diversion and misuse, (iii) promote behaviour change in the community and (iv) ensure continuous progress towards the vision of the programme.

Key Findings

- NPPC implementation is reported in nascent stage in most of the states. While in most of the states, the programme functionality is limited to District Hospitals, states like Meghalaya, Chhattisgarh, Jharkhand, Mizoram, Nagaland are yet to implement the programme.
- Palliative care services where rolled out, are limited to District Hospitals. Procedures like Ryle's tube insertion, catheterization and ascites tapping are available at the DH, but

are underutilized. Manipur is the only state which reported a ten bedded ward at DH level, and two bedded ward at 2 CHCs and 2 PHCs have been established and are being utilized.

- Lack of training is observed amongst the Service providers on Palliative care services, and those trained also requested for a reorientation on the programme guidelines.
- Manipur reported a high community awareness and engagement regarding palliative care services. At the level of community, regular awareness camps are organized by CHOs, and CHOs' involvement in delivering Palliative care services is well appreciated in the community.

Recommendations

- States may plan and develop comprehensive plan to develop referral linkages between primary and secondary level, to spread awareness in the community regarding existing services and increase utilization of services across the levels of care.
- States may organize orientation of service providers including frontline workers on palliative care services.
- Awareness and orientation on home-based palliative care to be undertaken in the community. Care giver's support may be strengthened by routing home visits and training of care givers.
- Follow up mechanism to be developed to ensure treatment compliance and supporting the care givers of the patients.

State Specific Findings

Andhra Pradesh

- Palliative care services are at nascent stage, where community awareness is also limited to the basic information.
- Health workforce needs an orientation on NPPC.

Bihar

- NPPC services limited to the District Hospital. Support services like Ryle's tube insertion and Catheterization is available at DH Begusarai.

Chhattisgarh

- Palliative care services are reported minimal in the state.

Delhi

- Palliative care services are limited to the secondary level facilities, and services are limited to procedures like Ryle's tube insertions, catheterization, ascites tapping, complex wound dressing
- Oral Morphine is not available with Medical Officers for palliative care services.
- Health care providers not visiting the terminally ill patients for care or orientation of care givers/ family members.

Gujarat

- NPPC is not fully operational in the state. As a part of support services, procedures like Ryle's tube insertion, catheterization and ascites tapping are available at the District Hospital.
- Training of Medical Officer, Staff Nurses and Community health workers is yet to be institutionalized.

Jharkhand

- Palliative Care services not yet implemented in the state.

Madhya Pradesh

- NPPC not fully operational in the state.

Manipur

- A ten bedded ward at DH level, and two bedded ward at 2 CHCs and 2 PHCs have been established in the state, dedicated to Palliative care services. Procedures like Ryle's tube

insertion, catheterization and ascites tapping are available at the District Hospital.

- Although Tab Morphine is not available at one of the DH, but Tab. Tramadol and Fentanyl analgesic patch is available.
- Continuum of care is observed in the HWC catchment areas. State reported of regular awareness camps being organized by CHOs, and CHOs' involvement in delivering Palliative care services is well appreciated in the community, PRI and NGO's involvement is also reported by the health officials.

Meghalaya

- Palliative Care services not yet implemented in the state.

Mizoram

- Palliative Care services not yet implemented in the state.

Nagaland

- Palliative care services are not available at the health facilities.
- Community lack awareness on Palliative care services. Many cancer and other chronic conditions' patients including elderly are under treatment who travel to higher facilities for treatment and return back to their homes. At present there is no facility in community/ facilities to provide care to such patients or to support their family members or caregivers who are going through compassion fatigue.

Odisha

- Community visits found many sick and bed-ridden patients without any support from the palliative care program.
- There is no awareness about the availability of the services and lacks orientation and information on care for bed-ridden patients.
- Staff is not trained in palliative care
- Equipment (Ryle's tube, urinary catheter, Ascites tapping facilities) for palliative care is lacking at all levels except at DH where it is not systematically organized.
- Lack of structural plan for the home-based palliative care is noted.
- Poor fund utilization in palliative care for the last three years is noted.

Rajasthan

- NPPC not fully operational in the state.

Tamil Nadu

- Home based Palliative care and counselling provided at Villupuram. In Virudhunagar, awareness regarding Palliative care services is low amongst the community members.
- Palliative care facility level services are limited to DH.

Uttar Pradesh

- NPPC is operational in only district and is yet to be implemented in Baharaich.

Uttarakhand

- NPPC is in nascent stage where only limited services are available.
- Community based interventions not fully operational, and at present no orientation of care givers being given in the community.
- Sensitization camps being conducted by front line workers.

National Overview: National Programme For Prevention And Control Of Fluorosis (NPPCF)

National Programme for Prevention and Control of Fluorosis (NPPCF) is launched in 2008-09 and is being expanded in a phased manner. Fluorosis is endemic in 132 districts across 19 states. Among CRM States, 10 have endemic districts: Andhra Pradesh (3), Bihar (10), Chhattisgarh (4), Gujarat (4), Jharkhand (13), Madhya Pradesh (15), Rajasthan (28), Odisha (3), Tamil Nadu (1) and Uttar Pradesh

(5).2 *The programme aims to prevent and control Fluorosis cases in the country, with an objective to collect, assess and use the baseline survey data of fluorosis of Ministry of Drinking Water and Sanitation for the project; Comprehensive management of fluorosis in the selected areas; and Capacity building for prevention, diagnosis and management of fluorosis cases.

Key Findings

- In the most of the states, National program of prevention and control of fluorosis is yet to be operationalised in a more effective way to yield better results from the field.
- In Chhattisgarh and Madhya Pradesh, screening activities of fluorosis is conducted and visible deformities are observed but physiotherapy services are not provided. Stockout of calcium tablets is also reported in Chhattisgarh.
- Although fluorosis screening is observed in states like Madhya Pradesh, Andhra Pradesh and Rajasthan, no further activities could be observed to reduce the impact of fluorosis.
- States like Delhi, Nagaland, Mizoram, Manipur, Uttarakhand and Meghalaya do not have fluorosis affected districts.

Recommendations

- Community level awareness can be strengthened and proactive measures to be undertaken for programmes implementation in the endemic districts.
- IEC activities to be planned to disseminate information on fluorosis, its prevention and on use of vitamin D, Calcium supplements, to minimize the impact of fluorosis.
- Regular review at district level and at State level needs to be institutionalized.
- Defluorination plants are to be installed in fluorosis affected areas.
- In fluorosis affected areas, the focus on prevention and control of fluorosis should also cover the community and primary level of health care services.

State Specific Findings

Andhra Pradesh

- In fluoride affected district, minimal measures are taken to reduce the impact of fluorosis.

Chhattisgarh

- Visible deformities are observed in most of the children of the community which is an alarming situation.
- Water Source testing is undertaken in PHCs and school water source.
- Stock out of calcium syrup and tablets is noted in the visited facilities. Physiotherapy services are not available for patients with skeletal deformities.
- The number of IEC materials placed is minimal and at inappropriate positions in the visited facilities.

Delhi

- Screening for fluorosis is conducted by dentists in the visited maternity homes of Delhi.

Jharkhand

- In both the visited districts, there is no component of NPPCF as they are not among the identified fluorosis affected districts.

Madhya Pradesh

- No programme specific interventions are reported in the fluorosis affected districts other than screening of children for fluorosis.
- District fluorosis lab is operated by trained person from NIN.

2 1*Source: DGHS, National Programme for Prevention and Control of Fluorosis, list of districts available at https://dghs.gov.in/content/1355_3_NationalProgrammePreventionControl.aspx)

Rajasthan

- No programme specific interventions are reported in the fluorosis affected districts. Cases of dental and skeletal fluorosis are observed in both the visited districts, yet no specific measure are reported.

Uttar Pradesh

- Both visited districts are not affected with fluorosis, hence the service delivery for this program is not observed in any of the facilities visited in district.

National Overview: National Iodine Deficiency Disorders Control Programme (NIDDCP)

National Goitre Control Programme (NGCP) is launched in 1962 which is later renamed as National Iodine Deficiency Disorders Control Programme (NIDCP) with a view of wide spectrum of Iodine Deficiency Disorders like mental and physical retardation, deaf mutism, cretinism, still births, abortions etc.. The programme is being implemented in all the States/UTs for entire population. According to survey conducted in 414 districts (data from 2015-16), 337 districts were endemic for IDD where prevalence of IDD was >5%. All CRM states have districts endemic for IDD.[3] *The goal of the programme is to bring the prevalence of IDD to below 5% in the country and ensure 100% consumption of adequately iodate salt (15ppm) at the household level.

Key Findings

- Community awareness on consumption of iodised salt is average, where states like Gujarat, Nagaland reported community being informed and well aware on benefits of iodized salt; while in few states the community is lacking the information on ill effects of iodine deficiency.
- In Nagaland, it is observed that even Salt traders are involved in the planning to ensure that only iodised salt is made available to the community. Meghalaya and Manipur also reported community using mainly iodised salt in their cooking.
- Salt testing is being carried out in few states, and Delhi, Jharkhand, Manipur and Mizoram reported of Salt Testing Kits being provided to ASHAs; in U.P., although the STKs are provided to ASHAs, due to lack in clarity on its usage, they are underutilized. Delhi also reported stock out of the kits during the time of visit. Bihar, Meghalaya and Uttarakhand reported of STKs not being available with ASHAs during the visit. In Tamil Nadu, STKs are available at the Sub Health Centre level.

Recommendations

- State may streamline the availability of salt testing kits with ASHAs and at the facility level, where needed.
- Proactive measures may be undertaken for monitoring a the implementation of the programme in the districts.
- Community based fora like VHSNC and MAS may also be utilize in generating the awareness in the community on benefits of iodised salt and also methods of cooking to avoid loss of iodine in food.

State Specific Findings

Andhra Pradesh

- The District IDD cell is formed but the training is yet to be done.

Bihar

- Iodine testing kits are not available at district level or below, and samples are being sent to State Headquarter PMCH Patna for testing.

3 2*Source: DGHS, National Iodine Deficiency Disorders Control Programme, list of districts available at https://dghs.gov.in/content/1348_3_NationalIodineDeficiency.aspx

Delhi

- Iodine testing kits are made available to the ASHAs for testing of salt samples, but are out of stock at the time of visit.
- Under NIDDCP programme, salt and urine samples are sent by districts to GTB Hospital on rotatory basis.

Gujarat

- Iodised salt is mostly available and utilized throughout all communities in the state. Many people are aware regarding health hazards of iodine deficiency.
- Salt iodine testing kits are not available as not procured. In CHC Bardoli, 350 urine samples tested since March 19 for urine Iodine level.

Jharkhand

- Out of 24 districts, 9 districts in state have been selected for IDD survey, and a line listing of villages is already completed in the visited district, as the first step.
- Test kits have been provided to Sahiyas for household sample testing.

Manipur

- State IDD Control Cell and IDD monitoring Laboratory are established.
- Test kits have been provided to ASHAs who are undertaking the testing activity in respective catchment areas.
- Salt Testing kits (STK) are supply is reported adequate in the states.
- Consumption of iodised salt reported at household level in 99%, and non-iodised salt is not being supplied in the state.

Meghalaya

- STK is not available with the ASHAs.
- Community reported of consuming iodised salt although, yet expressed a need to be trained on cooking methods to ensure that iodine content in the salt is not lost while cooking.

Mizoram

- Only a few ASHAs are observed carrying STK and undertaking the salt testing activity.
- Health facilities do not have iodine testing facilities.

Nagaland

- Community awareness is high on benefits of consuming iodized salt in diet.
- Salt traders are involved in the planning to ensure that only iodised salt is made available to the community. VHCs are aware of the salt testing activity and are able to describe the iodine deficiency being common in their area because of being located in Sub-Himalayan belt.
- With continuous IEC activities undertaken in the villages and concerted efforts by the service providers, state has shown a great progress where Goitre prevalence has been reported as 1% at present.

Rajasthan

- Community along with ASHAs, ANMs and other workers are mostly unaware of National Iodine Deficiency Disorder Control Programme.

Tamil Nadu

- Awareness in the community about IDD is low, however, usage of iodized salt is reported by community members in both districts as a matter of habit. Testing of salt for iodine presence in appropriate amount is done by VHNs and Health Inspectors at community level. Only random tests of 10 samples per block per month have been reported.
- Salt testing kits available at HSC.

Uttar Pradesh

- During home visit, it is observed that mostly iodised salts are being used at the household level.
- Salt testing kits are available with ASHAs, while the clarity on usage of kits is lacking. Monitoring

of usage of these kits is also not observed in the district.

- For quality control of iodised salt 10 samples per month are collected and sent for further analysis.
- Availability of IEC materials district and below is not observed.

Uttarakhand

- Poor community awareness on consumption of iodized salt and ill effects of iodine deficiency is observed in both the districts.
- Salt testing kits are not available with ASHAs. Involvement of ASHAs in the programme is minimal.
- Since, largely iodized salt is consumed in the community, the service providers did not perceive IDD as a major issue.

National Overview: National Programme For Prevention And Management Of Burn Injuries (NPPMBI)

Ministry of Health & Family Welfare initiated a "Pilot Programme for Prevention of Burn Injuries" (PPPBI) in three Medical Colleges and six Districts Hospitals in Haryana, Himachal Pradesh and Assam in year 2010.

The Goal of PPPBI is to ensure prevention of Burn Injuries, provide timely and adequate treatment in case burn injuries do occur, so as to reduce mortality, complications and ensuing disabilities and to provide effective rehabilitative interventions if disability has set in.

The programme is scaled up and launched as National Programme for Prevention and Management of Burn Injuries (NPPMBI) in year 2014. The key objectives of NPPMBI are to reduce incidence, mortality, morbidity and disability due to burn injuries, improve awareness among community including vulnerable groups, establish adequate infrastructural facility and to carry out research for assessing behavioural, social and other determinants of Burn Injuries in our country for effective need based program planning for Burn Injuries, monitoring and subsequent evaluation.

Key Findings

- Most of the states reported that at the primary level, only first aid and basic services for trauma and burn are available, and patients are being referred to DH and higher centres for further management.
- Mostly the referral transport being used for emergency cases is facility based ambulances and 108 services. States like Bihar also reported of 102 services being utilized for the same. Tamil Nadu also reported of training of 108 staff (including drivers) being undertaken for emergency care as first responders.
- Tamil Nadu has set up an Accident and Emergency Care Initiative (TAEI), which is functional across the facilities and providing comprehensive services for emergency care.
- It is reported in Uttar Pradesh, that ambulances have been advised to transport the patients to the nearest facilities i.e. PHC/CHC, irrespective of the severity; thus leading to loss of patients who lose critical one hour time in transportation between the facilities. Also, districts have well equipped ambulances which ae underutilized due to unavailability of services at the nearest government facilities.
- Basic first aid services for stabilization including suturing and splints are available at the secondary level facilities in most of the states.
- Availability of separate burn ward is not reported in most states; and where available are being utilized as post-operative care ward due to unavailability of trainer Human resources at the facilities.
- Triaging and zoning is not reported in most states and thus it is observed that mostly the facilities are not prioritizing the patients' treatments based on the severity of their conditions.

- In states with difficult terrain and poor road connectivity, services are not reaching beyond sub district levels. Also the referral to the higher facilities is getting delayed due to unavailability of referral transport and poor road connectivity.
- At the Community level, individuals are seeking care for trauma related services from private providers and thus incurring OOPE.
- In Chhattisgarh, one DH had outsourced the trauma care centre and is functional adjacent to DH.
- No separate record/statistics of emergency care are being maintained across the facilities in many states.

Recommendations

- Emergency care services needs to be strengthened across the level of care, to ensure the availability of services at the primary level as well.
- States may ensure availability of adequate Human resources and skilled personnel for emergency care services at the facilities. This would also ensure optimal utilization of infrastructure, where available.
- State may expedite the capacity building exercise to ensure training of Casualty Medical Officers on “Emergency Care Management”.
- State may expedite the implementation of triage protocols across the facilities delivering emergency care facilities.
- Referral linkages may be strengthened to ensure timely referral to appropriate facilities, depending on the severity of the condition.
- Monitoring of outsourced Trauma Centre should be done on regular basis to ensure that services are within the affordability of the population.
- Periodic monitoring of ambulance utilization and deployment at district as well as state level should be undertaken to make the efficient / optimal utilization of public resources.

State Specific Findings

Andhra Pradesh

- At primary level, only basic first aid facilities for trauma and burns are available, and patients are then being referred to CHC and higher centres for further management.
- Emergency care services are available at the DH level; and patients are being referred to tertiary centres only for cases like neuro surgery.
- Blood facilities across the facilities is being managed through voluntary means, and thus availability is adequate.

Bihar

- There are no separate burns and trauma wards, and patients are managed in surgery ward itself. Triaging is not done.
- Transport for referral to higher centres is made available through 102 ambulance
- Emergencies in most secondary care facilities are limited to minor surgeries and dressing.

Chhattisgarh

- Community is seeking care for trauma related services, from private providers and thus incurring OOPE.
- District Korba has outsourced the building for Trauma care to a private hospital adjacent to the DH itself.
- Emergency services to the patients are being provided in the DH Rajnandgaon and for further follow up they refer the patients to Medical College.

Delhi

- Emergency services like dressing and suturing, initial care, first aid is being provided at primary care level.
- At DH level 200-300 daily emergency patients are provided services. Major burns, trauma, cardiac and neurosurgery emergencies provided at LBS hospital.

- The emergency department has inadequate space and insufficient staff as per IPHS, especially OT technicians and BLS trained staff.
- No triage zone are present at emergency of LBS hospital.
- Referral transport through CATS ambulance in most facilities, from 30-45 minutes.
- Ambulances services are present for inter-facility transfer of all emergency patients.

Gujarat

- Emergency department of DH Dahod is well equipped with 30 beds and bedside multipara monitors, central oxygen supply, emergency medicines kit, 24X7 functional lab services, defibrillator etc.
- First aid services are being provided for trauma cases in the casualty department of the SDH,CHC. No splint application facility for fracture cases in CHC and PHC. But at this level, there are no dedicated areas and facilities designated for emergency care.
- The first aid in emergency cases is available only at block level; where the spectrum of emergency services provided is narrow.
- Dog bite and scorpion bite cases are managed as per the guidelines.

Jharkhand

- At the DH level adequate infrastructure and equipment are available ; however, triage and zoning is not practiced.
- 108 and facility are ambulances providing referral transport.
- No separate burn unit reported at the facilities.
- Anti-rabies vaccine is not available since August 2019 at CHC level in Gumla, even though good number of dog bite cases have been reported.
- Mostly basic first aid services are provided at the primary level and patients are referred to DH for further management.

Madhya Pradesh

- Community interaction indicated a need towards improving the services at the village level.

Meghalaya

- It is observed that the community still practices some traditional remedies for fracture and burn injuries, and also avail treatment from government and private hospitals, involving OOPE. Facilities till CHC are providing only first-aid.
- State should plan for setting up comprehensive emergency services across the facilities.

Mizoram

- At state Headquarter, civil hospital has all logistics and services available as per protocol, but there is no separate ward for such patients.
- Below state level, at DH/CHC and PHC, only first aid services are provided in OPD.
- No separate logistics/ infrastructure is built for burns and trauma. Cases are referred to higher facilities outside the state.

Nagaland

- Services are not reaching beyond sub district level due to difficult terrain, poor road connectivity and unavailability of transportation facilities.
- Emergency services including trauma and burns are not getting addresses at the community level. Any individual with an emergency condition is rushed to the higher facility where mostly the delay happens due to unavailability of referral transport and poor road connectivity.
- Road accidents are not commonly reported in the community; however, animal attacks/bites, fights/clashes and falls are some commonly identified causes of injuries. For minor injuries, community is seeking care from PHC and higher facilities.

Tamil Nadu

- State has set up Tamil Nadu Accident and Emergency Care Initiative (TAEI). Community awareness on TAEI and services available for burn and injuries including 108 referral transport, is found satisfactory.
- First aid facilities are available at primary level facilities and CHC/SDH; and patients are referred to DH for further management.
- Referral transport facility being used for emergency care is 108 and drivers and paramedical staff in the 108 ambulance has been trained as first responders
- IEC materials including SOP are displayed well.
- Five TAEI Regional Training Centre have been established in the state i.e. Rajiv Gandhi Government General Hospital, Government Vellore Medical College Hospital, Government Mohan Kumaramangalam Hospital Salem, Government Rajaji Hospital Madurai and Government District Head Quarter Hospital Cuddalore.
- TAEI centres are functioning at the level of medical college, DH and even SDH.

Uttar Pradesh

- Primary care facilities are available at the HWC-PHCs. Poor diagnostics and unavailability of HR is reported at the CHC level.
- Burn care is not available at the DH level, and cases are referred to the Medical Colleg with in the districts as well as outside.
- District Hospital is referring all kinds of trauma cases (minor to major) to the Medical College which puts an unreasonable case load at one Institute/facility and hampers quality of care.
- 108 ambulances functioning well in transferring cases of road accident/injury (Burn/assault/ animal bites victims) in both districts.
- The ambulances have also been advised to bring the victims to the nearest health facility which is a PHC/CHC with bare facilities in 80% of the cases. Also, this leads to loss of life for majority of the cases/victims who lose critical one-hour (Golden Hour) time in transportation from one facility to other.
- In Meerut, well-equipped and GPS enabled emergency ambulance services are available free of cost with provision to provide appropriate Pre-hospital care through trained EMTs; however, they are not being utilized efficiently in absence of availability of comprehensive emergency services at the nearest Government facilities.
- Trauma Care Facilities are available in DH, Meerut and ae well equipped Emergency OT is available; however, it is underutilized as most of the procedures are being conducted in regular/ surgery OT itself.
- Ten bedded burn ward in Meerut is used as a post-operative care ward due to non-availability of Burn specialist. While in Baharaich existing beds of emergency ward at DH is utilized for same.
- No separate record/statistics of RTA/Burns are being maintained at any level of health facility in both the districts.

Uttarakhand

- Emergencies services like dressing, suturing, administration of IV fluids, splinting facility for fracture, initial care of dog bites, burn management and first aid services are available at PHC/SDH and DH.
- At the level of HWC/SHC, only first aid services are provided and referred to DH for further management, if needed.
- Transport used for the referral is generally 108 ambulances.
- Triage system is not available at PHC/SDH nor DH.
- Expired Drugs are seen in the emergency tray in one of the PHC.

स्वास्थ रहना एक आदत है

इसे अपनाएं !

- भरपूर फल एवं हरी सब्जियां खायें
- योग/व्यायाम करें
- तनाव मुक्त रहें
- स्वच्छ वातावरण एवं साफ सफाई अपनाएं
- तम्बाकू व शराब से दूर रहें
- नियमित स्वास्थ्य जांच करायें

अधिक जानकारी के लिए अपने नजदीकी हेल्थ एव वेलनेस सेंटर में संपर्क करें

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जिला स्वास्थ्य समिति, मेरठ

TOR 4: COMMUNICABLE DISEASES

National Overview

The past decade has seen India go through an epidemiological transition in disease burden and deaths due to Non-Communicable Diseases (NCDs) taking precedence over Communicable Diseases (CDs). This has led to a tussle for policy attention and resources between proponents of Communicable Diseases such as Tuberculosis, NCDs like cardiovascular diseases and diabetes with malnutrition further contributing to this problem. In order to tackle this triple burden of disease the Government of India is running a number of CD and NCD programs. Almost one-fifth of the world's population lives in India and hence the health status and the drivers of ill health vary between different parts of the country as well as between states. This section of the CRM report assesses the status of the 16 selected States with respect to the Communicable Disease programs running in India.

IDSP is a decentralized reporting and laboratory-based IT enabled disease surveillance, which monitors disease trends and detects and responds to outbreaks in early rising phase through trained Rapid Response Team (RRTs). It also has provisions for field investigation along with laboratory-based data collection to take necessary action whenever a disease outbreak is detected. Media scanning is one of the most important components of surveillance which detects early warning signals and the media scanning and verification cell receives an average of 2-3 media alerts of unusual health events daily which are detected and verified. During the CRM visit it is found that in majority of the states the sanctioned posts of epidemiologists are vacant and therefore, the preparedness and mitigation activities for health emergencies are also found to be weak or redundant in spite of the outbreaks being reported and EWS being generated in few states like Bihar, Jharkhand, Manipur etc. Constitution and availability of the RRT is also non uniform across all the visited CRM states.

India has made considerable progress in reducing its malaria burden and has achieved a reduction of 59% in malaria morbidity and 90% in malaria mortality between 2000 and 2018,thereby achieving the Goal 6 of the Millennium Development Goals (50-75% decrease in case incidence between 2000 and 2018).Malaria cases have also declined significantly by 49.09%. The deaths due to malaria have also been reduced by 50.51% in 2018 in comparison to 2017. There has been a decline in malaria deaths in 12 States whereas 19 States have sustained zero malaria deaths status. As per the annual report of MoHFW, malaria has seen a considerable decline in the high burden States of India i.e. NE States, Odisha, Chhattisgarh, Madhya Pradesh and Jharkhand with introduction of LLINs and integrated vector management control strategy. The state of Odisha has reported a sharp decline (81%) in number of malaria cases in 2018 and 2019 (45% till September).An increase in number of Chikungunya and Dengue cases have been reported by few states with the diseases showing an increasing

trend.Currently, Chikungunya is endemic in 26 States and 6 UTs. Recurring outbreaks of Dengue have also been reported from Andhra Pradesh, Assam, Delhi, Goa, Haryana, Gujarat, Karnataka, Kerala, Maharashtra, Odisha, Puducherry, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh and West Bengal. Dengue is a notifiable disease at present in 23 States. For Community ownership, GNCTD is carrying out a special drive on Dengue '10 Hafte, 10 Baje 10 Minute' campaign with emphasis on weekly source reduction activities.

In India, Kala-azar cases are mainly reported from 54 districts of 4 states i.e. Bihar (33 districts), West Bengal (11 districts), Uttar Pradesh (6 districts) and Jharkhand (4 districts). Government of India has approached Kala-azar elimination with a target to reduce th1e annual KA case incidence to <1 per 10,000 at block level. At the end of December 2018, 92 % of KalaAzar endemic blocks have achieved the elimination target of <1 per 10,000 at block level. In Bihar, the team visited has reported 39 cases of visceral Leishmaniasis and 2 cases of PKDL in the district Begusarai in the last year. In 2019 cases of kala azar and PKDL reported were Bihar (2416, 439), Jharkhand (539, 281), Uttar Pradesh (97, 50,), West Bengal (87, 51), Kerala (4, 0), with no deaths in any State.*More than 70% of the disease burden of Japanese Encephalitis (JE) is contributed by Assam, Bihar, Tamil Nadu, Uttar Pradesh and West Bengal. Out of the six vector borne diseases, JE is the only disease against which vaccination is available and 234 JE endemic districts of 21 states are being covered under JE vaccination campaign while 31 districts in 3 States i.e. Assam, Uttar Pradesh & West Bengal, in 2018 have been covered for adult vaccination. Strengthening of Critical Care Services has resulted in 42% decline in case fatality rate in AES/JE cases from 18.6% in 2013 to 10.8% in 2018. The maximum number of cases in 2019 were in UP, Odisha and Manipur, maximum deaths in 2019 in UP and Bihar.*

NTEP (erstwhile RNTCP) has come a long way since its initiationand has undergone major changes over the past few years. Much effort is being put to make the program more patient-centric and provide comprehensive treatment care and support. The Ministry has developed the National Strategic Plan (NSP) for Tuberculosis Elimination (2017-25) which builds on the success and learning of the last NSP and encapsulates the bold and innovative steps required to eliminate TB in India by 2025, five years ahead of the global targets. More than 20 million TB patients have been treated and the treatment success rates have tripledfrom 25% in pre-NTEP (erstwhile; RNTCP) era to 83% presently. TB death rates have also reduced drastically from 29% to 4%. Nine states account for 65% of the total TB burden- Assam, Bihar, Karnataka, Maharashtra, Rajasthan, Tamil Nadu, UP, West Bengal.

The current Prevalence Rate (PR) of leprosy in India is 0.67/10,000 population. However, it is observed that the trend of two important indicators of NLEP i.e. Annual New Case Detection Rate (ANCDR) and Prevalence Rate (PR) has remained almost static since 2005 – 2006 and Grade II disability (G2D) rate has increased from 3015 (1.87%) in 2005-06 to 5852 (4.60%) in 2015-16, which indicates that a large number of undetected cases are still present in the community, and that the transmission of the disease agent still continues. Few interventions like introduction of Sparsh Leprosy Awareness Campaign (SLAC) has helped reverse the rising trend of G2D. Another initiative being carried out since July 2017 is the ASHA Based Surveillance for Leprosy Suspects (ABSULS) in order to screen the population at the village level for signs of leprosy and to refer the suspected cases to designated health centres.

National AIDS Control programme (NACP)-IV is under implementation for the period 2017-20. The national prevalence among adult population (15–49 years) is estimated to be 0.22%. The adult HIV prevalence at the national level has shown a continued steady decline. Mizoram has shown the highest estimated adult HIV prevalence of 2.04% followed by Manipur (1.43%), Nagaland (1.15%), Telangana (0.70%) and Andhra Pradesh (0.63%). The most common route of transmission identified in these high burden states is through sexual route. The annual number of AIDS related

1 * (Source: programme website https://nvbdcp.gov.in/index.php)

deaths has also declined by almost 71%. State wise Prevention of Mother to child transmission (PMTCT) number is the highest in Maharashtra followed by Uttar Pradesh , Bihar, Andhra Pradesh, Karnataka, Telangana, West Bengal, Gujarat and Tamil Nadu, least being in Sikkim.During NACP, the availability of safe blood has also increased from 44 lakh units in 2007 to 1.22 crore units by 2018-19. NVHCP is launched in July 2018 with the aim to benefit persons infected with viral hepatitis by reducing mortality and morbidity attributed toits early stages of implementation. The program is being expanded in a phased manner for testing and treatment of Hepatitis B and Hepatitis C.

Integrated Disease Surveillance Program (IDSP)

Key Findings

- Diligent filling of forms and weekly reportingobserved in most states but gaps in timeliness of reporting in Odisha and NE states is seen due to poor internet connectivity and difficult terrains.
- Post of Epidemiologist is found vacant in most of the states visited, which is a big area of concern. In Bihar and Chhattisgarh, other crucial positions like Entomologist, Veterinary and Training consultants are also vacant affecting smooth implementation of the programme.
- Thus, most of the states visited had poor epidemiological data analysis, forecasting and planning for communicable diseases.
- No orientation / training / refresher trainings of MOs and other staff regarding IDSP isobserved inseveral states. Where training is being imparted, it is of suboptimal quality like that in TN.
- In majority of the districts DPHL are either dysfunctional or did not exist. In Bihar, out of the 6 sanctioned DPHL only one lab at Patna is found to be functional.
- In some states Integrated Health Information Platform (IHIP) training had not been initiated.
- Community awareness regarding the signs and symptoms of vector borne diseases such as Malaria, Dengue and Chikungunya is found optimal in most of the states visited but the same about other communicable diseases like Leprosy, JE, Kala- Azar is found to be low. Even, knowledge among the frontline workers- ASHAs & ANMs, on various communicable diseases and their surveillance mechanism, inthe states of Bihar, Nagaland and Uttar Pradeshis found to be sub-optimal.
- In some states, especially the North East states such as Nagaland, majority of the people preferred to use traditional, locally available herbs and medicines for treatment of common ailments such as fever and cough as well as major ones like animal/snake bite.
- Other gaps like wrong data entry, weak or negligible reporting of Early Warning Signals (EWS) and non-reporting by Private hospitals in the IDSP portal are noted across all the states.

Recommendations

- States to sanction/fill in the key vacant posts at the earliest to ensure proper forecasting of early warning signals and adequate preparedness to deal with the impending outbreaks.
- Laboratory diagnoses of common outbreak prone diseases like Dengue, Cholera, Scrub Typhus, Leptospirosis etc. needs to be strengthened under IDSP.
- Statesneed to establish integrated public health laboratory at each district hospital.
- Medical officers, ANMs and LTs should be regularly trained in IDSP.Training of frontline workers for syndromic surveillance and regular reporting on IDSP portal must also be done.
- The IDSP report should be utilized for analysis and monitoring at District IDSP levels.
- Regular analysis and forecasting needs to be strengthenedand this data should be utilized in the preparation of District Health Action Plan.
- Ensure completion of data entry, weekly data analysis and review at every level for early

detection of impending outbreaks & timely intervention.

- Strengthen recording, reporting and feedback mechanisms to the blocks and all HCFs for taking appropriate action as per the forecast with special focus on seasonal trends.
- Reporting from private sector in the IDSP portal needs to be strengthened. Also, IHIP to be implemented in all the states.

Revised National Tuberculosis Control Program (RNTCP)

Key Findings

- CBNAAT is functional in all the facilities visited, however its utilization rate varied across the country, with states like TN and Meghalaya showing>90% utilization while others like Chhattisgarh, Nagaland and Uttarakhand had them under-utilized.
- Nikshay Poshan Yojana is being implemented in all the states. Payment through DBT is being provided in majority of the states but there are issues of timely disbursement in some states due to lack of beneficiaries bank account.
- "Nikshya Mitra"- an Integrated TB-Leprosy screening through ASHAs is being done in Jharkhand which has bridged the gap between public and private service providers and increased the programme coverage.
- TB-HIV coordination between facilities, ICTC and ART Centres under NTEP (erstwhile; RNTCP) programme is found to be good in majority of the States; however it is found that Isoniazid Preventive therapy is not being given to HIV patients in Mizoram.
- Transportation of sputum samples from Sub Centres and Primary Health Centres is done by the patient's kins in Chhattisgarh, which as a practice needs to be abandoned.
- Beneficiaries are not aware of the usage of funds received under Nikshay Poshan Yojana as seen in Andhra Pradesh, Delhi and UP.
- Health workers (ASHAs) and Community members are found to be unaware of Nikshay Poshan Yojana (INR 500 for nutritional support of patient) in Nagaland.
- No death audit is being conducted under the NTEP/RNTCP and overall low notification is reported from private sector in most states.

Recommendations

- IEC/ Intensified Advocacy Communication & Social Mobilisation (ACSM) activities oncreating community awareness on the newer activities under the program such as Nikshay Poshan Yojana, usage of funds received under NikshayPoshan Yojanaand the latest diagnostic and treatment facilities available at public health facilities needs to be done.
- Sputum collection and transport of samples across facilities should be systematized, especially in hard to reach areas, with adequate provisioning of equipment/ boxes to carry the collected samples. Also, cross-checking of sputum samples needs to be performed.
- A target for case finding may be considered to be given to ASHA instead of a target of sputum collection to improve quality of the sputum

sample; since a tendency is noted to collect more sputum samples in order to achieve targets and store them until they are submitted at DMC after long time leading to low quality contaminated samples.

- Death audit under NTEP to be initiated.
- Active Case Finding campaign in high risk areas needs to be taken up as well.
- Eventhough notification from both public and private health facilities is in place, notification from private sector needs to be strengthened.
- Collection and transport mechanism for LPA I & II line and culture and DST facilities need to be further streamlined.

National Leprosy Eradication Programme (NLEP)

Key Findings

- Sparsh Leprosy Awareness Campaign (SLAC) is being carried out in all the states and this initiative has helped to drastically reduce the G2D national average to 2.25%. However, few states like Meghalaya and Bihar have reported a G2D rate of>3%, which indicates need of more intense LCDC in these states.
- Community awareness regarding the signs and symptoms of Leprosy and its complications is found inadequate in most of the states.In some states, even MOs and other healthcare staff such as ASHAs are found to be unaware of their role in supervision and also had very limited understanding of the common communicable diseases like Leprosy.
- ABSULS is not being undertaken in majority of the states where the CBAC assessment forms also did not focus on leprosy case identification. However, peripheral health workers in Chhattisgarh, Jharkhand, Maharashtra and Andhra Pradesh are found to be aware of the signs and symptoms of leprosy and are actively involved in passive as well as active case detection as well as appropriate referral of leprosy cases.
- Follow-up visits of the leprosy patients by the supervisory staff are found to be lacking in most of the states.
- In some facilities drugs for leprosy are found to be unavailable. Also, gap in utilization (distribution) of MCR footwear as against the requirement/cases is found.
- Record maintenance is poor and separate registers are not available at the health facilities in most states visited.

Recommendations

- Urgent measures are required to avoid delayed detection& high transmission of leprosy cases.
- Addressing the gaps in demand, supply and utilization of MCR footwear is needed.
- Centres for reconstructive surgery for leprosy cases need to be identified.
- IEC/BCC for leprosy needs to be strengthened in urban slums with focus on early diagnosis and treatment and increase leprosy notification by community.
- Increasing involvement of private practitioners in surveillance and treatment.
- Periodic assessment of program at all levels is needed, especially in high endemic districts where prevalence data has failed to suggest further improvements, so as to look into systemic causes of high endemicity.
- Disability Prevention & Medical Rehabilitation services need to be implemented more stringently in some states like Bihar, Chhattisgarh. Also, active collaboration with Rehabilitation Centres, Government facilities and NGOs is needed in all the states to ensure proper management of the identified cases.
- Record keeping for leprosy needs to be improved. There is a need to further map hotspots for leprosy and have targeted strategies for reaching the most marginalized population.
- Focus to detect leprosy patients with grade 2 disability is needed.

National Vector Borne Disease Control Program (NVBDCP)

Key Findings

- RDT kits are available in most of the facilities surveyed but there is a need to increase their usage at the peripheries.
- Integrated vector management by source reduction, use of Personal Protective Equipment (PPE), anti-adult measures, anti-larvicidal measures and community engagement activities is being conducted throughout the States. For instance, '10 Hafte, 10 Baje 10 Minute' campaign for Dengue in Delhi and DAMAN programme (Durgama Anchalare Malaria Nirakaran) in Odisha.
- Many good practices to contain Malaria cases are seen in the field. For instance, in Nagaland the Surveillance workers submitted their tour programme in the office in advance so that the Malaria Technical Supervisor can track the movement of the Surveillance Worker. It also gives a picture about the villages that are regularly covered by the surveillance workers so that the uncovered areas can be planned in the subsequent months. In TN, 'fever corners'are created where neem water, ORS along with rice water and other liquids based on Siddha medicine are being provided at the government offices.
- In Odisha, LLINs are being distributed in residential schools of Kandhmal. At, Mayurbhanj, ASHAs are found to be ringing bells at 8:00 PM as reminders to use the LLINs and also made home visits to monitor the use of LLINs.
- In other states, active surveillance of Malaria is found lacking. Bihar, Chhattisgarh and Meghalaya are yet to declare malaria as a notifiable disease.
- Line listing of Lymphatic filariasis cases is being maintained at district level in some states.
- Micro and macro action plan for vector control is not available in many facilities in most states visited.
- Awareness about other VBDs such as JE, Kala-Azar and Chikungunya is limited among the community as well as the healthcare staff in most of the states visited.
- Also, adequate infrastructure to manage a sudden outbreak of Communicable Diseases like JE is lacking in many states. For e.g. in UP, in a 10 bedded ICU in Bahraich DH, 3 ventilators are non-functional.

Recommendations

- Focused efforts for early diagnosis and treatment at village level are required to reduce morbidity and mortality due to these diseases.
- Case-based surveillance and sub centre-wise stratification to be done as per NVBDCP guidelines.
- Adequate availability of basic diagnostics such as RDK kits, drugs and other equipment at all levels of HCFs to be ensured.
- Integrated vector management action plan (Micro and Macro) should be made available at all the levels, especially in endemic regions.
- Entomological monitoring to be strengthened with increased coordination and cross checking of entomological surveillance and vector control measures.
- Entomological Surveillance data to be used for the management of VBDs.
- Community ownership for preventive measures needs to be increased.
- Disease wise data needs to be maintained at each level.
- Also, increased reporting from private hospitals/ laboratories is required.
- MLHPs can be trained and equipped to manage common conditions/ illnesses.
- State needs to intensify surveillance activities for Kala Azar in 458 blocks of Bihar and Hot spot villages of Saran, Siwan and Gopalganj to reduce the case load. Also, key vacant posts such as VBD consultant in Gopalganj and KTS posts must be filled up immediately.

National AIDS Control Program (NACP)

Key Findings

- In most states HIV screening for all TB and ANC cases is being done with referral of positive HIV cases to the appropriate facility. At HWC-SHC, whole blood finger prick test for HIV screening in ANC is being carried out.
- The online integrated PALS portal (PLHIV -ART Linkage System) is functional in Delhi but is not linked with HMIS portal and SIMS is being used for reporting, Monitoring & Evaluation
- ICTC infrastructure facilities and HR are found to be inadequate to provide confidential and quality counseling service especially in states like Nagaland and Chhattisgarh.
- In Odisha, to financially support HIV positive cases Madhu Bau Pension Yojna is being run by the State government.
- Needle stick injury prevention and infection control protocols are lacking in majority of the facilities in most states visited.

Recommendations

- SOPs for infection prevention control and needle stick injuries need to be in place at all health facilities along with orientation and training of the staff and other HCWs.
- RBSK teams need to make efforts to educate adolescents about HIV, RTI &STIs.
- ICTCs should maintain privacy and confidentiality and the same should be monitored.
- Partner treatment needs further promotion.
- IEC activities forminimizing social stigma attached with HIV-AIDS to be done to enhance reporting and adequate treatment.
- Conducting survey (snowball survey) to trace high risk groups with the support from NGOs.

National Viral Hepatitis Control Program (NVHCP)

Key Findings

- Zero dose immunization for Hepatitis B is being done for all institutional deliveries in the states visited.
- Some states are yet to implement the program fully.

- Low awareness found in the community, e.g. in some areas blood donors are detected positive but are not linked for treatment.
- Training of staff is lacking in most states visited.
- Availability of RDKs at every health facilities isnot seen in all the states e.g. Manipur.
- Programme is either not running in the states, like in Bihar or is poorly implemented as seen in most of the states visited such as Chhattisgarh, Gujarat, UP etc.
- Auto-disable/Reuse prevention syringesare being used in most states visited except Mizoram and Rajasthan.

Recommendations

- Community needs to be made aware about the prevention of Hepatitis.
- Model Treatment Centres (wherever proposed) should be made functional and trainings for management, lab diagnosis of viral hepatitis and using National Viral Hepatitis Control Program - Management Information System (NVHCP-MIS) Portal is needed before operationalizing these treatment centres.
- Need to take stock of Case load versus HCV RNA test kits as well as Antiviral drugs procured and those lying unused.

National Rabies Control Program

Key Findings

- In most facilities in most states visited, SOPs of post-exposure prophylaxis is being adhered to.
- Shortage of ARV is observed in few districts where patients had to buy their own medicines e.g. in Uttarakhand.
- Referral of animal bite cases to higher centre is done in most states visited.
- Lack of awareness on correct administration of ARV is seen among most health workers. In most of the states, ARV is being given by IM route instead the intradermal route which is recommended.
- Community knowledge regarding the post exposure prophylaxis of Rabies is not satisfactory in most states visited.
- Programme is either not running in states or not well implemented in few states like Bihar and Nagaland.

Recommendations

- Sensitization of community on services provided by health facilities.
- Ensuring availability of ARV.
- Control on population of stray/wild animals to reduce the risk of Rabies.
- Need to establish protocols for snake bite / dog bite emergency clinical conditions, along with regular training of medial officers.
- Inclusion of ARV in EDL, if not already done as it leads to OOPE (E.g. Meghalaya)

State Specific Findings

Andhra Pradesh

IDSP

- ANM is filling the S form and weekly reporting is being done in the IDSP portal.

- IHIP implementation:P and L are being filled at the PHC and District level. ANMs had received the tablets and the training and reporting is due to be initiated next month.
- EWS are not paid attention to as reported by the ANM. Recently, 51 boys from ST welfare boys hostel had developed food poisoning (July 2019).

NTEP (erstwhile; RNTCP)

- DOTS is being implemented and both MDR and non-MDR TB cases are being treated at SCs and PHCs visited, with records of the patients on treatment present at the health facility. Drugs for both drug sensitive and drug resistant TB are available at all facilities for follow up.
- Awareness about symptoms of TB is present but people are not aware of TB testing centers. Also, low awarenessis seen regarding the travel and monetary support given for nutrition supplementation for a TB patient.
- Samples are being transported in falcon tubes by STLS.
- CBNAAT is functional at the facility visited andon an average around 900-1000 samples are being tested in a month. 171 DSand 14 DR cases are found registered.
- Treatment cards of the patient are available at the facility from where drugs are being dispensed.

NLEP

- ASHAs and the ANMsare aware of their role under the NLEP in terms of leprosy screening, referral and treatment protocols but not the MOs.
- LCDC (Leprosy Case Detection Campaign) initiated since December2018 in which house to house screening for leprosy is being undertaken. Two rounds had been completed till the time of visit.
- Drugs for leprosy are available at CHC and DH level but are not available at the PHCs visited.
- Records for leprosy patients for treatment are being maintained, however for others categories (disability register, contacts) a separate register is not available at any facility.
- Complicated/Disability cases of leprosy are being referred to Medical college hospital.

NVBDCP

- Community awareness about vector borne diseases like Malaria, Dengue and their mode of spread and prevention methods is there but not for Kala Azar, JE and Filariasis.
- Only passive surveillance of malaria is being done as this area is non endemic for malaria. Over last 1 year, only 1 malaria case is recorded with no deaths.
- RDT kits and anti-malarial drugs are available at all levels of HCFs. But people are not aware that the ASHAs had RDT kits for diagnosing.
- Record of M1 and M4 forms are being maintained at the places visited. IEC materials for malaria and Dengue arealso available.
- Usage of LLINs in endemic and tribal areas is seen.

NRCP

- The health care providers are adhering to the SOPs of PEP for animal bite and are aware of the treatment protocols but IM route is being used for rabies vaccination.
- IEC on the management of dog/animal bite are available at the sites visited.
- Community knew about the facilities available in case of dog bite/animal bite.

NVHCP

- Zero dose immunization is being done for all the deliveries.
- 164 Hepatitis B and 3 Hepatitis C tests are done in the last one month at a CHC visited.

NACP

- HIV screening for all ANC and TB cases is being done and positive cases are being referred to DH/RIMS for ART. For TB patients, sample is taken using hand. Prick method is generally not being used.
- Awareness regarding HIV is there in the community but not about its mode of spread, prevention and treatment.

Bihar

IDSP

- Only 1 DPHL, at Patna, and 5 Referral labs are functional in the state. In 2018, total 150 disease outbreaks are reported and in 68% of these EWS/Outbreaks, clinical samples are sent to these labs out of which 11% are laboratory confirmed.
- HR vacancy is one of the major issues in Bihar. The positions of Consultant Entomologist, Consultant Veterinary, Consultant Training and Consultant Finance are vacant. Also, 22 posts of district epidemiologists, 17 posts of District Data Managers are vacant in the State.
- Syndromic surveillance under IDSP is weak and the forms for IDSP (P, L) are filled in by the facilities.
- Very limited understanding of the programme is seen among the key functionaries about picking up any possible clusteringof cases, detecting outbreaks and responding through trained RRTs.
- IHIP trainings have been initiated in districts but not yet completed.
- Guidelines, Action plans/SOPs for monitoring and response to the diseasesare not found at the field level. Moreover, ASHAs and other community workers also elicited very limited understanding of communicable diseases.

NTEP (erstwhile; RNTCP)

- DHs are implementing the NTEP (erstwhile; RNTCP) well and records for TB testingare well maintained. For DST, samples are referred to the DH, where the CBNAAT machines are functional.
- The LT and STLS are well trained to perform the roles allocated under the NTEP (erstwhile; RNTCP) programme; and proper reporting is being done under NIKSHAY.
- Gaps such as low notification against the estimated target, low treatment initiation rate of diagnosed MDR patients, low utilisation of newer drug containing regimen and sub-optimal state level programme supervision & monitoring observed. Outreach activities like referral of suspected TB cases, monitoring for DOTS compliance are also not being undertaken as desired.
- Only 45% of the notified beneficiaries had been paid under Nikshay Poshan Yojana and 10% of the bank accounts had been rejected by PFMS. Also, sub-optimal utilization of Nikshay Aushadhi at the TU & PHI level is seen.
- Low presumptive TB examination rate in districts with lesser utilization of DMCs. The treatment success rate of notified TB patients for the year 2018 is 51%.
- Lack of district wise decentralized sample collection and transport mechanism, resulting in low U-DST services to presumptive DRTB cases.
- Pending recruitment of state level key contractual positions are seen to hamper the State level programme monitoring.

NLEP

- LCDC has been implemented in all 16 districts selected by CLD and 72.91% population iscovered in round 1. Total 20,132 (90%) suspects are screened and 1,418 new cases confirmed during the activity. SLAC is also being implemented in the state.
- Disability Prevention & Medical Rehabilitation services need to be implemented more effectively as only 7% of the required MCR footwear has been distributed during 2019-20.

- Training status of HR in health section with respect to leprosy needs improvement in the state.
- G2 disability rate in the state is 3.45% which is concerning. About 650 new leprosy cases are detected in the year 2019-20 in the districts visited (455- Bhagalpur; 196- Begusarai). MDT is available without interruption.

NVBDCP

- In 2018, ABER (Annual Blood Examination Rate) for malaria is 0.09% against desired ABER of 10%.All 38 districts have poor surveillance with ABER<1. 14 districts have negligible / nil surveillance (ABER<0.1) and 11 have nil screening.
- The reported API for 2018 is 0.01. All 38 districts have reported API<1 thus needfor focused efforts for early diagnosis and complete treatment is required at all levels to reduce the morbidity.
- It is observed that no malaria microscopy is being done even at the DH level and only kit based rapid testing is done.
- State is yet to declare malaria as a notifiable disease.
- **Dengue & Chikungunya:** Till October 2019, total 4810 Dengue cases (data till 5th November) are reported in Bihar- a number much higher than that seen in previous years. However, no deaths due to dengue are reported.
- Cases of Lymphatic filariasis are detected, and line lists are being maintained at district level, however surgical interventions for Hydrocele is limited as observed by the team visiting Begusarai District Hospital.
- Drug compliance during MDA needs to be monitored, as despite 12 MDA rounds over a period of 15 years, none of the district has cleared TAS. All districts are still undergoing MDA. Many districts have failed the 1st TAS done.
- 39 cases of Visceral Leishmaniasis and 2 cases of PKDL is registered last year in Begusarai district.
- Kala-azar is endemic in 458 blocks of Bihar with 3 high focus districts viz. Saran, Siwan and Gopalganj reporting more than 70% of the total cases of the State.
- Preventive activities (2 rounds of IRS in endemic areas & IEC/BCC activities), Curative activities (Active case finding, drug treatment at identified treatment centres) and payment of wage loss compensation as per **NHM & Mukhyamantri Kala-azar Rahat** Yojana are being carried out in the state. Also, ASHAs are given an incentive of Rs. 500/- (Rs. Five Hundred) per Kala-azar patient for case detection, treatment and 6 months follow-up. Facilities for treatment of Kala Azar are found to be available without interruption.
- Japanese Encephalitis- In 2019 (till October), statereported total 525 AES cases and 116 AES deaths (Includes 16 JE cases and 1 JE death).
- 24 endemics including 15 high priority districts are identified in the state, but only 2 PICUs are found functional in 2 out of 15 high priority districts.
- Service providers are not found undertaking outreach activities related to CDs such as vector control, preparation of malaria slides etc.

Chhattisgarh

IDSP

- IDSP cell is non-existent at Medical College Rajnandgaon.
- Post of Epidemiologist is vacant and must be filled urgently.

NTEP (erstwhile; RNTCP)

- In Rajnandgaon, DMC and CBNAAT are in separate buildings and sample is transported through patient which is not advisable. Cross checking of sputum samples is not being practiced.
- Sputum examination rate is lower than normal (less than 1% of OPD attendance) and needs to be increased as per norms.

NLEP

- Involvement of PHC and HSC staff is minimum and diagnosis and treatment of Leprosy cases is being done by vertical staff. Even MDT stock is being maintained by vertical staff.
- High number of Grade 2 disability cases in Rajnandgaon and high number of child cases in Korba are found, indicating a high transmission & delayed detection.
- Drug supply for the treatment of MB children is often interrupted.
- Gap in demand and supply of MCR footwear is found in Korba.

NVBDCP

- Malaria not yet a notifiable disease in the state. Sharp decline in number of malaria cases is reported in Korba.
- Use of RDT kits at periphery is suboptimal. Also, slide samples for cross verification are not being sent or minimally sent by the districts to the RLTRI/Central Malaria Lab.
- Mud plaster/'Potai' of houses after completion of IRS seen.

NRCP

- Shortage of ARV seen across the facilities visited and patients have to buy on their own.

NVHCP

- Programme is yet to be implemented fully and low awareness in the community is observed.
- 21 blood donors are detected with Hep B, but not linked for treatment.

NACP

- ICTC infrastructure facilities are inadequate to provide confidential and quality counseling.

Delhi

IDSP

- Data entry facility for IHIP is available at district level. Weekly data reporting done in P and L under IDSP.
- District IDSP cells are found regularly reporting on the portal for various diseases.
- RRTs have been constituted at both District offices and LBS Hospital (DH) for epidemic outbreak investigation.Early warning signals are reported by facilities.
- No public health laboratory under IDSP has been established in the District.
- Post of District Epidemiologist is not sanctioned. Only Data Entry Operator is in position.
- No trainings organized under IDSP in 2018. In 2019, training is proposed for MOs &paramedical staff for strengthening reporting on IDSP portal and syndromic surveillance by frontline workers.

NTEP (erstwhile; RNTCP)

- Interaction with TB patients at facilities and during community visits showed that most patients are on regular treatment. The same is cross verified from the registers maintained at the facility.
- DOTS implemented in almost all DGHS health facilities, with a dedicated TB Health Visitor (TBHV). Treatment cards for all the cases with ongoing treatment available in the facilities.
- Free diagnostics (including CBNAAT) & treatment facilities are available. All the latest guidelines & policies are being implemented as per the guideline.
- DOTS microscopy centres have a lab technician (Hub & Spoke Model).
- The supervisory and monitoring activities by staff are found to be satisfactory at various levels.
- Nikshay Poshan Yojana is being implemented and payment through DBT is being given,

however only about 50% beneficiaries received the same due to issue with opening or validation of bank accounts. Also, beneficiaries are not aware of the usage of funds received under NPY.

- All the TB patients who are being tested for Diabetes and HIV co-morbidity in both districts arevisited.
- NTEP (erstwhile; RNTCP) success rate in terms of treatment outcome is 89%. Effective tobacco control initiatives such as banning of e-cigarettes, actively collecting challans are seen to be in place.
- Both districts have good TB-HIV coordination between facilities, ICTC and ART Centres under NTEP (erstwhile; RNTCP) programme.
- 100% of HIV-TB patients are given Clotrimazole Preventive Therapy (CPT) and ART in the state.
- Active TB case finding has been done amongst IDUs, CSWs, Prisoners and those in night shelters, in 2018 and 2019, and 454 cases are diagnosed.
- Backlog of cases for CBNAAT for one week is observed at SPM District Chest Hospital due to old version of the machine.
- DOTS centres are operational for only 3 days a week across several UPHCs, with one DOTS provider being posted at 2 facilities.
- Sputum collection and transport of samples across facilities is not systematized. There is lack of equipment/ boxes to carry the collected sputum samples.
- No death audit is in practice under NTEP (erstwhile; RNTCP).

NLEP

- Special awareness drive LCDC Campaign isconducted in 2018 and 2019.
- Extensive IEC/BCCactivities have been undertaken- Rallies, munadi, Nukkad Nataks, health talks, poster competitions in schools. Community is found to be aware of the signs of leprosy and facilities where it is being screened.
- ASHA Based Surveillance of Leprosy (ABSUL) case is being carried out. Elderly population is catered to through fixed day clinics.
- 10 skin camps are undertaken as pilot in underserved areas with mobile healthscheme teams.
- Single dose for Post Exposure Prophylaxis given to contacts of Leprosy patients.
- MDT drugs are available at dispensaries and hospitals without any interruption.
- Lack of adequate number of centers for reconstructive surgery for leprosy cases areseen in the state, active collaboration with rehabilitation centres and NGOs is not found.

NVBDCP

- Awareness in the community on spread and control of Vector Borne Diseases (VBD) is fairas is the awareness of the treatment facilities available for these disease at public health facilities.
- Many IEC activities and school campaigns areorganized for generating awareness on VBDs.
- Diagnostics and treatment facilities for Malaria, Dengue and Chikungunya are found satisfactory at the facilities visited. Also, the laboratory staff at all the facilities visitedare aware about diagnosis of VBDs including microscopy for malaria and ELISA based tests for Dengue and Chikungunya.
- There is a mosquito abatement committee at Delhi Cantonment Hospital.
- Separate Dengue Ward with dedicated beds for dengue patients is available at LBS Hospital.
- Mosquito nets are being provided to patients.
- No post of District VBD Control Officer is sanctioned which is a matter of concern.

NRCP

- Posters for community awareness on rabies and animal bite prevention are available at

healthfacilities.Good community awareness and health seeking behaviour for dog bite cases seen.

- Only Tetanus Toxoid Injection is being given at primary care level for animal bites and cases arereferred to tertiary care for ARV and Rabies Ig.
- Rabies and Typhoid vaccines arenot available in the facilities since several months. However, Maternity home at Munirka had a regular supply of the vaccine, but staff from nearby centres is not aware of it and hence, did not refer cases.

NVHCP

- Selected facilities have trained manpower (lab technician – Polyclinics/tertiary centre) underthis programme.
- HBsAg screening done at primary care level through Rapid Diagnostic Kits but testing for Hepatitis C, E is being done by referral to Mohalla Clinics or to tertiary Hospitals. Also, sustained availability of kits is an issue at health facilities.
- Treatment of Viral Hepatitis is being done at DH/tertiary level.
- Community is aware of the mode of spread of HIV but not of Hepatitis.

NACP

- Screening of all the TB and ANC cases for HIV is done.Counseling followed by referral to ICTC centre within LBS and LHMC Hospitals is being done for HIV andVDRL testing.
- More than 700 counsellingsessions are done each month at LBS Hospital, several of which arevoluntary/self-motivated.
- The ICTC counsellor has PG degree in psychology and has received 11 days induction and 7 days refresher training at LBS hospital.
- Partner treatment is being promoted though at present it is only around 5-7%.
- DAPCU is functional in the district.
- ART is available at LBS Hospital. However, Nevirapine is reported to be out of stock at the ART centre.Non-availability of Kit-3 has also been reported since several months.
- The online integrated PALS portal (PLHIV -ART Linkage System) is functional but is not linked with the HMIS portal. SIMS is being used for reporting and Monitoring & Evaluation.
- ICTC services are provided in 6 facilities and PPTCT at 2 facilities (LBS Hospital and MaternityHome, Patparganj) in East District.
- 156 new cases detected during last six months (April- Sep 2019) out of which 122 started on ART.

Gujarat

IDSP

- Rapid response team (RRT) has been constituted at the PHC level for investigation in case of any EWS. P, S and L forms are being filled & reported weekly. 100% forms are analysed.
- District public health laboratory is functioning in both the districts.
- Integrated Health Information Platform (IHIP) training has not been initiated at the District level.
- Vacant posts of entomologist and other VBD positionsare seen in both the districts visited.
- There is discrepancy in filling of P & L forms in certain instances (e.g.CHCOmarpada, regarding Enteric fever).

NTEP (erstwhile; RNTCP)

- Both districts have CBNAAT testing centres and SOPs displayed for CBNAAT laboratory.
- Treatment of MDR-TB cases with newer regimens including Bedaquiline have been streamlined from district levels.
- Success rate of new microbiologically confirmed patients is reported to be 87% in Surat and 92% in Dahod in 2018. But Dahod still has a

high burden of pulmonary and extrapulmonary tuberculosis.

- Percentage of public and private samples tested on CBNAAT at Surat is 58% and 42% respectively, which in Dahod is reported to be 72% and 28% respectively. Involvement of private sector in TB care alongside of NTEP (erstwhile; RNTCP) has progressively increased. Systems are in place to allow sputum samples from private clinics for CBNAAT testing at district hospitals.
- Senior Treatment Supervisor visits DMC of CHC every month.
- MERM Box-Medication Event Reminder Monitor is available for better adherence monitoring of daily FDC drug intake apart from 99 DOTS.
- NikshayPoshanYojna is in place and Rs 500/- as nutritional support per month is provided to all TB patients through DBT, but delay of payments up to 02-03 months is observed in some cases.
- Contact screening of children is symptoms based and is done by frontline workers.
- IEC materials are not displayed at the community level and the level of information and awareness in community is low, more so in remote blocks.

NLEP

- While state has been able to achieve significant decline in leprosy prevalence over the years, including elimination from 06 districts; Dahod continues to be an endemic district and has steady prevalence rate/10000 population around 1.76 that is unchanged over last 2 years.
- New cases are being detected in Surat-243 (71 PB & 172 MB) and Dahod- 335 (130 PB and 35 MB) in 2019.
- Leprosy case detection campaigns (LCDC) are being held from district level. MCR footwear & self-care kits are available at PHC level.
- State has institutionalised camp based approach for reconstructive surgeries at district hospital level.
- ABSULS is being implemented and ASHAs are reporting suspected cases of leprosy and it is monitored at supervisory levels.
- Recently joined medical officers and fresh medical graduates are specially noted to lack clinical skills regarding leprosy.

NVBDCP

- State's API is less than 1 (0.66) and it has reported a progressive decline in deaths due to malaria.
- Total LLIN are distributed only to ANC cases (9400) and IRS 2nd round has been conducted
- Micro and macro action plans for integrated vector control are not available during team visit.
- Dengue &Chikungunya SSH are provided with Elisa based NS1 Kits.
- In Gujarat 11 districts are reported to be endemic for Lymphatic Filariasis. One district namely Tapi is under annual Mass Drug Administration (MDA). Surat district has completed TAS-2 activity and is under Post MDA surveillance while district Dahod is a non-endemic zone.
- Filariasis- at DH 100% cases are managed and over 90% of line listed hydrocele cases operated. For augmenting diagnostic facilities, 40 Sentinel Surveillance Hospitals (SSHs) have been identified in the State.
- Chloroquine, Artesunate Combination Therapy (ACT) and Primaquine tablets are found to be stocked out at one of the SHC-HWC visited by the team. Even, RDK kits are not available in the visited SCs and CHCs in both the districts.

NRCP

- Training on NRCP has been completed in both the districts.
- Anti-Rabies Immunoglobulin is not available even at block levels. Though ARV is available at all levels but it is being administrated through IM. ID regimen is not yet institutionalised at many places.

- Animal bite register is not being maintained at CHCs though Snake Bite cases are commonly observed. e.g. 17 Snake bite cases are reported in CHC OMARPADA out of which 13-14are referred to higher centres due to neurological complications and 11 of them died in hospital.
- In Dahod district, Medical officers at CHC Fatepura are not sure about correct administration of ASV. This suggests the need to establish protocols for such emergency clinical conditions throughout the state, along with training of medical officers.

NACP

- All TB and ANC cases tested for HIV.
- There is a separate room for counselling at Zydus Medical College Dahod and about 15-20 cases per day for RTI and STI are served by counsellors.
- Link ART centre is available and functioning.

Jharkhand

IDSP

- 6 outbreaks are reported during current FY from the 2 Districts visited by CRM team. However, data collected through existing network is not effectively analyzed for predicting outbreaks (e.g. in last week of June 19, 550 ARI cases are reported out of approximately 900 OPD cases at Basia CHC, but there is no response from the district level).
- IDSP training done as per IHIP in June, 2019 and implementation will be supported by WHO from December 2019 onwards.
- Both the Districts have "Media Scanning Verification Cell" whose role is to verify the EWS/outbreaks and track further spread of disease & enhance outbreak reporting.
- Average reporting status of S, P, L form is 12%, 17% and 17% respectively in Gumla and 89%, 94% and 95% respectively in West Singbhum district.
- HR shortage isobserved. DEOs are seen compiling and submitting reports.

NTEP (erstwhile; RNTCP)

- "Nikshay PoshanYojana" functional in the state and Nikshay Mitra/ volunteers have been engaged for bridging gap between public and private facilities.
- 36+1 CB-NAAT machines are there in the state – at least one in every district. Installation and demonstration training is also being carried out for the staff.
- **Integrated TB-Leprosy Screening** through Sahiyas (ASHA) is being done at the community level. This initiative not only increases knowledge base and awareness but also program penetration to grass root level in minimum contact sessions.
- Patients are found to be availing services from private practitioners. Total 8085 cases (21%) out of 37,615 notified cases are from private facilities in 2019.
- Intermediate Reference laboratory at "Itki", at Ranchi and Drug Culture & Sensitivity testing facility at Dhanbad is under construction.
- 364 out of approved 415 DMCs established/ 187 TUs of 207 approved are established.
- 5 Nodal DRTB centers and 10 District DRTB centers are present. Average treatment success rate is 84%.
- The CBNAAT machine at Gumla DH is functioning with only 2 modules. 2 remaining modules are out of order since some time.
- Sputum Microscopy for AFB is done at the CHC level and all cases are referred for CB-NAAT confirmation at the DH.
- X-Ray machine at Basia CHC is non-functional.

NLEP

- Mapping is being done for hard to reach areas and a total 4141 cases have been detected.
- ABSULS implemented in the CRM districts.
- LCDC and Sparsh leprosy awareness campaign is conducted in high focus districts.

- Need based indent of MCR shoes is not being done. Backlog of RCS is seen in Gumlaand RCS is not being done in West Singbhum.
- Visited facilities (CHC and DH in both districts) have stock of MCR shoes and Self-care kits.
- Health Workers (MOs, ANMs,Sahiyas) knowledge on leprosy case detection is satisfactory.
- Partnering with development partners (Damien Foundation-India) for case management (Leprosy and associated disability) increased timely case management and also reduced the burden on the public sector.

NVBDCP

- In Gumla district, it is noted that, RDKs used at HSC level are giving false negative results.
- State level microscopy centre is found to be non-functional. As a stop gap arrangement, LTs from district and sub district level are being trained for 10 days at Patna.
- Micro-plan for LLIN and IRS is available with state.
- JE child vaccination is taking place in 17 out of 24 districts; including West Singhbhum.Gumla is not an endemic for JE. JE cases are referred to PICU available at RIMS, Ranchi.
- JE diagnostic kits available in Sentinel Surveillance Hospitals. In 2019, 47 cases of JE are reported in the state.
- At Gumla, Hydrocele cases are being operated case to case basis, however no line listing of cases is being maintained.
- At West Singbhum, 7 rounds of MDA have been performed; no hydrocele cases have been operated and no records for MDA areavailable at CHC.
- Contingency plan for Dengue and Chikungunya is available for epidemic with the state. 112 volunteers have been engaged during season across the state for2019.However, relevant IEC isfound to be poor.
- Out of 9 sanctioned Sentinel Surveillance Hospitals, 5 SSH are functional in the state.
- No diagnostic facilities are available for Dengue in the district

NRCP

- New IEC posters have been displayed at CHC and UPHC.
- IM route is being practiced for giving ARVat Gumla and West Singbhum.
- Vaccine Procurement is being done at the state and district level, which is at bay due to the development of vaccine storage warehouses.
- ARV is found to be unavailable since August 2019 and ARV is being locally purchased under Ayushman Bharat- PMJAY Scheme.
- No existing convergence plan with Municipal Corporation seen.
- Community knowledge regarding post exposure prophylaxis on rabies is not satisfactory.

NVHCP

- Only first dose of Hepatitis B vaccination done for existing staff. No plan for regular Hepatitis B vaccination for new recruits/transferred personnel noticed.

NACP

- ICTC facility available at both, DH and SDH.
- Screening of all TB and ANC cases done for HIV.

Madhya Pradesh

IDSP

- Proactive involvement of IDSP unit with district administration is noted for investigation and control of cholera outbreaks.
- Training for IDSP has been completed for all MOs, LTs, Pharmacists and ANMs. Also, training for IHIP is done for 35 out of 69 MOs, all LTs, Pharmacists and ANMs. However, data entry facility for IHIP is not yet operational.

- EWS is reported from CHC Mundi for Acute Diarrheal Dysentery. The outbreak is declared and investigated by RRT.

NTEP (erstwhile; RNTCP)

- Sputum referral of all Public Health Institutes (PHI) is less than 2% against the set norms of 4-5% of new adult OPD (District Hospital Khandwa-1.5%).
- Low notification from public sector has been observed. All MOs/BMOs/ANMs shall be reoriented to improve notification from Public Health Sector and private sector.
- Khandwa district has 7 TUs and the HR is sanctioned for only 4 TUs previously. Also, out of 17 sanctioned posts only 5 are filled. These HR issues must be addressed on priority to smoothly run the programmes.
- The District and block level officials are not involved proactively and program indicators are not being reviewed as needed.
- Treatment cards and TB registers are also found to be incomplete.

NLEP

- LCDC is conducted and 188 (Paucibacillary- 122, Multi Bacillary- 66) new patients are identified and put on treatment.
- Good quality IEC material is available.
- As large number of cases is still being detected, state and district need to focus on intensification of case search, early detection and management in order to achieve eradication status.

NVBDCP

- Drugs, diagnostics, injectables and other logistics for treatment of uncomplicated and complicated malaria cases are available in adequate quantity at all levels.
- In spite of favourable environmental conditions for mosquito breeding in the district (heavy rains, urban slums, tribal areas), vector borne diseases are not being detected.
- District has reported 27 malaria cases, 4 dengue cases and none of Chikungunya since January till September 2019. No death due to Malaria has been reported in last 3 years
- Refresher training of all ANMs/ASHA for blood smear collection and all LTs for blood smear examination is needed.

NRCP

- Adequate stock of Anti-Rabies Vaccine is available at all health facilities.
- Record of complete vaccination and animal bite exposure registers is not being maintained uniformly.
- SOPs of post-exposure prophylaxis algorithm of animal bites at CHCs are not available.

NVHCP

- The state had proposed one Model Treatment Centre (in Bhopal) and two Treatment Centres (District Gwalior and Datia).
- Proactive Nodal Officers need to be identified at state and district levels for the launch of diagnostic and treatment services of Viral Hepatitis.

NACP

- ART is available at all CHCs.
- All TB patients are being tested for HIV by Whole Blood Finger Pricking Test.
- A box of HIV kits with expiry date of October 2018 found to be stored in the refrigerator at CHC Pandhana of District Khandwa.

Manipur

IDSP

- Weekly report in Form S is submitted from PHCs and in both P and L forms from the PHCs, CHCs and DHs. Training on IHIP for S reporting is completed in all districts except Bishnupur and Chandel districts.

- There is no data entry facility for IHIP available at PHC level.
- There is no epidemiological analysis at the institutional level. At the district level, the hilly districts did not analyse the data generated through IDSP to identify the EWS.
- Two epidemics of Scrub Typhus in 2018 (13 cases) and 2019(11 cases) have been reported and followed up with IEC activities and distribution of diagnostic kits in Bishnupur district. But there is no evidence regarding epidemic forecasting provided by IDSP.
- Only one private hospital in the Imphal East district is found to be sending report to the SSU.

NTEP (erstwhile; RNTCP)

- There is one post vacant at both district and 24 posts at the state level under the program.
- CBNAAT machine present in both the districts visited but are sub optimally utilised. Also, functional X-ray Machine is not there at Chandel District. The microscopes are not working properly as well affecting adequate testing and overall programme outcome.
- There is inadequate number of DMCs for diagnosis at both the districts. The state has started, on PPP model, Designated Microscopy Centre Scheme in East Imphal &Ukhrul district with annual charges of 1.5 Lakh INR.
- Active Case Finding in vulnerable pockets and proper sample transportation services needs to be started in hard to reach areas of the states.
- No Information is submitted by the district and state on H1 Schedule maintenance of the TB drugs by Chemist. Notification from private sector also needs to be improved.
- No Pulmonologist or Medicine specialist is available at the DH which affects the management of DR TB.
- The Intermediate Reference laboratory (IRL) at Imphal is having only facility for solid Culture for diagnosis and management of DR TB and the samples are being sent to Guwahati for other tests such as LPA and liquid culture.
- Most of the Staff including MOs at the PHC, CHC, District Hospital, CHOs, ANMs & ASHA are not trained in the program. Also, the Community is not aware of TB symptoms and where they need to get investigated in case of problem.
- The Supervisory & Monitoring activities at the District level and below are minimal.

NLEP

- Much reduced incidence of leprosy than before and good treatment of detected cases is seen. Sparsh Leprosy Eradication Campaign is seen in the state.
- Five districts are identified for LCDC but due to lack of funds LCDC could not be conducted.
- DLOs did not have mobility support to carry out the FLC and SLEC. PEP with Rifampicin is carried out to the eligible contacts of new cases.
- No MCR foot wear are distributed. ABSULS did not pick up due to lack of motivation of ASHAs.

NVBDCP

- State is nearing certification of elimination statusfor Malaria. There is high use of bed-nets in the state. All the districts had micro action plan for distribution of LLIN.
- ABER is 3.46 in 2018 but improvement in surveillance with greater involvement of ASHAs has helped it reduce greatly in 2019. In Bishnupur district only one imported Pv case detected in 2019 and Chandel district has reported no malaria case since 2018.
- Malaria Elimination Committee and Malaria Elimination task force are constituted in the districts visited.However no meeting has been held till date.
- The sanctioned post of entomologist under SVBCP has not been filled up and the entomological support to the programme is lacking.
- Despite availability of JE vaccination and intense IEC activities, 342 cases and 6 deaths

due to JE are reported in the state till October 2019 as compared to 57 cases and 3 deaths in 2018.

- Larval source reduction drive, IEC and Fogging is carried out in the area of occurrence of Dengue, yet about 305 cases of Dengue are reported till October 2019.
- No case of Lymphatic Filariasis and Kala Azar are reported.

NRCP

- Animal bite register is maintained in the health facilities. 4032 dog bites are registered in the state during the current year till September 2019 and 4 cases of Rabies are confirmed.
- Anti-Rabies Clinics are identified in the 7 DHs, 2 Sub-Divisional Hospitals, 2 CHCs and 1 PHC. Anti-Rabies Vaccine and ERIG are made available in the Anti Rabies Clinics.
- DNOs, MOs and Paramedics have been identified and trained about NRCP along with their roles and responsibilities.
- The dogs are killed immediately after they bit a human being which prevented observation for next 10 days. IEC activities must be carried out to prevent the same.

NVHCP

- Screening during ANCs for HBV and HCV are undertaken at PHCs and above. Zero dose immunization for HBV is given to babies born via institutional deliveries. Vaccines are available in DHs, CHCs and PHCs.
- No facility for treatment of Hep Cis available in the DHs and the cases are referred to RIMS and JNIMS.
- Very little utilization of HCV RNA test kits as well as antiviral drugs like Sofosbuvir, Declatasvir, Ribavarin in the tertiary care centresare available in Imphal compared to the quantities procured and large stocks lying unused as per their report which needs urgent attention. At the same time no RDKs for HBV and HCV had been received.
- The Steering committee and Viral Hepatitis Management Units are formed but no meeting had been held.

NACP

- In Chandel district HIV prevalence is high among ANCs and IDUs. Awareness on HIV-AIDS is high among the community.
- As a routine practice, all the ANCs and TB cases are screened for HIV.Nevirapine prophylaxis is given to the new-borns of positive mothers, within 72 hours of delivery.
- The ART Centre in the Bishnupur DH is co-located with the DOTS facility. All the TB cases are tested for HIV in the districts visited.
- FICTC at KomlathabiChandel district is not functioning.

Meghalaya

IDSP

- P, S, and L forms are available & reporting done. However, medical /paramedical staffs are not yet skilled/ trained in reporting of Early Warning Signals (EWS).
- State is highly dependent on other laboratories outside the state for diagnosis with respect to emerging& re-emerging diseases like NIPAH, EBOLA, Swine Flu and Yellow Fever.
- Entomological surveillance reports are not properly analysed for pre-emptive action towards outbreak containment.

NTEP (erstwhile; RNTCP)

- Community is aware regarding tuberculosis and is knowledgeable regarding availability of treatment. No social stigma attached to TB isseen.
- Separate Functional TB Hospital with 30 indoor beds, and DNO is present in the districts. CBNAAT machine available & functioning in full capacity or has 100% utilization rate.
- District is engaged in mapping vulnerable hotspots of TB for initiating intensive

elimination activities but District TB comorbidity coordination committee has not yet been formed/functional.

- DOTS centres are functional, medicines are available, prophylactic treatment is in place for contacts, nutrition support is being provided under NPY. NIKSHAY entry is regularly being done.
- The district/state is still dependent on drug sensitivity testing except Rifampicin, on facilities outside the state (UDST).
- In District Ri Bhoi, ASHAs are not involved in NTEP; and are unaware of their entitlement of benefits of TB Cases notification and are also unaware of patient's entitlement for nutrition (DBT). Hence, no DBT is received by any ASHA or TB patient in the District.
- Sample collection and transportation to CBNAAT sites and report collection from CBNAAT Sites is not being followed as per guidelines.Reporting from private facilities is also an area of concern.
- There is no District DR TB Centre or DR TB indoor facility.

NLEP

- Community is not aware of the early signs & symptoms of Leprosy.
- IEC/BCC campaigns with daily progress and group discussions are being shared on Whatsapp.
- The state NLEP is also publishing in their e-newsletter and this pioneering work is being included in the best practices.
- LCDC campaign remains satisfactory. All the contacts are offered prophylactic treatment and counseling.

NVBDCP

- Community is aware of Malaria & its preventive measures & need of IRS, usage of LLIN, & treatment through the ASHA and other Government& Private Hospitals. Good display of IEC / BCC materials and adequate HR for malaria is observed.
- Even though API has remained high in the state during the last 3 years, state has not declared Malaria as a notifiable disease.
- Few pockets of falciparum seen in the state. The rubber cultivation may have added to the mosquito density.
- IRS compliance is low &is sprayed only in localities having API more than 2. All the 95 villages (West Garo Hills) are distributed with LLIN during 2016 & this has reduced the incidence of malaria considerably.
- Facilities have drug, diagnostic & injectables with laboratory for malaria microscopy. The forms M1 and M4 are found to be filled in both the districts.
- Strategic macro/ micro action plan for vector control & malaria isnot in place till date as per the NMEP Action Plan.
- JE is endemic in the area; however, the community is not adequately aware regarding signs & symptoms of JE. JE investigation report comes very late, hampering early case detection.
- Community is not aware of the signs & symptoms of Dengue and Chikungunya. A few cases of Dengue are reported in the districts. No Kala-azar & Lymphatic Filariasis cases are seen in the state.

NRCP

- Cases of dog bite have been reported however, ARV is not available in the EDL of the State. Thereby, leading to OOPE.

NVHCP

- The community does not understand Hepatitis but they are familiar with "Jaundice" and quite a large number of people still believe in traditional and alternative medicines for treating jaundice.
- All pregnant women are screened during ANCs. Reuse prevention syringes are used in facilities.

NACP

- Community is knowledgeable regarding HIV AIDS and its transmission.
- Universal precautions are not fully practiced.
- HIV testing kit is not found in some HWCs.

Mizoram

IDSP

- Timely reporting of S, P and L form under IDSP is being done. Surveillance units under IDSP are operational at all the health facilities.
- Inadequate implementation of IDSP and partial reporting is observed at few centres. Analysis of data for giving feedback and taking appropriate actions for prevention of outbreak of disease or epidemic is not being done.
- MOs are not trained in IDSP in few of the facilities visited.

NTEP (erstwhile; RNTCP)

- Sputum Smear Microscopy services for TB diagnosis id decentralized up to PHC level.
- 4 module CBNAAT machines deployed by NTEP (erstwhile; RNTCP) are available and functional at the DHs. All presumptive TB patients are tested on CBNAAT.
- A separate 6 bedded DR-TB ward has been created at Mamit District hospital for management of DR-TB cases. But there is no TB treatment centre or DOTS centre in Civil Hospital Aizawl and TB Patients are referred to DTC Falkwan for treatment initiation, which is approximately 15 km away from the civil hospital.
- CBNAAT machine at Mamit district hospital is underutilized, performing on an average 25 tests per month while CBNAAT machine at Aizawl Civil hospital is optimally utilized performing on an average 210 tests per month.
- Average load at DMC located in Aizawl Civil hospital is 45-50 sputum samples per month. These samples are from tobacco users categorized under key population, which needs to be tested on CBNAAT as per NTEP (erstwhile; RNTCP) Policy.
- Treatment success rate is observed to be more than 90% among Drug Sensitive TB patients.
- Isoniazid preventive therapy is not being given to eligible HIV patients. Also, eligible MDR-TB patients are not being initiated on newer drug containing regimen.
- Incomplete data entry is observed in Nikshay platform.

NLEP

- No formal record keeping for contact investigation or IEC activities for Leprosy are observed at any of the health facility.
- Community as well as Peripheral health workers are found to be unaware of the signs and symptoms of the disease and its complications.

NVBDCP

- Downward trend in incidence of malaria cases indicated progress in control of Malaria. RDT kits for malaria are available at all levels and ASHAs/MPREGNANT WOMENs are trained in referring suspected fever cases and using these kits.
- IEC messages for malaria are displayed at every health facility level. However,Anti-malarial Drugs are not available at some of the facilities.
- Micro and Macro plan for vector control is in place at district level.
- Malaria Sentinel surveillance Centre is not available at Mamit district hospital.
- Considering non prevalence of Kala Azar, Japanese Encephalitis, Lymphatic Filariasis, Dengue, Chikungunya and Leprosy in the state, no awareness/ interventions are available for management of aforesaid communicable diseases.
- There is a need to improve referral and transport system for samples to diagnostic Centres.

NRCP

- Vaccination facility is available for animal/ dog bite and is being done according to SOP/National Guidelines of PEP algorithm of Animal Bite under National Rabies Control Programme.
- Animal bite register is available at all the facilities.
- Patients need to procure ARV and ARS from private chemists.

NVHCP

- Hepatitis B and Hepatitis C tests are available at health facilities CHCs & above.
- Though Medical Officers and LTs have been trained at the State level, health staff are not aware about National Viral Hepatitis Surveillance Programme activities.
- Reuse prevention syringes are not available at any of the health facility visited.

NACP

- Implementation of Elimination of Mother to Child Transmission (EMTC) of HIV seen. Screening of ANC cases is being done at PHC and above. Positive cases are referred to DH as ART facility is available only at DH.
- CD4 testing machine is available and functional at DH. Sample for HIV VL testing for eligible cases are being sent to Metropolis Lab Mumbai every Tuesday. Average TAT of reporting of results is 4-5 days.
- Line listing of all the person living with HIV having chest symptoms who are being referred for CBNAAT testing is maintained in ART centre but no information about the reverse referral is being maintained.
- Voluntary Blood donation, especially by the students is observed.
- Single window service delivery at ART Centres and treatment to HIV patients is being given as per National Programme Guidelines.
- Cross referral of patients is happening between TB and HIV for all eligible cases.
- Incomplete records are observed in ART clinic of Civil Hospital, Aizawl.

Nagaland

IDSP

- Passive Case Detection is happening in IDSP but when an outbreak is declared, the strategy shifts from passive to active. Also, Rapid Response Team is not in place in District, Kiphire.
- Reporting, data management and trend analysis is satisfactory. However, the staff at the facilities are not trained in reading the trend charts displayed in SCs or PHCs.
- No training had been conducted in the current year of 2019-2020 till September 2019, due to shortage of funds. Monitoring and Supervisory visits are also lacking.

NTEP (erstwhile; RNTCP)

- The service providers at all health units are aware and skilled for diagnosing Pulmonary TB; however, the same is questionable for Extra-Pulmonary TB (EPTB).
- Transportation of sputum samples from SCs and PHCs is achieved with the help of community. Health workers and service providers used bikes or free public transport for sputum collection and transport.
- Activities such as IEC hoardings at DTC Kiphire, World TB Day at Pungro DMC, NTEP (erstwhile; RNTCP) Modular Training, Trainings of ASHAs and Nurses, Community level awareness at Singrep, Amahator villages are conducted during the year 2019-2020 in Kiphire District to strengthen NTEP (erstwhile; RNTCP) initiatives. However, collaborative activities for TB-HIV, TB-Diabetes are not being held regularly in both the districts.
- Community awareness about TB & Extra-pulmonary TB (EPTB) is suboptimal. Even

ASHAs are not aware of Niksay Poshan Yojana (INR 500 for nutritional support of patient) in some areas.

- Social stigma regarding high morbidity and mortality related diseases like TB, HIV/AIDS is found in the community and hence people are not willing to visit health facilities regarding these diseases and rather preferred home remedies on their own. ASHAs being from same socio-cultural context also did not understand the importance of active screening of such cases.
- District TB centres are co-located along with DHs and offered treatment for both DS and DR-TB.
- Chest x-ray, in Phek District Hospital, is not being used as an investigation for suspected cases, despite service providers being aware of the guidelines, because the chest x-ray is not being offered free of cost for patients. Similarly, CBNAAT is not functional since past 2 weeks due to non-functional UPS in Phek during the time of visit.
- LT posted in DMC (PHC Chizima, Phek district) is found to not been performing all tasks and duties expected for sputum microscopy and required further training.
- Formal system for collection and transportation of samples to higher testing facilities for presumptive tuberculosis, drug resistance tuberculosis cases needs to be strengthened for testing as cases are being missed when they are referred to these facilities.
- DST testing continues to remain suboptimal at 44% in the State. TB/HIV known status has improved over the past two years to 70% but continues to remain below the set target of 90%.
- Medical Officers arefound to not conduct DM-2testing for any of the TB diagnosed cases.

NVBDCP

- Community pooled its resources to procure test kits for Scrub typhus due to high burden of disease in PHC Pfutseromi, as they are not supplied under IDSP due to shortage of funds.
- IEC activities regarding identification of signs and symptoms are lacking for all diseases irrespective of their burden to the state and so is the community awareness regarding these diseases. Knowledge of ASHAs and Surveillance workers regarding signs and symptoms of major CDs (except for extra-pulmonary TB) is satisfactory.
- Annual Blood Examination Rate (ABER) for malaria is 14.67% and Annual Parasitic index is 0.02 which is well below the national targets i.e. >11% and<1 respectively. It is to be noted that the State has set its own target (higher that national target) of ABER at >15%.
- Malaria technical supervisor regularly tracks movement and work of surveillance worker.
- No cases of Acute JE, Filariasis, Dengue and Chikungunya reported in either of the districts. Most JE kit and vaccines are supplied to Kohima and Dimapur districts, where number of cases reported are high.
- NVBDCP related Microplans for Kiphire district are not available.
- LLINs, distributed in the communities in 2016-2017 drive, are still being utilised by many families. However, demand for replacement of torn nets had been raised.
- Active screening, testing of symptomatic cases and follow-up of referrals by ASHAs is severely lacking. IRS of DDT has not been utilized since past 2-3 years.

NRCP

- National Rabies Control Programme is not implemented on the ground level.
- Designated registers are neither maintainednor are the required vaccines supplied in facilities under the program.
- No animal bites/snake bites are listed in a designated register.

NVHCP

- Implementation of NVHCP has started in phases in only Phek district.

- Tests for Hepatitis B virus and Hepatitis C virus are available in DH and are offered free of cost under the programme. Drugs for treatment are expected to be received by the end of the year.

NACP

- Sexual route of HIV transmission is the most common in the State.
- The state's prevalence rate continues to be amongst the highest in the country at 1.15%.
- HIV screening of ANC registered women, functionality of F-ICTC, Mobile ICTC are satisfactory.
- There is also a need to identify specific occupational groups besides Truck drivers and Female Sex Workers (FSWs), in regions of the state where high prevalence rate is observed.
- Staff of either the F-ICTC or the Mobile units is not trained for conducting sessions with adolescents on HIV/AIDS or other Sexually transmitted diseases, such as Syphilis.

Odisha

IDSP

- IDSP reporting being done from all level of health facilities but gaps in timeliness of reporting is observed up to PHC level due to lack of digital communication and difficult terrains in both the districts.
- ANMs at HWCs have been trained in IDSP in Mayurbhanj district. ANMs are receiving alerts about spread of diseases in the community from ASHAs, AWWs and word of mouth from community members in both the districts.
- In both the districts a fully functional unit with all staff except LT and RRT is found.
- Most of the EWS of outbreaksare generated through event based surveillance. Total 12 number of private health facilities report weekly data under IDSP.
- Training on IDSP part of IHIP has been completed in 15 districts.
- In Kandhamal, IDSP booklet has been published by Programme Officer.

NTEP (erstwhile; RNTCP)

- Adherence to treatment, follow-up, monitoring and supervision under the NTEP (erstwhile; RNTCP) is reported well in both the districts. District DR TB Centres are functional, free diagnostics and drugs including 'Bedaquline' are available.
- Nikshay Poshan Yojana is being implemented in both the districts. Direct benefits are being transferred under NTEP (erstwhile; RNTCP) to patients. Community reported zero OOPE for treatment of tuberculosis, malaria or any other disease.
- Active Case finding is being conducted periodically. The NTEP (erstwhile; RNTCP) staff are well trained and had SOPs.
- TB patients are found compliant to DOTS. They are also getting 500 rupees per month for nutrition supplementation. ASHAs are the main source of follow up and ensuring compliance.
- CHCs and higher facilities are functioning as DMC and all drugs for DS- TB w ere available. But drugs for DR-TB are available on request from district based on the diagnosis.
- CBNAAT is functional at SDH Rairangpur and is doing approximately 5-10 samples per day, and out of them approximately 20-25 samples per month are being tested from private facilities.
- Dedicated 2 and 10 bedded wards are available for drug resistant TB patients at DHs at Kandhamal and Mayurbhanj, respectively.

NLEP

- Leprosy cases are being detected both at OPD and during LCDC campaigns. ABSULS is implemented at CHC and above.
- MDT, footwear and self-care kits for leprosy patients are available at CHC level and above. MO at PHC referred suspected leprosy cases to nearby CHCs. No active case search finding is being conducted for leprosy in the community by PHC.

- Record maintenance for Leprosy is updated at CHC level and above in Mayurbhanj however the same is not found in Kandhamal.
- Hard to reach areas are not mapped for leprosy, training at all levels had not been imparted and no IEC activity is being conducted for leprosy.

NVBDCP

- Integrated vector management by source reduction, use of PPE, anti-adult measures, anti-larvicidal measures and community engagement activities is being conducted through the **DAMan programme** (Durgama Anchalare Malaria Nirakaran) initiative of the State.
- The state has reported a sharp decline (81%) in number of malaria cases in 2018 and 2019 (45% till September) with zero to not more than one case being reported from the previous endemic communities in both the districts. No deaths have been reported in last 3 months.
- High risk villages have been identified and interventions are being targeted towards them.
- Awareness among the community members and ASHAs about VBDs like malaria, dengue and to some extent about Filariasis is good. Community members are provided LLINs which theyare using on regular basis. LLINs are also seen in the residential schools of Kandhamal district.
- They are also aware about other protective measures against malaria like using full sleeve clothes and maintaining mosquito free conditions in the village by reducing water bodies like filling water bodies with sand.
- ASHAs in the community arereported to use larvicidal fishes, but community is not aware about the same. Release of Gambusia fish in slow moving streams is observed in Kandhamal district.
- Community in Mayurbhanj informed that ASHAs are ringing bells at night 8:00 PM as reminders to use the LLINs. She also visits some houses to monitor the use of LLINs.
- Malariais one of the major agenda for discussion in Gram Kalyan Samiti (VHSNC) meetings as affirmed by community members and ASHAs. Rapid diagnostic kits are available with ASHAs to diagnose malaria, about which community members are also aware.
- Treatment charts are available for all malarial cases admitted in SDH Rairangpur and line listing of malarial cases in the community is also being done. Staff at all health facilities are well informed and well-versed with SOPs for malaria prevention and treatment.
- Antimalarial drugs and RDTs are available at all levels of health facilities. In one HWC (Mayurbhanj) no antimalarial drug is available, and they had been referring patients to CHC for treatment.M1 to M4 forms are filled and maintained at all levels.
- At DH Mayurbhanj, injection Artesunate is stocked out, which shows the gap in procurement and supply chain.
- Regular IRS is not being done.
- No case of Dengue, lymphatic filariasis, kala azar and chikungunya has been registered at any health facility in both Mayurbhanj and Kandhamal. However, regular surveillance activities are being carried out at sentinel sites.
- JE vaccination has been completed in 17 districts in campaign mode and is being continued in routine immunisation which includes the visited district Mayurbhanj.
- There are 20 Lymphatic Filariasis endemic districts identified in the state and with intense efforts, Malarial fever rate has come down to <1 in these districts.

NRCP

- Rabies vaccines are available at the level of CHC and above, which are being given by intradermal route.
- Many cases of dog bite and monkey bite have been reported in the community, which are referred to nearby CHCs or sub district hospital for vaccination where the patients failed to go.

- No IEC is displayed for rabies awareness. Treatment SOP is also not there.
- Animal bite registers are not maintained.

NVHCP

- District viral hepatitis management unit has been established.
- Health care workers have been immunized against Hepatitis B vaccine.
- One Model Treatment centre is functional in the state. Hepatitis B testing is being done at CHC level, and Hepatitis C testing and treatment is available at DH of both the districts.

NACP

- HIV screening is being done for all ANC and TB cases at all levels.At DH Mayurbhanj all diabetic cases are screened for HIV.
- Madhu Babu Pension Yojana to provide monetary support to HIV positive is functional in the State. Awareness of community and health staff is very high regarding transmission of HIV.
- Trained staff areavailable at SDH Mayurbhanj to counsel adolescents on sexual and reproductive problems and HIV/AIDS.RBSK teams also supported in educating adolescents about HIV.
- Needle Stick Injuries prevention and infection control protocols areobserved and known to health care workers at PHCs and CHCs in Kandhamal district.
- PPTCT facility is not available at SDH Mayurbhanj but is available at DH.

Rajasthan

IDSP

- The forms (P, S and L) are filled and reported. District Surveillance officer is in place and forecasting is done based on data analysisat district level.
- Early Warning Signal (EWS) is generated in case of occurrence of cluster of cases and investigated before declaration of outbreak. Rapid Response Team is in place at the district level.
- State level orientation of Integrated Health Information Platform (IHIP) is conducted recently and one person from each district is trained.

NTEP (erstwhile; RNTCP)

- DOTS facility iswell in place in all the facilities visited.
- The treatment cards of all the cases under treatment are available at the health facilities.
- Drugs for Drug sensitive and Drug resistance TB are adequately available in the pharmacy of the health facilities of Sirohi and Churu districts. NIKSHAY entries found to be up to date in the districts visited.
- There is suboptimal involvement of private sector-enforcement for mandatory notification for TB in the state. Schedule H1 implementation also needs to be strengthened.
- Sub optimal coverage of contact screening and INH prophylaxis among PLHIV is observed.
- Optimal utilization of CBNAAT needs to be ensured and decentralization of DRTB services required.

NLEP

- There is no visibility of Leprosy program in the state and there is no active case finding efforts visible. Even in CBAC forms, questions regarding leprosy are missing.
- No case of Leprosy identified in the last seven years in the state.

NVBDCP

- Incidence of malaria is higher in Sirohi district compared to Churu. There are no reports of other vector borne diseases like Kala Azar, JE, Lymphatic Filariasis, Dengue and Chikungunya and no cases of any of these diseases are reported in last 1 year in the state.

- M1, M2, M3, M4 forms are filled but not in all facilities.Lack of awareness about M-forms is observed.
- Blood examination by slide is being done in both the districts. There is no RDT kit available for malaria testing in peripheral facilities of Sirohi district.
- Lack of facility as well as community level IEC activities about vector borne disease is observed in the visited districts.
- Source reduction is done at community level by ASHA workers.
- No RDT Kits are available at health facilities for Kala Azar diagnosis.

NRCP

- Anti-rabies vaccines are available at the health facilities.
- Line list of animal bite cases are not maintained at all the visited health facilities.

NVHCP

- There is no visibility of Hepatitis program in the state.No tests for Hepatitis B and Hepatitis C arebeing done at the visited CHCs in the last 6 months.
- Reuse prevention syringes are not available at the CHCs visited.

NACP

- HIV screening is done during ANC and at the time of delivery. However, cold chain maintenance is compromised for the test kits in some of the health facilities.
- ART is available for the positive cases at the district level.

Tamil Nadu

IDSP

- P, S and L forms are being filled from the SC, PHC, CHC and reported in both the districts visited. The data entry is through the IDSP portal and is done within 3 days. Reports generated are shared through email to PHC, CHC and the State.
- The VHN and the MO have received induction training in IDSP. However, their current involvement and awareness regards the different reporting formats is observed to be suboptimal.
- Villupuram District had reported outbreak of Diphtheria in the last one year which is investigated by the District RRT. Follow up measures are undertaken through mop up vaccination of the vulnerable population in the community.

NTEP (erstwhile; RNTCP)

- At Villupuram District, the percentage of referrals for CBNAAT testing from private sector is minimal The RBSK team and the AWWs are not aware of the screening of children for TB. Even VHNs at SCs are also found actively involved in the program in terms of TB symptom screening, home visits, and Isoniazid Prophylaxis Therapy for the eligible contacts.
- At Villupuram district, the Nodal officer for NTEP (erstwhile; RNTCP) activities in the DH is a Chest Physician. DH & Medical College are found equipped with LED microscopes.
- Considerable backlog of samples to be tested through CBNAATare found at both the centres in Villupuram DH. Also, >50% of the samples tested at the CBNAAT laboratory are samples couriered from across the district.
- At Virudhunagar district, 2 CBNAAT centers are functional. All PHCs have not been functioning as DMCs , due to the non-availability of the Binocular Microscope.
- The entries in NIKSHAY do not completely coincide with the entries in the treatment card across the facilities visited. More than 90% of the registered patients have been enrolled for DBT.
- The total number of MDR patients diagnosed from the public sector is 44 and those from H

Mono Poly Resistance is 67.All TB patients are referred for HIV and Blood Sugar testing.

NLEP

- At Villupuram district, community awareness regarding the common symptoms of leprosy is good. The Women Health Volunteers (WHV) and the VHNs are involved in the screening for leprosy symptoms and Saturday surveys are being conducted in the villages.
- 190 cases of leprosy in last 10 months are reported in this district which is very high.
- At Virudhunagar, regular outreach activities, such as annual camps, periodic surveys etc are able to register new cases of leprosy; however there is no specific Red Zone. It is worth noting that the District Collector has allotted land to one leprosy patient and 219 cases are receiving Disability Pension of Rs. 1,500 per month.
- The treatment services are focused more at the SDH,DH and the Medical Colleges. Referrals to Medical Colleges or NGO hospitals are based on the need for corrective surgery.
- MDT is available and being provided to the patients. MCR footwear and self care kits are also provided.
- There is a felt need for the MOs at the PHC to undergo re-training on leprosy screening and treatment.

NVBDCP

- Community is aware about the control of mosquitoes in both districts visited. The districts have engaged 'Domestic Breeding Checkers' to address mosquito control. Also sensitization of the Headmasters and the school children regarding mosquito control measures is done.
- Fever Corners have been set up in all government offices to provide neem water, ORS along with rice water and other liquids based on Siddha medicine.
- Villupuram district reported 47 Malaria cases, 180 Dengue cases and 8 cases of JE in 2019. In view of such high rate of dengue, Government Medical College, District and the Sub-district Hospitals have been identified to focus on Dengue.
- While Villupuram Medical College has been identified as the Sentinel Surveillance Hospital, DH at Virudhunagar district has dedicated 15 male and 15 female beds for fever cases and 6 beds in isolation ward for identified infectious cases.
- The children are being routinely immunized for Japanese Encephalitis.
- No malaria deaths have been reported in last 3 years. No new cases of Filariasis detected in Villupuram district. The districts have malarial fever rate at<1% and the last MDA round is conducted in 2012.
- Line lists of the already diagnosed cases are present, self care kits are being provided to old cases of Filariasis and they have been linked to pension scheme.

NRCP

- None of the two districts have reported any Rabies cases in the present calendar year. Sufficient stock of ARV is present at the PHC, CHC, SDH and DHs.
- Community awareness regarding first aid to be provided following a dog bite is good.

NVHCP

- The Health Care Providers have been vaccinated against Hepatitis B at both the districts.
- The districts visited are yet to receive drugs for HCV from the State. Currently, anti HCV drugs have been procured and are available at Chennai and 10 other districts.
- Viral Hepatitis Surveillance is done through existing frontline workers at the HSCs.

NACP

- Good quality IEC display at the health facilities is seen in both the districts; however the community level IEC seemed lacking.

- District teams with the help of partner NGOs have identified vulnerable pockets and high risk people with adequate profiling.
- The transgender (trans-women) community seemed more cohesive; more empoared and well informed about the health and social sector services targeting them as well as their incentives and promotion activities from the government. They are also aware of the Gender Clinic at Chennai where counseling, testing and sex-reassignment surgeries take place under one roof , all provided free of cost by the State government.
- Printed HIV-TB registers are not being used at the ART Centre. NIKSHAY entries did not reflect the ART treatment status of the HIV-TB co-infected individuals.
- Police harassment of the vulnerable high risk groups is common especially towards the FSW.

Uttar Pradesh

IDSP

- Integrated Health Information Platform training has been completed in both districts but IHIP is not implemented in Bahraich district. Also, data entry facility for IHIP is not available at PHC level in Meerut.
- S, P and L forms are not available in most of the UPHCs and SHC-HWCs visited.
- RRT is established at district and block level in both the districts. In Bahraich, 12 outbreaks had been identified since January 2018 and investigated by district RRT. Also, in Meerut, 399 cases of H1N1 and 84 Dengue cases are reported till 20th October 2019 and investigated by RRT team.
- In Bahraich- Post of Data manager at IDSP Unit is vacant for last 2 years. Also, EWS identification is lagging owing to inadequacies in timely reporting and completeness of reporting formats especially Form S (only 12%).

NTEP (erstwhile; RNTCP)

- Community level interaction revealed that beneficiaries are aware of TB testing and treatment facilities available at public health facilities but awareness regarding nutritional support (Rs 500) to TB patient is low in Bahraich.
- All TB patients are tested for HIV. Also, Nikshay entries are found to be updated.
- DBT is regularly being given to the patients however, it is pending since past three months in Bahraich.
- Apart from sputum examination, no other work related to tuberculosis control is being done at UPHCs. HSC- HWCs and UPHCs are not serving as DOTS Centre despite catering to dense population.
- CHCs are functioning as TU as well as DMC and DOTS centre in both the districts.
- Slide examination rate has been reported to be poor.
- DTO Bahraich is not trained in NTEP (erstwhile; RNTCP).
- Notification from private sector is only 74% in Bahraich.
- The percentage of public and private samples tested on CBNAAT is 90% in public and 10% private sector.

NLEP

- Community awareness about leprosy- mode of spread, treatment options at public facilities and curability is suboptimal in both the districts.
- Difficult to reach cases have been identified and special strategies like school health education regarding prevention and control of leprosy is ongoing in Bahraich.
- Prevalence rate of Leprosy is decreasing gradually. The PR has come down to 0.96 from 2.17 per 10, 000 population in 2011-12 in Bahraich district.
- MDT adult and child for PB and MB are available in both the districts. MCR footwear and self-care kits are being distributed in both the districts.

- ASHA based surveillance for Leprosy suspects (ABSULS) is not being done at UPHC, PHC and HSC-HWC level. Active case finding is missing as well.
- No activity related to leprosy control is observed in the UPHC and SC-HWC in Bahraich.
- RCS is done for 6 cases and focus leprosy campaign is also conducted in all patients with grade-2 disability in Bahraich. Full Time DLO is posted in Meerut District.

NVBDCP

- Community is not aware of transmission of VBD like Dengue/ Chikungunya/ JE/ Lymphatic Filariasis.
- Malaria diagnosis is done only by RDT Kit at the HSC-HWC and UPHC level. The ASHAs do not have diagnostic kits or drugs for malaria treatment or M1 form.
- No referral mechanism for Dengue and Chikungunya cases isavailable in the state. Also, uninterrupted supply of RDT kit is reported.
- The general condition of the village for health and hygiene is not good and least involvement of Gram Panchayat is seen in developmental activities to maintain mosquito free conditions.
- Functionality of VHSNC is observed but vector borne diseases are not included in their agenda.
- Two doses of JE vaccine is given to all the children as seen in the MCP cards. 7 JE cases arereported in the district Bahraich.
- Shortage of key HR affected program implementation in Bahraich as posts of DMO, AMO, SMI, LT and Field Workers arevacant. National Filaria Control Unit has also relatively high vacancies (10 out of 33 posts are filled). Also, training of Malaria Staff is not conducted since their posting.
- Filaria Control Officer in Bahraich is not aware about the grant received under NHM to purchase morbidity management kit under National Filaria Control Program. So no morbidity management camps and hydrocelectomy camps are organized.
- In Bahraich, malaria program implementation showed certain gaps like poor involvement of ASHAs in source reduction or micro plan of malaria, unavailability of reporting formats, treatment chartand ACTs at most of the facilities.
- In UPHC Bahraich, binocular microscope is available, but it is not used as the Lab Technician is not trained in malaria microscopy which needs priority attention.
- At DH, Bahraich, 10 bedded ICU is there, but three ventilators are out of order at the time of visit which is concerning and reflected poor management overall.
- In Meerut, Malaria Elimination Committee and Malaria Elimination Task Force are not constituted. Micro Plan available for vector control activities based on API (Anti larval methods). DH & Medical College are functional as Sentinel Surveillance Hospital.

NRCP

- Intradermal is the preferred ARV administration route and as reported, ANM & Pharmacists are trained in giving intradermal injections except in DH, Bahraich where the Chief Pharmacist is not found trained in giving intradermal injection.
- Sufficient ARV vials are available in both the DH. Vaccination is being done at DH and CHCs but not below.
- No IEC material is displayed regarding post exposure management in most facilities.
- High dropout rate (94.6%) from 1st to 4th dose of ARV is seen in the district hospital Bahraich.
- Animal bite exposure register is not available at UPHC and CHC in Bahraich and ARV is also not available at UPHC.

NVHCP

- NVHCP has not been implemented in both the districts. However, Hepatitis screening of all ANC cases and blood is being done.

- No activity related to viral hepatitis surveillance is done at HSC-HWC, PHC and UPHC level and no investigation is carried out even with RDT kits for Hep B or C.
- Reuse of syringes is not seen in both the districts.

NACP

- People interacted with are found to be aware about the causes of HIV/AIDS.
- HIV screening of ANC cases is being carried out at the health facilities. Facility for Nevirapine prophylaxis to the newborns of HIV positive mothers and delivery of HIV positive person is available at District Hospital.
- All TB patients are tested for HIV with whole blood finger prick at CHC Risia.
- IEC/BCC material for display and hand out for clients are available at the ICTC centre. At RTI/ STI (Suraksha Clinic) Clinic, Bahraich, 2050 clients had been counselled since 1st April-2019.
- ART centre- The post of Data Entry Operator is vacant for last 4 months and so updated data could not be provided. Also, CD-4 count machine is not available in ART centre.
- All the 1st& 2ndline drugs are available in adequate quantity in the ART centre.

Uttarakhand

IDSP

- Facility is reporting weekly data in S form but details are missing. Good documentation of records and reporting in L form seen.
- Although Medical officers are aware of IDSP, no specific training on IDSP is given to them.
- MPREGNANT WOMENs are not aware of number of patients in their area and there is no action plan for active case search and follow up. Even doctors posted at HWCs are not aware of disease surveillance.

NTEP (erstwhile; RNTCP)

- DOTS facility is available at CHC level. No examination and screening are conducted at PHC. Confirmed cases are being sent to DTC Rudrapur and cross checked for MDR.
- CBNAAT lab is functional at DTC. The drugs (both sensitive and resistance) are available at the facility.

NLEP

- No Grade II Disability (G2D) casesare reported in last 3-4 years. Focussed leprosy campaigns are planned to be conducted in November 2019.
- Lack of awareness about Lymphatic Filariasis is seen in community.

NVBDCP

- Good awareness of symptoms and treatment for Malaria and Dengue isobserved. Low prevalence and lack of awareness about VBDs like Kala Azar, Lymphatic Filariasis and Leprosy also seen.
- Functional labs for malaria slide examination (both active and passive) are available. Severe malaria cases are being referred to DH.
- Measures to prevent dengue, malaria and maintain good village hygiene are discussed in Gram panchayat/ VHSNC meetings. Anti-Malarial drugs are available. No case of falciparum has been reported in last one year.
- No screening, testing is conducted at PHC. Suspected dengue cases are referred to CHC but the cases are confirmed at DH. For JE too, ELISA test and positive case confirmation is done at DH.
- Lack of documentation and maintenance of recordsis noticed.
- No awareness of LLINs seen in the community. LLINs are also not supplied by the government. M-1 form, RDT and anti-malarial drugs are not available with ASHA.

NRCP

- ARV is available for BPL patients. In-case of animal bite, people are advised to go to private hospitals/clinics for anti-rabies vaccination as ARV is not available at government facilities in the entire district for last 6-8 months.
- Proper documentation and adherence to SOPs regarding vaccination is being followed.

NACP

- Lack of awareness of HIV and its transmission seen in the community.
- 11 positive cases reported in 2019. HIV screening is conducted at the facility and positive cases are referred to ART center which is at Sushila Tiwari Medical College, Haldwani.


ANTENATAL EXAMINATION

TOR 5: NATIONAL URBAN HEALTH MISSION

National Overview

All state reports note that the institutional structures created to support implementation of NUHM in the states, are in place. Functionality of various programs under NUHM also demonstrates considerable improvement in the states visited by CRM. CRM teams further observed that the primary healthcare facilities are functional in most of the states visited, though further strengthening of the network is required through augmentation of number of UPHCs and UCHCs (as per the gaps indicated under RHS 2019), so as to reach saturation levels. The UPHCs are being converted into Health and Wellness Centres (UPHC-HWCs) in order to deliver comprehensive primary healthcare. The infrastructure at block level is adequate in majority of the states visited, with around 60-65% of facilities functioning in government buildings. The Programme Management Units are in place in most of the states. Convergence of NUHM with various National Health Programmes has been improved. The inter-sectoral coordination has also improved in many states, although medical colleges still lack required coordination with NUHM.

Key Findings

Planning and Mapping

- In the sixteen states that CRM visited, mapping in urban areas has seen considerable progress. The mapping of urban health facilities as well as urban slums has been completed in Chhattisgarh, Delhi, Gujarat, Madhya Pradesh, Manipur, Mizoram, Meghalaya, Odisha, Rajasthan, Tamil Nadu and Uttar Pradesh. While Andhra Pradesh, Nagaland and Uttarakhand have completed approximately 70% of both facility and urban slum mapping, Bihar has completed facility mapping but urban slum mapping has not been done yet. GIS mapping of urban slums is ongoing in Jharkhand since October 2018 after empanelment of Jharkhand Space Application Centre (JSAC).
- The vulnerability assessment mapping is reported to be completed by Chhattisgarh, Delhi, Manipur, Mizoram and Odisha. Andhra Pradesh, Meghalaya, Nagaland, Rajasthan, Tamil Nadu and Uttarakhand have finished vulnerability mapping of around 60-70% of population. While Bihar, Gujarat and Madhya Pradesh are in the process of continuing with this mapping. In Jharkhand, the VA tool for ward level and ASHAs has been prepared. The training is yet to be comducted. In Uttar Pradesh vulnerability assessment has not been initiated yet.

Convergence

- Well established convergenceamong ULBs, WCD, MoUD, etc. was observed in Gujarat, Odisha, Rajasthan, Chhattisgarh, Mizoram and Tamil Nadu. However, a need to strengthen coordination with ULBs was felt in Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Jharkhand,

Manipur, Madhya Pradesh, Meghalaya, Uttar Pradesh, Uttarakhand and Nagaland for better planning, community education on water and sanitation, creating awareness on vector borne diseases and source reduction. In Delhi, major challenge observed was the lack of coordination of State Health Department with the Municipal Corporation. In Uttar Pradesh, the service delivery at AWCs was found to be poor.

- Integration of other National Health programmes with NUHM was satisfactory in almost all the states, except Meghalaya. In some states like Gujarat, programme-wise reporting for RCH, NCD, NTEP (erstwhile; RNTCP), Urban Health and PMJAY has resulted in verticalization of programmes rather than their integration. However, in Chhattisgarh NUHM was seen to be integrating other national programs such as RMNCH+A, NTEP (erstwhile; RNTCP) and NACO successfully.
- Andhra Pradesh has a good intersectoral coordination of Health Department (eUPHC) with ICDS. A SHG "Mission for Elimination of Poverty in Municipal Area" (MEPMA) is involved in MAS formation.
- Odisha has set a good example inBhubaneswar Municipal Corporation, wherein several UPHCs in the state have developed Rain Water Harvesting System, cow catchers, constructed boundary walls, deep burial& sharp pits and engaged night watchmen in all UPHCs of Berhampur. Financial grant for security guard of UPHCs is also provided by the ULB. Along with this, outreach health camps for sanitary workers of ULB are organized and health cards for regular check-ups are issued in several districts of Odisha. ULB supports the MAS in identification of household without toilets and collection of garbage.
- In Mizoram, construction of community toilets has been done through initiative of ULBs. An integrated model for nutrition has been adopted in Tamil Nadu, wherein several PHCs and Anganwadi Centres are co-located. In Rajasthan, ASHAs are paid an additional fixed amount of Rs. 2700 from ICDS apart from the incentives from NHM programmes.

Service Delivery

Institutional Arrangement and Programme Management

Programme management units at state, district and city level have been established and strengthened in most of the states visited by CRM teams. Approximately 80% programme management staff is in position at various PMUs.

Infrastructure

- Majority of the States have got all approved primary health facilities being functional, except Madhya Pradesh, where only around 50% of the approved facilities have been operationalised. The primary health centre infrastructure is adequate in most of the states, with approximately 60-65% of facilities functioning in government buildings while others are operationalised in rented premises. While states like Andhra Pradesh, Chhattisgarh, Gujarat, Manipur, Mizoram, Odisha, Rajasthan and Tamil Nadu have more than 80% of facilities functioning in government buildings, Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh have 15-30% of these in government buildings. Majority of UPHCs in Delhi, Meghalaya and Uttarakhand are functioning in rented buildings.
- Overall, the infrastructure is good at primary care level, especially in Andhra Pradesh, Delhi, Manipur, Nagaland and Tamil Nadu. Andhra Pradesh has 243 eUPHCs using digital platform through PPP with Service Providers. In Tamil Nadu, health services are provided by State health department, 11 municipal corporations (MCs) and 75 municipalities. States such as Delhi have several key stakeholders providing primary and secondary health services, which include the State Health Department, Municipal Corporation of Delhi (MCD), New Delhi Municipal Council (NDMC), CGHS, Railways, ESI, etc. Besides these, 364 facilities provide AYUSH services.
- Urban Primary Health Centres have been converted into Health and Wellness Centres

(HWCs) for provision of Comprehensive Primary Health Care with Bihar (95%), Gujarat (51%), Andhra Pradesh (100% eUPHCs), Meghalaya (25%) and also in Mizoram, Madhya Pradesh, Nagaland, Odisha and Rajasthan. Ayushman Bharat Scheme has not been implemented in Delhi. HWC Branding with appropriate display of IEC materials was seen to be achieved in Bihar, Gujarat, Manipur and Meghalaya.

- Health Kiosks are functional in Rajasthan and Uttar Pradesh. MMU services have been operationalised in Odisha, Rajasthan and Delhi.
- Major infrastructure challenge observed in Uttar Pradesh, due to rapid urbanization is, the shortage of health facilities with respect to the population that is being catered to. While in Andhra Pradesh, only 42% fund released for civil works has been utilised by during 2018-19.

Human Resources

- Approximately 75% of medical and paramedical personnel are filled positions. In Gujarat 75-90% of the key service delivery posts are reportedly filled, against those sanctioned. Adequate HR in line with NUHM guidelines was found in Meghalaya. Public health managers were appointed in Jharkhand, Odisha and Rajasthan.
- In Andhra Pradesh, there is shortage of staff of all cadres at the state level, with nearly 65% of positions vacant under NUHM sanctioned posts. States like Bihar, Jharkhand and Madhya Pradesh report more than 50% vacant positions of Medical Officers. Rajasthan has around 80% of positions lying vacant for Staff Nurse, Lab Technician and Pharmacist. In Chhattisgarh, the urban health facilities are understaffed and clinical services are being augmented through deputing AMOs and AYUSH doctors. The Corporations in Tamil Nadu have not filled up most of the vacant positions of Health Officials/ Workers.

Range of Services

- UPHCs across states are being converted into UPHC-HWCs for providing comprehensive primary care that includes preventive, promotive and curative services, along with implementation of National Health Programmes, in urban slum and non-slum population. The treatment of general ailments, maternal and child health conditions, NCDs and facility of day care for emergencies and minor procedures is being provided. ANMs and ASHAs are providing ANC, PNC, Family Planning and Immunization services on a regular basis. DOTS is also being given in maximum of the UPHCS. In majprity of the

states, UPHCs converted into HWCs are also conducting wellness activities.

- Several states have extended their OPD timings of urban facilities in order to improve access for urban community to the UPHCs. OPD services in dual shifts (morning and evening) are being continued in Jharkhand and Rajasthan. eUPHCs in Andhra Pradesh are functioning throughout the year. In Uttar Pradesh, service provision is now extended on Sundays as well. Few 24x7 UPHCs are functional in Tamil Nadu, Chhattisgarh, Odisha and Madhya Pradesh.
- Opportunistic as well as Population based NCD screening is ongoing in Bihar, Chhattisgarh, Gujarat, Rajasthan, Meghalaya, Nagaland and has started recently in Uttar Pradesh. Population based NCD screening is not being carried out in Delhi. The data of CBAC form was not being entered properly on the portal in Chhattisgarh and Bihar due to lack of training. The NCD data collected is not entered on portal in Gujarat as new version of TECHO+ app with NCD features is underway.
- Few of the states are also providing specialist services at UPHCs. Specialists provide services on fixed days with support of Government Medical College in Chhattisgarh and Tamil Nadu. In Tamil Nadu, medical colleges are also involved with Skill Lab trainings. Specialist services of cardiology, endocrinology, orthopaedics / rheumatology and general medicine are being provided through Tele consultation in e-UPHCs in Andhra Pradesh.
- Wellness activities like yoga sessions are being conducted in Chhattisgarh, Gujarat, Manipur, Odisha and Mizoram. In Chhattisgarh, a novel initiative of “Wellness beyond Yoga” has been started with conducting “Zumba Classes” along with Yoga sessions at select urban health centres. This is intended to improve overall wellness of urban population of all age groups. Limited wellness activities are,however, taking place in UPHC-HWCs in Bihar, Meghalaya and Rajasthan due to lack of space in the premises and also because of not hiring Yoga trainers.
- Family planning services are being provided in most of the sates except the urban facilities in Jharkhand and Madhya Pradesh. The IUCD services, despite staff nurse/ANM being in place were not being delivered. The UCHCs in Meghalaya reportedly also do not provide sterilization services. While one of the UPHCs in Rajasthan despite being equipped with well-established labour room and staff trained on SBA, no delivery services were made available.
- Diagnostic services are being provided in-house in almost all the UPHCs, except Bihar, due to lack of lab technicians. However, eye screening for refractive errors is being continued in Bihar.
- Jharkhand has started “Atal Clinics”, which are structures equivalent to health kiosks, providing curative services at present. The “Mohalla Clinics” in Delhi are an initiative of the state government to provide curative and diagnostic services (Hub & Spoke Model) to the population. Tamil Nadu has started Urban Polyclinics under NUHM for providing fixed day specialist OPD services during evenings. Similarly “AMA Clinics” in Odisha, provide specialist services of Medicine, Physiotherapist and Nutritionist in UPHC as part of Geriatric Clinic. The Urban Vision Centres “Sunetra Clinic” have also been rolled out in Odisha as a part of the Universal Eye Health Programme of the State Government.

- Odisha has set an example of public health and disaster management initiatives during the Cyclone 'FANI'. It had caused catastrophic landfall on the Odisha Coast, south of Puri, in May 2019 and had a devastating effect in District Puri and UrbanBhubaneswar. Pre and post cyclone Preparedness activities helped in attending emergencies & distribution of logistics to overcome the calamity with zero casualties.

Quality

- The facility timings, citizen charter, EDL and IEC have been displayed in most of the facilities visited. In order to ensure continuum of care, almost all the states are seen to be implementing the Free Drugs and Diagnostics Initiative. Centralized Procurement of Drugs through e-Aushadhi; a web-based application is being done in Andhra Pradesh, Gujarat and through "*Jan Aushadhi*" in Nagaland. Besides this, Delhi has "Delhi Arogya Kosh" and "Delhi Arogya Nidhi" schemes for free treatment is provided to BPL accident victims in private hospitals also aims to reduce OOPE on diagnostic services.
- Adherence to Biomedical Waste Management (BMW) was satisfactory in most states except in Uttar Pradesh and Nagaland. BMW is an area of urgent concern in Bihar as the BMW contract has been taken for the District Hospital and UCHC only. Even from District Hospital, where numerous deliveries are conducted every day, the BMW collection occurs once in two days.
- State and District Quality Assurance Committees have been constituted and quality initiatives such as Kayakalp and NQAS are being implemented well in Delhi, Gujarat and Nagaland. These states have functional infection control committees and service provision is satisfactory. Gujarat has strategic ''Mission NQAS 151'' facilities for FY 2019-20 and the UPHCs have been integrated into the ''MeraAspataal'' App.
- Focus on quality measures however, is required to be reinforced in Meghalaya, as none of the UPHCs assessed for Kayakalp programme could qualify for Kayakalp. Bihar and Rajasthan also showed lack of implementation of Quality Assurance programmes at urban health facilities.

RKS

- RKS have been formed in Bihar, Chhattisgarh, Gujarat, Odisha, Mizoram, Nagaland, Rajasthan, Tamil Nadu and Uttar Pradesh, though account opening for a few is still pending. In other states such as Jharkhand, RKS has been registered this year but no funds have yet been provided while RKS formation is under progress in Manipur
- No RKS have been formed in Andhra Pradesh, Delhi, Madhya Pradesh, Meghalaya and Uttarakhand. In Delhi, the nomination of MLA as Chairperson of RKS by Health & Family Welfare Department is pending, hence the RKS (Assembly RKS) formation is delayed. This has led to delays in grant of untied funds to facilities and non-disbursal of funds under quality initiatives such as Kayakalp.

- Utilisation of funds under RKS needs attention. Untied grant utilisation was poor among the states with Bihar, Jharkhand, UP and Manipur. In Bihar, RKS has been formed but non utilisation of funds is reported. Similarly, in Rajasthan, it was observed that there is delay in funds transfer from state to district. Thus, the activities planned for the year are not implemented as planned in the health facilities.

Outreach Services

- Outreach services through UHNDs and Special Outreach Camps were found to be conducted regularly in Rajasthan, Mizoram, Meghalaya and Uttar Pradesh. In Delhi UHNDs are being conducted regularly but not special outreach camps. In Tamil Nadu, Urban Health Nurse (UHN) provides the designated services during UHND. Besides this, fixed day specialist services through urban polyclinics are being provided but no special outreach is being done. UHNDs are not being conducted in Bihar due to lack of ANMs. In Meghalaya, there is difficulty in hiring specialist doctors for attending special outreach camps. NGOs provide support for outreach camps in Mizoram. The number of outreach camps were reduced over last year in Chhattisgarh.

Community Processes

ASHA

- The engagement of urban ASHAs was found satisfactory, in the range of 85-100%, in most of the states visited. Required number of ASHAs had been recruited in Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Gujarat, Jharkhand, Manipur, Mizoram, Nagaland, Odisha and Rajasthan , where as Uttarakhand, Madhya Pradesh, Meghalaya and Uttar Pradesh had about 70-80% ASHAs in place. The number of urban ASHAs and ASHA-population ratio was found to be extremely low in Uttar Pradesh, as a result of which, community awareness was found weak in many areas. In Tamil Nadu, instead of ASHA workers, Urban Health Nurses (UHN) provide the designated services at UPHC and during UHND.
- The performance of urban ASHAs was satisfactory in Andhra Pradesh, Bihar and Gujarat which reflects in community awareness and their trust with ASHAs. In Odisha, the ASHAs use “Swasthya Kantha” (health wall) as a communication tool to disseminate information on health and sanitation within the community. One unique role of ASHAs in Manipur, rather than being just health worker, also act as Social Activist, where they have become a part of a movement called “MeiraPaibi”, a vigil against alcoholism and hooliganism.
- The training mechanisms for ASHAs need to be strengthened in Bihar, Jharkhand, Manipur and Uttar Pradesh as per the guidelines. Andhra Pradesh does not follow the NHM guideline of performance-based incentives to ASHAs, instead it provides them monthly fixed incentives.

MAS

- States where MAS have been formed include Andhra Pradesh, Chhattisgarh, Jharkhand,

Manipur, Mizoram, Meghalaya, Nagaland, Odisha and Rajasthan. Tamil Nadu and Uttarakhand do not have MAS in place as yet.Tamil Nadu engages women's Self-Help Groups (SHGs) in urban areas to perform functions similar to MAS.Overall, around 75-80 % MAS formation has been observed across the states.

- The functioning of MAS was satisfactory in Andhra Pradesh, Bihar, Chhattisgarh, Gujarat, Madhya Pradesh, Manipur, Odisha, Rajasthan, Nagaland, Mizoram and Uttar Pradesh. In Odisha, MAS have their own letter head through which communications are sent to Electricity Department and Municipality for activities such as cleaning of sewage lines and open drainage system. In parts of Odisha, like Mayurbhanj, The MAS members are also part of SHG and undertake activities like making *agarbattis*, stitching clothes and making earthen pots. MAS at Behrampur has also played an important role in identification of TB cases and follow up of breast cancer patients.
- In Delhi, only 4% of approved MAS have been formed, which also need to be trained for their role in the community. High attrition rate of ASHA and MAS is observed in Meghalaya. MAS funds remain under-utilized in most of the states.

IT Initiatives

- Computers and internet facility are available at all urban facilities. Tablets have been provided to ANMs in Bihar, Odisha, Nagaland and Gujarat. The data of CBAC forms was not properly updated on the portal at most places and the staff needs re-orientation on use of NCD portal.
- FP-LMIS was not being used regularly to receive and issue stock in a few states. Orientation on FP-LMIS needs to be done.
- Chhattisgarh has generated an urban health monitoring tool "U- Health", for monitorable indicators andit is being utilised by all districts regularly for better analysis of urban health program achievements. Besides, it has also signed an MOU with TATA Trust to develop Electronic Health Services (EHS) and modal immunization room at UHCs.
- In Gujarat, all the facilities are reporting on state devised software ImTeCHO and on HMIS portal. Besides this, smartphones were available with ANMs, with Techo+ loaded software for RCH data entry. NCD related application in Techo+ was also to be started soon. Vector borne surveillance system under Surat Municipal Corporation is well developed with support of 900 primary health workers provided with tablets for daily reporting.

Public Private Partnerships

- Andhra Pradesh has started 243 e-UPHCs utilising a digital platform, through PPP mode, that have been designed exclusively keeping in view the needs of urban slum dwellers. These e-UPHCs function on all 365 days in a year, in two shifts from 8.00 AM to 12.00 Noon and 4.00 PM to 8.00 PM. Electronic Medical Records of patients are maintained, which can be retrieved using their Aadhar Number. This enables the patients to access services at any of the centers. Uttar Pradesh is also initiating the use of digital platform through e-UPHCs in certain of its urban health facilities.
- In Odisha, 25 UPHCs under NUHM are managed by NGOs under PPP initiative.

Rajasthan is operating 30 UPHCs on PPP mode with an objective to provide competent clinical care and community outreach services. Urban PHCs at Dehradun in Uttarakhand have been contracted out to different NGOs in PPP mode, since June 2019. However, the contract was only for 6 months and the provision of urban health services is uncertain beyond October 2019. No PPP project on urban health has been commissioned in Tamil Nadu. However, several NGOs/Agencies are working in Urban Health through CSR funding, which may be tapped by the State.

- Chhattisgarh has signed a MOU with TATA Trust NGO to develop Electronic Health Services (EHS) and modal immunization room at Urban Health Centers.

Innovations

- In Odisha, as an innovative step towards motivating the functionality of MAS, grading of the performance of MAS is done and an additional incentive of Rs.3000 is provided to 20% of the best performing MAS. Besides this, the ASHAs in Odisha use "Swasthya Kantha" (health wall) as a communication tool to disseminate information on health and sanitation in the community. Also, rain water harvesting system and herbal gardens in UPHCs are also few of the new inititives started in Odisha.
- Tamil Nadu has started Urban Polyclinics that provide specialists OPD clinic under a single roof at fixed timings. The specialists are hired for these OPD clinics.
- As part of innovations, a Social Protection Scheme by the name "Dr. YSR Aarogyasri Scheme" is being run by Andhra Pradesh. This scheme provides end to end cashless services to BPL beneficiaries for 1059 procedures that are recognized by Civil Supplies department.

Finance

- Utilization of NUHM funds reportedly varied across states. Tamil Nadu (88%) and Manipur (73%) reported good utilisation of funds against approved during FY 2018-19. Fund utilisation was reported as approximately 24% in Delhi, 27% in Meghalaya, 34% in Gujarat, 43 % in Andhra Pradesh, 60% in Rajasthan and 65% in Mizoram. Low utilization of NUHM funds was observed in Chhattisgarh, Jharkhand and Bihar.
- Banking Guidelines are not being followed in Andhra Pradesh. All transactions have been carried out from a single bank account at SHS and DHS, though separate accounts have been opened for all programme accounts. Hence, the exact programme wise expenditure and balance could not be ascertained. Even for JSY payments at facilities in Andhra Pradesh, non -account payee cheques were being issued to beneficiaries.
- In Meghalaya, no funds could be released to the state under NUHM due to high unspent balance or non submission of audited UCs. On the other hand, there was reported shortage of funds at the district and facility level in Meghalaya, while sufficient funds were reported being available at the State HQs. Huge backlog in payments of demand driven activities (JSY, ASHA incentives, compensation to the contractual staff) was observed.
- A delay in the disbursement of funds from the State Treasury to SHS bank account for NUHM was observed in Manipur. Non-Account Payee (bearer) cheques are being handed to JSY beneficiaries in districts visited in Andhra Pradesh. In Nagaland, financial record keeping was insufficient and inadequate. Personal account was seen to be used for financial transactions and fund utilisation in cash was adopted through self-cheques.

Recommendations

- All types of mapping under NUHM should be completed on priority and in a time-bound manner.
- There is a need for prospective planning in urban areas keeping in mind the future requirements.
- Strategic relocation/planning of UPHCs should be done based on GIS, facility mapping and Vulnerability Assessment.

- There is a need to strengthen the convergence with ULBs and other concerned departments to develop strategy for delivering uniform quality services and improving sanitation and hygiene, improved drainage systems and better solid waste management in urban slums.
- A state level Coordination and Monitoring Committee under the Chairpersonship of Chief Secretary/ Additional Chief Secretary may be constituted to ensure effective coordination among various authorities having members from States (including MDs, DHS), ULBs/ Corporations, Other government departments (Social Welfare, Water and Sanitation, WCD), Smart City Mission, Medical Colleges and Development partners.
- The State PIP should be comprehensive and based on District Health Action Plans. Appropriate training should be provided at the district level officials prapration of DHAP.
- Periodic inter-sectoral review meetings should be planned at state, block, district and ward levels to assess implementation of DHAP.
- All States should have HR policy to recruit and retain all HR and also to tackle attrition of the frontline healthworkers. A dedicated HR cell should be formed at SPMU and DPMU level.
- Rational deployment of HR to be done under all categories, keeping in mind facility wise load. All the sanctioned key positions under the SPMUs, DPMUs and CPMUs should be filled and trained under NUHM. All the vacant positions at facility level, including that of Medical Officers and Public Health Manager, as sanctioned, should be filled on priority.
- Orientation on various NUHM modules and CPHC guidelines of GOI need to build the capacity of NUHM functionaries in the state, district and sub-district levels. A time bound road map needs to be developed for the capacity building.
- UPHCs need to expand the range of primary care services including services for elderly, mental health or tobacco control as per HWC guidelines.
- ANC, Family Planning, immunisation and NCD screening should be initiated at all the UPHCs, after adequate training of ANMs. Population based NCD screening and reporting on NCD portal should be initiated on priority at all UPHCs. States should complete procurement for NCD tablets. Provisions for wellness activities like regular yoga sessions should be made.
- Specialist clinics should be initiated during evenings or as per local community needs. The specialist healthcare providers can be hired by collaboration with Medical Colleges or by hiring private doctors on daily remuneration basis.
- Quality assured delivery services should be made available 24*7 at Secondary care level like UCHCs and Maternity Centres.
- All health kiosks in an area should be functionally upgraded as UPHCs to ensure effective service delivery.
- Referral Mechanism needs to be strengthened by developing linkages with higher centres, especially in cases of emergency.
- Special need based Outreach and UHNDs should be planned in urban slums. Developing a calendar of UHND sessions for slum areas can be attempted to provide consistent outreach services. Coordination amongst ANMs, ASHAs and MAS members can be achieved through regular meetings.
- MAS should be formed as per guidelines and to be linked with income generation activities under NULM. Strengthening of supportive supervision for MAS at the community level is required. Role of MAS needs to be explored in outreach activities or camps and NCD screening. Opening a bank account for MAS with zero balance should be facilitated.
- Recruitment and retention of Urban ASHAs to ensure the reach of Health care delivery services specially in the urban slum areas.
- State should develop a mechanism to review the POSHAN Abhiyan in coordination with WCD. Engagement of Civil Societies is recommended for Maternal and Child and Perinatal death reviews.

- States should target all the Urban facilities to get accreditation under Kayakalp and NQAS initiatives. The urban health nodal officers in states and districts along with CMO and Medical Officers should be a part of Quality Assurance Committees and conduct regular meetings.
- Leveraging partnerships with NGOs, CSR projects and Private Sector should be considered as a way to enhance service coverage and strengthen linkages. CSR collaboration should be explored, especially in the states with metro cities. Non-financial agreements may be signed with NGOs and CSR projects to leverage additional resources and also get periodic reporting from their field observations.
- PPPs under NUHM may be explored, especially for slum areas where there is no physical presence of UPHCs. States should sign MoU that clearly defines the responsibilities of private partner, time bound deliverables, measurable outcomes and a monitoring framework.
- The allocated budget under NUHM should be utilised to the fullest by planning activities in a time bound manner.
- Bank accounts to be operationalised as per FMG Guidelines of Ministry.
- Financial documentation at UPHC and UCHC should be reviewed and audited regularly as per norms. A system of separate audit of RKS of the CHCs and PHCs under NUHM needs to be developed on priority.
- Payments to ASHAs and beneficiaries of programs should be done through Direct Benefit Transfer and PFMS. States should refrain from making cash or cheque payments to maintain transparency.

State Specific Findings

Andhra Pradesh

- Vulnerability mapping done in all 746 Slums in Vishakhapatnam but not in Kadappa.
- Health Department (eUPHC), ICDS and a SHG "Mission for Elimination of Poverty in Municipal Area" (MEPMA) are together involved in MAS formation, which happens in well coordinated matter. But efforts need to be made to further strengthen the coordination with Urban Local Bodies,Social Justice & Empowerment, Water & Sanitation.
- ASHAs are getting their payments on regular basis through e-Transfer as a fixed honorarium of Rs. 10,000 per month (Rs. 7200 from State Fund and Rs. 2800 from NHM Fund).
- The state now has 243 e-UPHCs functional. Out of these 243, 193 are upgraded from Urban Helath Centres, 19 are dispensaries and previously established 10 eUPHCs. 21 are newly formed eUPHCs. The upgradation has been done through PPP mode with Apollo Health Care, e-Vaidya and Dhanush LLP, to provide specialist services.
- Adherence to Bio Medical Waste management (BMW) is followed in all the e-UPHCs at Vishakhapatnam. Mixing of waste and poor liquid waste management was observed at Kadappa.
- The State has a target of selecting 3200 ASHAs, out of which 2609 (81.5%) have been selected. Vishakhapatnam reported 100% ASHA selection, while Kadappa reported 80% selection of ASHAs against the sanctioned positions.
- 10,440 MAS have been constituted which are under control of SHG "Mission for Elimination of Poverty in Municipal Area" (MEPMA).
- Social Protection scheme by the name "Dr. YSR Aarogyasri Scheme" is being run by the State Government for providing end to end cashless services to BPL beneficiaries as identified by Civil Supplies department for 1059 procedures. All the BPL ration card holders (WAP, AAP, YAP, TAP, RAP, and JAP card) are eligible for availing the benefit under the scheme, which intends to benefit approximately 1.44 lakh BPL families as per civil supplies data of the State.
- During 2018-19, only 42% fund released for civil works has been utilised by APMSIDC.
- There is underutilization of untied funds for MAS, for the Financial Year 2018-19 in both

the districts, Visakhapatnam and Kadappa, even after release of funds from State Health Society. The file is in process for the Financial Year 2019-20 and fund release pending at the level of CHFW.

- Average utilization of NUHM funds reported as 43.39%.
- Statutory Audit has been conducted for the Financial Year 2018-19. Concurrent Auditors for the FY 2019-20, havenot been appointed by the State yet.
- For JSY payments at facilities of Vizag District (CHC-K. Kotapadu, PHC-Chowduvada) and Kadappa Districts (RIMS- 80% Bearer Cheques) Non-Account Payee Cheques are being given to beneficiaries.
- Banking Guidelines have not been followed at State and District level. All transactions have been carried out from a single bank account, though separate accounts have been opened for all programme accounts opened at SHS and DHS. Hence, the exact programme wise expenditure and balance could not be ascertained.

Bihar

- Facility mapping has been completed while urban slum mapping is yet to be carried out. The mapping for vulnerable population has started manually.
- State has a well-established and operational 98 Urban Healthcare Facilities. Branding with proper display of IEC materials was found at all the UPHCs visited.
- State has changed its OPD timings of urban facilities to 11:00 AM till 7:00PM in order to improve access for urban community to the UPHCs. Services are now also provided on Sundays.
- Approximately 95% of its Urban Primary Health Centres have been converted into Health and Wellness Centres (HWCs) for provision of Comprehensive Primary Health Care to the urban vulnerable population.
- Limited wellness activities are taking place in some of the UPHC-HWCs due to lack of space and because of not hiring Yoga trainers.
- The process of filling CBAC forms has started but ASHAs are unable to fill complete information in CBAC forms due to lack of training. ANMs have been provided with tablets & NCD App, however they have not received any formal training yet.
- Laboratory Services are not available due to the vacant positions of lab technician.
- Lack of proper implementation of Quality Assurance programmes was observed at urban health facilities.
- RKS were functional in UPHCs however, RKS members need to be oriented thoroughly through regular RKS meetings. Non utilisation of RKS fund was reported as regular Medical Officer in-charge was deputed on a rotation basis in UPHCs and visited the UPHC once or twice in a week.
- Outreach sessions are held in the community but UHNDs are not conducted due to lack of ANMs. Special outreach camps are held for slums and identified vulnerable sections.
- While more than 90% of rural ASHAs positions filled, only about 50% of urban ASHAs are in place. State has selected 708 new ASHAsin FY 2019-20. ASHAs were found to be overburdened as many ASHA positions are vacant which in turn has increased the workload. This is also hampering quality of survey and other tasks allocated. It was also noted that quite a few of the ASHAswere not skilled enough to meet the current reporting requirements.

Chhattisgarh

- Mapping of the notified and non-notified slums done with maps available from municipality. The health facilities such as UPHCs and SSKs have been mapped with JSK. The vulnerable population of migrants has been mapped. Vulnerability mapping is completed for all 19 cities.

- Mapping of Dengue cases and deaths is completed. The same needs to be replicated for other diseases.
- Integrations with other national programs such as RMNCH+A, NTEP (erstwhile; RNTCP), NACO etc.is established.The urban health facilities take up the role for Diagnostic and treatment provision under these programs. The convergence with Women and Child Development is also streamlined.
- State level workshops with urban administrations and representatives of the ULBs and Medical College have been conducted.
- MOU has been signed with TATA Trust to develop EHS (Electronic Health Services) and model immunization room at Urban Health Centers. However, coordination with urban development department or Urban local bodies should further be strengthened for synchronized action on water and sanitation, better planning, source reduction and community education.
- Under the umbrella of NCD control, an innovative activity "Wellness beyond Yoga" has been started by conducting Zumba classes with Yoga sessions. The activity is carried out selected urban Health centers to improve overall wellness of urban population across all age groups.
- 3699 MAS have been formed in the state. MAS members have largely been oriented about NUHM. Meetings are held regularly in Korba district. Untied funds utilization is seen to be satisfactory.
- Urban health monitoring Tool, "U- Health" has been generated for Urban Health monitorable indicators. U-Health is being released to all districts on regular basis for better analysis of urban health program achievements.
- The urban health facilities are understaffed and services are being augmented through deputing AMOs and AYUSH doctors.
- Services are being provided at UPHCs for RMNCHA, NCDs and other disease control programs. Fix day specialist services in Urban Primary Health Centre with Support of Government Medical college in Raipur being done.
- Urban health facility upgrading model plan has been initiated for 4 selected UPHCs (Gudiyadi, Bhatagaon, Labhandi& Raja talab) in Raipur urban areas. Specialist services, inclusion of modern diagnostic equipment, physiotherapy unit with longer OPD timings (07:00 A.M. to 10:00 P.M) are planned.
- There are 17 MMUs under urban health and 5 new MMUs have been planned.
- The number of outreach camps has declined over last year.

Delhi

- GIS Mapping of all the urban public health facilities is completed. Web based portal has been used to define population assigned to health facilities. Demographic mapping of urban population has been done with identification of unserved or under-served and urban slum population.However, no progress in Vulnerability Mapping of urban slums in accordance with the VA tool of NUHM is reported.
- The State has well established urban healthcare infrastructure with 262 Delhi Government Dispensaries, 209 Mohalla Clinics, 23 Polyclinics, 62 Seed PUHCs, 40 Municipal Corporation Dispensaries, 136 Mother & Child Health Centres of Municipal Corporation, 27 NDMC facilities, 80 Central Government Health Centres, 12 Railway Dispensaries and another 90 from various statutory bodies like ESI, DJB, DTC, SBI, etc. Besides these, 364 facilities provide AYUSH services. The State has also operationalized 62 Seed PUHCs utilizing NHM funds to cater to unserved urban areas.
- Collaboration is lacking with other departments such as Municipal Corporation of Delhi, WCD, MoUD, WASH, Road transport, etc, with the health department in creating awareness on vector borne diseases, sanitation activities, outreach or other social determinants of health.

- The major challenge in the States is a lack of coordination between State Health Department and the Municipal Corporation.
- Approx 30% of posts at SPMU are vacant, 20% at the 11 DPMUs. Approx. 15% Medical Officer posts under NUHM are vacant. There is no Public Health Manager post in the UPHCs.
- The state has not implemented Ayushman Bharat Scheme. Population based NCD screening has not been started and CBAC forms are not being filled. No Yoga or other Wellness activities organized at the facilities.
- The "Mohalla Clinics" provide diagnostic and curative services (Hub & Spoke model) to the population. It was observed that medicines for chronic conditions such as diabetes and hypertension are provided for only 5-7 days to the patients. Owing to which patients need to visit the clinic every few days, which may lead to non-compliance. Focus on preventive, promotive and wellness components is found to be lacking in the Mohalla Clinics.
- The OPD timings of all the primary care facilities are from 8am to 2pm. Average OPD is around 100-150 patients per day in the DGHCs, Seed PUHCs, Mohalla clinics and Polyclinics.
- The state has Free drugs and diagnostics initiative, Delhi Arogya Kosh, Delhi Arogya Nidhi Schemes. "Delhi AarogyaKosh" (DAK) scheme for ensuring continuum of care. The initiatives have also been attempting to reduce OOPE on diagnostic services. Free treatment is provided to BPL accident victims in private hospitals.
- Direct referrals are taking place from primary to tertiary care centres like RML, LHMC, SJH, GTB and AIIMS, for specialist consultation or complications or deliveries. This has often led to underutilisation of secondary level healthcare facilities. This inadequate utilisation is also possible due to lack of assured referral linkages, and non -strategic location of the secondary care centres.
- State and District Quality Assurance Committees and Hospital QA teams / Infection Control teams are in place. Quality Circles have been formed in all PUHCs (GNCTD). Quality initiatives like Kayakalp and NQAS are being implemented by the State. 70 UPHCs have qualified under Kayakalp out of which 362 participated.
- The RKS at UPHCs have not been formed. the nomination of MLA as Chairperson of RKS by Health & Family Welfare Department is pending which has delayed RKS formation. This has contributed to non-disbursement of Kayakalp incentive to awarded facilities and overall underutilization of funds. RKS formation completed in 25 Hospitals and 8 Maternity Homes in the state.
- Regular outreach and UHND are conducted by ANMs and ASHAs. Screening for leprosy by ASHAs was also reported in both districts. However, no Special Outreach sessions are being conducted in slums visited, except at Delhi Cantonment region in New Delhi District.
- The state has 6035 ASHAs (96%) in place against a target of 6258.Of these, 87% are trained in Round 3, 92% in Module 6 and 89% in Module 7. ASHAs have also been trained in Drishti Module / Basic first aid by CATs Ambulance.
- The state has limited MAS formed till now and proper linkages of MAS need to be developed in the community. Formal training of MAS has not been done. Untied funds had not been utilised in the districts visited.
- Cleanliness and maintenance of community toilets and surrounding areas of the slum was not satisfactory as the Municipal Corporation workers were not regular. Garbage was seen accumulated in several areas within the slums. Drainage system was compromised, with almost all drains being open and overflowing at several places making it breeding ground for vectors of malaria, dengue, chikungunya and typhoid. There were no concrete approach roads for several urban villages and slums visited. Accumulation of water during rainy season and overflowing or blockage of drains reported.
- All urban health facilities facilitate fund transfer through PFMS portal.

- The major issue found was underutilisation of Funds (only 26% of NUHM fund is been utilised till date).

Gujrat

- The GIS mapping of all urban health facilities has been done. The mapping of vulnerable population has been completed and area maps have been generated. The mapping of all health facilities on HMIS portal has been completed.
- NUHM has been rolled out in 69 cities or towns. Good Convergence with ULBs, WCD, Urban development etc. was observed in Surat district.
- Vector borne surveillance system under Surat Municipal Corporation is well developed with support of 900 primary health workers provided with tablets for daily reporting.
- Programme wise reporting for NCD, NTEP (erstwhile; RNTCP), RCH, Urban health and PMJAY in Surat and Dahod has resulted in verticalization of programmes rather than coordination.
- Out of 318 sanctioned UPHCs (108 at District and 210 at Corporation), 317 UPHC (99.7%) are functional. Of these, 262 UPHCs are in Government buildings and 56 UPHCs are in rented premises. 131 UPHCs have been approved as HWC of which, 71 (51%) UPHCs are functional as HWCs. HWC branding was completed in all the facilities visited in Surat district except for UPHC-Bardoli. In Dahod district, none of the UPHC are upgraded to be HWC.
- 7 UCHCs are functioning in own newly constructed buildings under Surat Municipal Corporation from Jan, 2019.
- The facility timings are from 8 am to 5 pm in Surat district.Weekly specialist visits are organized which have been regular. In Surat district, all the HWC-UPHCs visited conducted yoga session every Wednesday with support of UPHC Trained staff from Art of Living.
- UPHCs under Ahmedabad Corporation have Laboratory Management Information system (LMIS), but LTs have not been trained under the same.
- All the facilities are reporting on state devised software ImTeCHO and on HMIS portal. Smartphones were available with ANM i.e. Techo+ loaded software where the RCH related data entry was done. NCD related application in Techo+ is to be started shortly.
- State and District Quality Assurance Committees have been constituted, with the Urban Nodal officer as its member. The state has strategic ''Mission NQAS 151'' facilities for FY 2019-20. It includes 14 UPHCs for National Certification under NQAS. The State has so far 9 State certified NQAS UPHCs. Internal assessment and external assessment completed in 311 and 230 UPHCs respectively, till September 2019.
- Kayakalp activities have been completed for FY 2019-20 and out of 335 UPHCs, 76 UPHCs are selected for external assessment and awards. Kayakalp activities have not been started in the state for UCHCs.
- Under MeraAspataal, till September 2019, 260 UPHCs have been integrated into the ''MeraAspataal'', out of which 95 UPHCs have not started reporting. Discrepancy was observed in data reported on TECHO+ and HMIS portal.
- The *Rogi Kalyan Samitis* (RKS) have been formed and bank accounts opened in 311 UPHC but RKS registration has been completed only for 284 UPHCs. Untied grants have been sanctioned to all the facilities. RKS formed in all the health facilities except in 7 UCHCs under SMC.
- *MamtaDiwas* (for outreach for ANCs) and special outreach session are held regularly. The special outreach camp is held under the supervision of Medical Officers & Specialists.
- 99% ASHAs in position and 99% MAS have been formed in urban areas.
- NCD training has been imparted to all ASHA for 5 days in Surat district whereas in Dahod district it has not been started. The NCD data collected

at present is not entered in TECHO+ as new version with NCD features is underway.

- The NGO "CHETNA" is providing support for community processes in the state.
- Total reported expenditure under NUHM for FY 2019-20 is 34% (till 30thSep, 2019) and about 86% for FY 2018-19.

Jharkhand

- GIS mapping of the urban slums was started in October 2018 by empanelling Jharkhand Space Application Centre (JSAC) for the task. The draft maps have been received for 6 districts and are in pipeline for 7 districts.
- For Vulnerability mapping, VA tool for ward level and ASHA has been prepared but the training has not been completed. Data obtained from these tools will be collated by JSAC for VAM.
- A state level coordination meeting with 3 medical colleges Ranchi, Dhanbad and Jamshedpur has been held for empanelment of resident doctors from colleges in UPHCs. 13 Coordianton meetings have been held till date in different districts.
- 48 UPHCs in the state are functioning in two shifts from 8 -10 AM and 3 - 8 PM.
- "Atal Clinic" is a Govt. of Jharkhand Initiative, which a structure equivalent to Health Kiosks, providing curative services at present. Currently 25 Atal Clinics are in position, functional from 8am to 10am in the morning and 6pm to 8pm in the evening with an OPD of 10- 12 per day. The state targets setting up of 100 such clinics by 2020 with expanded the scope of services including NCD screening and health promotion activities.
- 58 RKS have been registered this year but no funds provided yet.
- The outreach camps are conducted quarterly and 4 camps conducted so far in 2019-20.
- The total number of ASHAs (Sahiyas) in the urban area is 23 which is 62% of sanctioned ASHAS (37). Sahiyas cater to a population of 5000-6000 as against the norm of 2000-2500 population per ASHA. Good support structure of Sahiyas through "SahiyaSathis", BTT, STT is available in both urban and rural areas.
- Total no. of MAS formed is 37. MAS meetings held in coordination with ULBs for deciding the areas of outreach camps.

Madhya Pradesh

- Mapping and listing have not been done. Census data and data of Urban Local Body for wards and slums can be utilised as a source.
- Convergence with ULBs was lacking. Vector control activities were not taking place at community visited, despite malaria, dengue cases being endemic in the urban slums.
- An adhoc approach seen towards urban Health. Nodal Urban Officer is yet to be nominated for monitoring and implementation.
- There are 136 Urban PHCs in MP, of which 124 have been operationalised as HWCs.
- Staff Nurses are stationed at UPHCs but there is no uptake of any IUCD services. Antara and Chhaya were not available in the facilities visited.
- Outreach and UHND are not being held in the Chhindwara district.
- Training of Urban ASHAs on their roles and responsibilities especially related to PMJAY and their engagement in activating Mahila Arogya Samitis is required.
- MAS members in the marginalized community in urban areas were mostly working females, hence no training could be given to MAS.

Manipur

- Imphal is not having large clusters of urban slums unlike other metro cities in the country. Both facilities visited are under-utilized owing to close proximity to two medical colleges.
- RKS grant has been utilised in improving the facility and services.
- Infrastructure is good and all components of Urban Health Services were in place.

- AYUSH facility is co-located with UPHC and Yoga practice is also ongoing.
- 150 MAS are present and meetings are held regularly.
- One unique role of ASHAs besides working as a health worker, is that of Social Activist, where they form part of a movement called “MeiraPaibi”. The women in groups with lighted torches night vigil against alcoholism and hooliganism, move around streets sloganeering and looking for miscreants. Any men found drunk and creating nuisance are tied to electric poles till they become sober and apologize. This is quite effective and demonstrates the women empowerment in Manipuri society.
- The overall fund utilization till the end of 1st Quarter 2019-20 is 11% (NUHM – 8%).

Meghalaya

- Mapping to identify slums and vulnerable population has been completed in 3 out of the 4 targeted cities in the State. Challenges noted in mapping and coverage of urban population- some areas are scattered and are sparsely populated.
- The State has identified 19 slum areas with a population of 62,755 and 19 UPHCs are functioning to provide health services in these areas. 5 of the 19 UPHCs are also stated to be converted to Health and Wellness Centres.
- Efforts for convergence of NUHM with other National Health Programs have not yet been initiated. The coordination between the ICDS and health administration needs improvement.
- Most of the urban Centres (18 out of 19) are functioning in rented buildings and are too congested. The facilities (Urban and Rural) visited in both the districts have completed the branding as per HWC norms.
- These UPHCs were assessed for Kayakalp programme but none could qualify. There seemed to be good scope of improvement in urban health activities being provided by UPHCs. Laqshya certification of UPHC are under process.
- The staff position at the State / District PMUs and urban health centres seems to be satisfactory. TMIS portal for training is implemented in the state.
- UPHC are running between 9 am -5 pm and offering HWC services. PMJAY program is not being implemented through the UPHCs. The UPHCs are not providing full CPHC package of services. No Yoga or any other wellness scheme has yet been initiated at the UPHCs.
- Limited curative or referral services are being provided or institutional deliveries conducted at the observed UPHC in WGH. Immunization services are being provided at the UPHC but there was no AEFI register, unlike the rural centres.
- The average OPD cases in the three UPHCs in WGH district is in the range of 150 to 490. In Shillong, the average OPD was around 40. Absence of MOs in two out of 3 UPHCs in the district is hampering delivery of services.
- The UCHCs do not provide sterilization services.
- The State has conducted 50 % of the UHNDs and 41% special outreach camps during 2019-20, till the time of visit.
- There is difficulty in getting specialist doctors for attending special outreach camps. In Shillong, the catchment population (nearby slum) shared that the doctor is available only for a few hours at the UPHC and the nurse is attending the OPD.
- Community desired that it would be useful if the OPD timings of UPHCs are kept according to the need of the population (labourers, maids, etc) they serve. They also demanded better ambulance services and tailored flexible stretchers for taking patients up-hill.
- In the state, 177 (84.3%) urban ASHAs are in-position against the approved 210 urban ASHAs. 92 MAS have been formed and trained against the state target of 105 MAS (87.62%). All these 92 MAS have functional bank accounts.
- High attrition rate of ASHA and MAS and non-availability of new recruits to fill up the vacant positions in the urban areas.

- Anganwadi centres had no permanent structure to run it.
- Low Utilization at only 27% observed against approved NUHM Flexible Pool budget of Rs. 631.83 Lakhs, till June 2019. No Funds could be released to the State of Meghalaya under NUHM due to high unspent balance/ non submission of audited UCs. On the other hand, there is shortage of funds at the District and facility level in both the districts despite sufficient funds being available at the State HQs. Huge backlog in payments of demand driven activities (JSY, ASHA incentives, compensation to the contractual staff) was observed.

Mizoram

- Vulnerability assessment has been done for urban population as per GoI norms.
- Good convergence between Urban Local Bodiesand health department was observed. Construction of community toilets in UPHCs are done through ULBs.
- Wellness activities such as Yoga are being done by yoga instructor from AYUSH Department conducting yoga classes once in a week.
- Good Referral mechanism is in place for referring patients to higher facility.
- The state has RKS constituted and functional in all of its 77 facilities – 9 DHs, 9 CHCs, 57 PHCs. 37 UHNDs are being conducted every month and a monthly calendar is prepared for these camps. Outreach and special outreach camps are conducted once a month according to the plan submitted by MO at the UPHC level. Insufficient funds for transportation for conducting outreach camps due to hilly area. NGOs supporting in conduct of these camps are YMA (Young Mizo Association), MUP (Mizo Upa Pawl) and MHIP (Mizo HmeicchhiaInsuihhawm Pawl), Loxal Council.
- The State has 100% ASHAs in position. MAS is formed and trained. Bank account for all MAS groups are opened.
- There is a transportation & network coverage problem at urban health facilities
- 65% utilization of funds under NUHM seen.

Nagaland

- The mapping of the UPHC catchment area is under process and vulnerable population has been identified. However, the methodology, technical guidance, documentation required strengthening.
- “State of the Art” infrastructure is available at UPHC Seikhazou with wide range of available services and free diagnostics, including RCH, Family planning, NCDs and CDs.
- UPHC visited by the team was found upgraded to HWC. The facility was found equipped with labour room as per MNH Toolkit and with all the basic services.
- Almost 60 to 100 cases were attended per day in OPD and the facility recorded 5-10 institutional deliveries per month. The ambulance services were found to be lacking.
- RCH and NCD related data were reported through smart phones provided to ANMs. Record keeping and documentation needs to be strengthened.
- The state has 2 UPHC facilities targeted for the NQAS certification for FY 2019-20. Of these, one UPHC has also undergone external assessment by CQSC. Kayakalp activities have been completed for most of the UPHCs.
- It was observed that Bio-medical equipment maintenance mapping is yet to be done in the facility. The bio-medical waste management also needs to be strengthened and needs to be carried out as per protocol.
- UHNDs were conducted according to the planned schedule, although activities weren’t documented.
- State has 74 ASHAs (82.2%) in position against the sanctioned 90 ASHAs in urban areas. A drop out of 47 ASHAs was reported in last FY 2018-19 and 15 ASHAs in current FY 2019-20. Non-functional ASHAs have been dropped out by the system itself. In urban areas, the state has formed 64.6% Mahila Arogya Samiti (MAS)

with functional bank accounts against a target of 113 approved MAS for 7 districts.

- Reporting, monitoring and supervision of ASHAs, MAS were found lacking. No training has been imparted to ASHAs recruited after 2015.
- Inter-sectoral coordination with other departments is weak.
- IT Initiatives: OPD registration is done online, however software application use is limited. The app does not track elderly patients.
- Financial documentation at UPHC were not adequate. Cash-book and ledger not updated. Two separate accountswere being operated jointly by Medical Officer in-charge and Chairman RKS for programme and hospital management. Personal account is also being used for financial transactions and fund utilisation in cash is adopted through self-cheques at UPHC Seikhazou.

Odisha

- The mapping of urban health facilities as well as urban slums has been completed. City Profile and City maps are also created for cities. State has also completed mapping of service area for 94 UPHC, Slum level household assessment, listing of slums (Total slums-2584). Vulnerability assessment of 2,85,221 households is completed by ASHA.
- State level workshop for orientation of ULB members was held.
- Coordination with ULBs and other departments is well achieved in the State. With support of ULB, Rain Water Harvesting System, Cow catcher, construction of boundary wall, engagement of night watchman in all UPHCs of Berhampur has been achieved. Construction of deep burial & sharp pit is in place because of convergence with other departments.
- In Berhampur and Bhubaneswar ULB is strengthening the Health Facilities as per gap assessment. Financial grant for security guard for UPHC and beautification of the facilities has been provided by the BMC. Outreach health camps for sanitary workers are being organized and health cards are issued to all of them for regular check-ups in Baripada, Phulbani, Bhubaneswar and Berhampur.
- A Regional workshop for collaboration with Medical colleges in Eastern India was held in Bhubaneswar.
- Elected representative (Corporator/Councilor) is the chairperson of Ward Kalyan Samiti at ward level and of the Rogi Kalyan Samiti where UPHC or UCHC is located. Ward Kalyan Samiti (WKS) has been formed to strengthen convergent action at ward level. Till date 919 WKS have been formed. 98 Rogi Kalyan Samiti (RKS) formed at UPHC & UCHC level.
- The state has well functional UPHC and UCHC with good interdepartmental coordination. 25 UPHCs under NUHM are managed by NGOs under PPP initiative. UPHCs are being run in PPP mode by an agency. They have provision of two observation beds and minor operation facility. Yoga service is provided weekly in all UPHCs (time 7 AM to 8:30 AM).
- 82 out of 90 functional UPHC are targeted to be converted to HWCs in the district.
- PPP run initiative “AMA Clinic” is a fixed day free specialist clinic at UPHC and UCHC level. The Specialist Services of Physiotherapist (3 days a week), Medicine Specialist (one day) and Nutritionist (one day) are available in UPHC under Geriatric Clinic.
- Sunetra Clinic “Urban Vision Centre”- The Urban Vision Clinics have started functioning since 7th April 2018, as part of the Universal Eye Health Programme (Sunetra) of Govt. of Odisha.
- 1522 urban ASHAs facilitate service delivery at slum level. Updation of “ Swasthya Kantha” by Urban ASHA is a unique strategy of communication. Urban ASHAs are acting as member secretary of the MAS.
- Total of 3132 Mahila Arogya Samiti (MAS) have been formed in the state. Bhubaneswar has 580 MAS groups. MAS have their own letter head through which communications are sent

to Electricity Department and Municipality for cleaning of Sewage lines and open drainage system. MAS in Behrampur has also played an important role in identification of TB cases and followed up a case of Breast Cancer. The performance of MAS is being graded and additional incentive of Rs.3000 is provided to 20% of the best performing MAS.

- 94% of the untied fund of MAS was utilized in the year 2018-19. MAS convention organized in five major urban areas of the state. The MAS members are also part of SHG group and making *agarbattis*, Stitching Clothes and making earthen Pots in Mayurbhanj.
- Community action for health was piloted in two cities. Now it is being implemented in other urban areas.
- Tablets are being provided to ANM. The data in NCD portal/NCD App is regularly monitored by district and state officials.
- Rain Water Harvesting system, Herbal Garden, MAS grading, Assessment of MAS scoring is new way to assess the working of MAS. Herbal Gardens were developed in UPHCs.
- Monthly Progress Report is an innovative process to see the process of implementation on the basis of KPIs with total 276 indicators and 154 marks.

Rajasthan

- GIS Mapping through android based Rajdhara Survey application is nearing completion. Vulnerability assessment has not been initiated.
- The inter sectoral coordination with the WCD department is staisfactory. ASHAs are getting fixed amount of Rs. 2700 from ICDS as well apart from the incentives from NHM programmes.
- Active participation by ULBs was observed in all health-related activities. Regular meetings with ULBs at the city level were held. Nigam Parshads regularly visit the facility.
- One of the facilities visited in Churu has been adopted by the Medical College as a training center. Gynecologist and Pediatrician from Medical College visit the center.
- 244 UPHCs, 5 UCHCs, 4 MMUs and 8 kiosks are operational in the state. The services are provided in two shifts- morning (8.00 am to 12.00 pm) and evening (5.00 am to 7.00 pm).
- Out of 80 UPHCs, 57 UPHCs are upgraded as HWC-UPHC. No wellness activity was observed at the facility.
- Overall, there are 50% vacant positions in UPHCs in the State. Of these, 79% of sanctioned positions at UPHCs for Staff Nurse, Lab Technician and Pharmacist are lying vacant. Similarly, 53% vacancy of ANMS and 27% for Medical Officers is seen in the State.
- Public Health Manager is recruited to look after community processes.
- UPHC visited in Churu had good infrastructure with well-established labour room and staff trained on SBA but no delivery services were available.
- Outreach calendar was being followed. Dentist and Psychiatrist and other National Programme teams were invited to provide services during Special Outreach Camps.
- Sirohi UPHC has a portable lab which is not being used as the lab techniciam position is vacant. Due to state instructions to hire only retired lab technicians on contract, CMHO has not been able to fill out the position. The state was reiterated to send revised communication to engage trained lab technician.
- In Urban areas the selection process of the ASHA Sahoginis workers is being done by the MO of the PHC in consultation with the area ANM and AWW.
- Mahila Arogya Samitis are formed and all have bank accounts.MAS are actively participating in all health related activities.
- NUHM is operating 30 UPHCs on PPP mode with an objective to provide competent clinical care and community outreach services. An eligible private sector/non-government organization has been given the responsibility

of maintenance and service delivery in the selected UPHCs and their attached Health Kiosks (if any) to achieve the objectives of NUHM and other National Health and Family Welfare programmes. MoU is signed between CMHO of respective district and Concessionaire which is valid for period of 3 years subjected to review and confirmation of the arrangement after every one year. NUHM is doing annual performance review for continuation of the agreement. Financial assistance of Rs. 21.59 lakh is provided to the concessionaire to maintain and operate the facilities.

- Fund utilization was 60% in year 2018-2019 with low expenditure in Training, Quality and IEC.
- Delay in funds transfer is noted from state to district. The activites planned are not being implemented because of such delays.

Tamil Nadu

- The GIS mapping has been done in Chennai and in 10 municipal corporations and 2 municipalities. The GIS mapping of 73 municipalities and 1 (Tirunelveli) corporation is yet to be done.
- In 73 municipalities manual mapping is completed. The household (HH) assessment is done in these centres using printed register by Urban Health Nurse (UHN) and family folders are available with UHN.
- In general, the coordination of TNULM, ICDS and municipal administration is found.
- Tamil Nadu is implementing programmes for health and nutrition with a well integrated model. Interestingly, it was found that both Health and WCD Departments were earlier part of Health Corporation, thereby showing good coordination both at State and district levels. In fact, many of the PHCs and Anganwadi Centres are co-located since their establishment.
- The medical colleges are involved in the specialty evening OPs and skill lab training.
- In Tamil Nadu, there are 31 DHQ, 204 Taluk Hospitals, 74 non-taluk Hospitals, 460 Urban PHCs and 7 Women and Child Hospitals. Tamil Nadu has 1 metro city (Chennai), 11 municipal corporations (MCs) and 75 municipalities.
- The Chennai city has 140 urban PHCs and 16 urban CHCs; 11 Municipal Corporations have 154 urban PHCs; and 75 municipalities have 126 urban PHCs. The Rest of Tamil Nadu has 280 urban PHCs and 17 urban CHCs. In addition, 40 UPHCs in Urban Local Bodies (ULBs) having below 50,000 population are supported by NUHM.12 RBSK teams in the urban areas have also been deployed for early detection and treatment of 4 Ds in children from 0 to 18 years of age.
- Corporations seem reluctant to fill up the vacant positions of Health Officials or health workers.
- Urban Health Nurse (UHN) provides the designated services during UHND and at UPHC only. With the absence of field level workers, there are no home visits taking place.
- Outreach camps (three) are being organized every month in urban slum areas by UHNs.
- The Urban Health, Sanitation and Nutrition Day (UHSND) is a platform for community engagement in urban areas.
- Tamil Nadu does not have Mahila Arogya Samitis (MAS) in place as yet. Instead, the State engages women's Self-Help Groups (SHGs) in urban areas to perform functions similar to MAS especially for initiatives related to health promotion and disease prevention.
- No PPP project on urban health has been commissioned in Tamil Nadu. However, several NGOs or agencies are working in Urban Health through CSR funding, which may be tapped by the State.
- The State has started Urban Polyclinics under NUHM providing specialists OPD clinic in a single roof at fixed timings 4.30 PM to 8.30 PM. Urban Polyclinics provide fixed day specialist services for General Medicine & Skin, O&G and Dental, Paediatrics & Eye, Orthopaedics & Physiotherapy, Dental & ENT and Psychiatry by hiring specialists.

Uttar Pradesh

- Both UHNDs and Special outreach were found to be conducted regularly.
- The UPHCs have registered RKS and it is meeting regularly.
- Due to rapidly urbanizing population, the sanctioned facilities are being overburdened.
- Certain UPHCs are initiating the use of digital platform of e-UPHCs to provide services. The quality of service delivery was found satisfactory.
- Not all medicines listed under EDL were available. Those which were available, were adequately stocked. EDL was found painted on walls of the UPHCs.
- Inadequate convergence between ULBs and other departments like water and sanitation was noted. Also, there was no coordination with medical colleges.
- Lack of awareness regarding POSHAN Abhiyaan seen. Huge gaps were observed in the service delivery at AWCs.
- Population based NCD screening for hypertension, diabetes mellitus and cancer has just been started at few locations.The range of laboratory tests offered was not as per the list.
- BMW is an area of urgent concern in the State. The BMW contract is taken for the District hospital and CHC only. The BMW (including placenta) from UPHC Bharaich (where deliveries are also conducted), is transported to another UPHC on bicycle for disposal. The BMW vehicle collects waste once in 2 days from DH, Bahraich where around 28 deliveries are conducted every day. Besides, the infection control and sanitisation of the BMW room is definitely an area of concern.
- Living conditions in slums were largely filthy and below average standards. Utilization and faith towards the public health system was poor as community mostly preferred availing services (especially delivery services) from private sector. Community awareness was low on health facilities, health schemes, services and health determinants. However, people did seek RCH and immunization services from Public facilities.
- Against the target of 8336 urban ASHAs, 6426 (77%) are working. The number of urban ASHAs and ASHA-population ratio was found extremely low, which reflects into lower community awareness.
- One of the main reasons for low number of Urban ASHAs was lower incentives that the rural ASHAs received. The reason cited by the State is low incentive in urban areas and possibility of better opportunities of working as industrial workers and domestic helps (Average salary 8,000-10,000).

Uttarakhand

- Only 60% of Vulnerability mapping has been completed and a few MAS have been formed in urban areas.
- HBNC and post-natal visits are being conducted by ASHAs.ASHAs were seen to be very active in the field.
- Dehradun has 11 existing health posts (with 44 staff members) in addition to the 12 Urban PHCs. Urban PHCs in both the districts have been contracted out to different NGOs in PPP mode, since June 2019. The provision of urban services is not certain beyond October 2019, as the contracts are for 6 months.
- The State should develop a strong and sustainable public urban primary health care system and not through the current PPP mode.
- There is a widespread discontent among the staff members due to non-payment of dues.

TOR 6: COMMUNITY PROCESSES AND GENDER

National Overview

Over the past 15 years, with nearly 10 Lakh ASHAs responding to local health needs and playing a critical role in improving access to care, the ASHA programme has become one of the most important components of the National Health Mission. The ASHAs are aptly positioned at the community levelto undertake new and complex tasks such as identification and long term follow up of patients with chronic illnesses, in addition to the ongoing tasks related to RCH and communicable diseases services. Under Ayushman Bharat, ASHAs are part of the primary health care team at Health and Wellness Centres and are expected to play a key role in ensuring continuum of care.

Currently, there are 9,68,483 ASHAs in position i.e. about 95% ASHAs against a target of 10,22,160 across 35 states and UTs. Selection in rural areas is around 96% (9,05,047 against target of 9,46,563) and 85% in urban areas (64,272 in position out of 75,597). Training of Module 6 and 7 of ASHAs is nearing completion across most states as over 90% rural ASHAs have been trained in three rounds of Module 6&7 and73% have been trained in the fourth round. In urban areas about 69%, 65%, 61% and 48% of urban ASHAs have been trained in Round 1, Round 2, Round 3 and Round 4 of Module 6 and 7 respectively.

ASHA certification is launched in 2014 and so far, 35 state training sites, 104 district training sites, 232 state trainers and 686 district trainers have been certified by NIOS. About 17,718 ASHAs and ASHA Facilitators across 15 states[1] have been certified. In addition, about 9280 ASHAs and ASHA Facilitators from 16 states[2] have appeared in the fourth examination held on 10th August 2019. The two new initiatives launched in last two years have shown good progress, with about 2,71,359 rural ASHAs and 20,942 urban ASHAs trained in universal screening of NCD and training of trainers at state and district trainers being near completion in most states for Home-Based Young Child Care (HBYC).

The three social security measures for ASHAs and ASHA facilitators to provide life insurance, accident insurance and pension benefits under under Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY) and Pradhan Mantri Shram Yogi Maandhan Yojana (PMSYMY) have been rolled out across the states.

1 Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Jammu and Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Odisha, Punjab, Sikkim, Tripura and Uttarakhand

2 Arunachal Pradesh, Assam, Chhattisgarh, Delhi, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Mizoram, Nagaland, Odisha, Sikkim, Tripura and Uttarakhand

Community based platforms of VHSNCs and MAS have been created across all states, with formation of 5.4 L VHSNCs (95% against the target of 5.7 L VSHNCs) and 77,003 MAS (86% against the target of 89,446). Overall training progress across states has been slow as only 2.5 L VHSNCs (47%) and 49,681 MAS (65%) have been trained so far. The limited investments in capacity building and handholding of these platforms have affected their functioning and potential to fulfil the mandate of community level planning to address social determinants and ensure regular monitoring.

Key Findings

- Findings from all sixteen states underscore the instrumental role played by ASHAs at the community level. Reports have acknowledged the commitment of ASHAs to their communities and the strong rapport between ASHAs and community. The findings from most states also indicate that ASHAs have started undertaking new tasks at field level, such as community-based risk assessments for NCDs.
- However, reports from most states highlighted gaps in critical programme components that affect functionality of ASHAs such as non-availability of functional HBNC equipment and medicines with ASHAs, delays in payments, variable quality of training resulting in poor skill acquisition, insufficient attention to grievance redressal and provision of safe working conditions. As ASHAs are expected to undertake newer roles for delivery of comprehensive primary health care services, these essential components need to be strengthened on priority.
- Community-based platforms like VHSNC, MAS and RKS have received little support across most states and have largely remained underutilized. Efforts to build capacities of these platforms to engage them in addressing social determinants and building accountability measures are found to be limited.
- Health systems preparedness to ensure gender equality and creating mechanisms to address the issues of gender-based violence and discrimination is found to be suboptimal across the states visited.

Accredited Social Health Activist (ASHA)

Selection

- ASHA selection in rural areas is reported to be over 90% complete in all visited states (except Tamil Nadu) while in urban areas shortfall is noted in ASHA selection in states of Bihar (with 50% selection), Jharkhand (with 55%), Uttar Pradesh (with 77% selection), AP, Nagaland (with 82% selection) and Meghalaya (with 84% selection). Low incentives and better working opportunities are cited as most common reasons for shortfall against the target of urban ASHAs.
- Tamil Nadu has selected ASHAs only in tribal and inaccessible areas, but even here, only 81%

are selected. The State has engaged Women Health Volunteers (WHV) from Self-Help Groups through Department of Women and Child Development. WHVs receive performance-based incentives and are primarily engaged for follow up of Non CommunicableDiseases. Reports fromSirohi district of Rajasthan, Gumladistrict of Jharkhand and Kiphre district in Nagaland highlight several left-out villages / areas. The gap is on account of Rajasthan's strict adherence to the education criterion of 8th standard despite the flexibility provided in guidelines and inadequacy of target setting in Kiphireand Gumla where some villages/ urban settlements are not considered while estimating targets. In Bihar, about 37% of ASHAs are covering over 1500 population while 14% ASHAs have been allocated additional villages to fill in for vacant villages, increasing their work load and population to 3000.

- Community led selection process is reported from Meghalayaand Jharkhand. Nepotism is reported in Nagaland as selection of ASHAs is led by the Village Council and Village Head in consultation with "Gamboora" (Village Elderly) who mostly select their relatives. This leads to high drop outs as the selected candidates are often not keen to work as ASHAs or leave the village after marriage. In Rajasthan, the selection is led by the WCD, Gram panchayat and ANM with no community level consultation. Equitable representation of ASHAs is observed in Gujaratwith 42% of total ASHAs belonging to the SC/ST community, against 22% of SC/ST population.
- Attrition rate of ASHAs is within the range of 1- 4% as reported from states of AP, Delhi, Gujarat, Meghalaya and Nagaland. Most attrition occurred on account of migration, marriage, pregnancy, family problems, health issues, non-performance (based on performance monitoring 10 ASHA functionality indicators in Jharkhand and Meghalaya), irregular/delayed payments and better job opportunities.

Training

- Most states have completed the training of ASHAs in Module 6 & 7. Thirteen out of sixteen visited states have completed training of over 95% rural ASHAs in all four rounds of Module 6 and 7. Pace of ASHA training in Round 3 & 4 is reported to be slow in Andhra Pradesh (70%), Bihar (Rd 3- 69% and Rd 4- 28%) and UP (Rd 3- 86% and Rd 4- 74%). Delay in training of newly selected ASHAs is reported from Manipur and Meghalaya as training of newly selected ASHAs has been pending since 2015 in Manipur and since 2017 in Meghalaya.

- For urban ASHAs, training of module 6 &7 has been completed only in Delhi (since state has launched the ASHA programme in 2009). Among other states, AP has reported good progress with over 90% urban ASHAs being trained up to round 3 while slow pace is reported from Mizoram, Uttar Pradesh, Bihar and Jharkhand (Gumla district) where training in Module 6 and 7 is yet to start.
- With regard to training of ASHAs in newer areas like NCD and HBYC, variable progress has been reported across states. Training of ASHAs on common NCDs has been undertaken in Gujarat, Jharkhand, Uttar Pradesh, Mizoram and Meghalaya while in Andhra Pradesh only one day orientation has been conducted due to state's focus on completing the pending training of ASHAs on Rounds 3 & 4 of Module 6 & 7. Most states are in the process of training of district trainers on HBYC. This is reported from

AP and UP while training for ASHAs has begun in Odisha, Mizoram and Meghalaya.

- In addition to conventional methods of training, Gujarat has used SATCOM to orient ASHAs on current priorities on a weekly basis. Though this has proved to be useful in disseminating new and important information to ASHAs, the effectiveness of SATCOM as a medium to train ASHAs needs to be reviewed, particularly in terms of skill acquisition.
- Most states have established training teams at state and district level to conduct training of ASHAs on a regular basis. However, gaps such as attrition of trainers and non-availability of trainers conversant in local dialect are reported from Bihar, Meghalaya and Nagaland. Lack of adequate infrastructure to organize residential training is quoted as key factor affecting the quality of training in states of Nagaland and Meghalaya. Adhoc planning of training in Gujarat and Nagaland are noted as a major factor affecting the quality of training.
- ASHA certification is currently underway in 12 CRM states- namely Chhattisgarh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Rajasthan and Uttarakhand.

Support Structures

- Provision has been made for dedicated CP support systems comprising of state and district programme officers in 15 of the 16 states visited. Andhra Pradesh, Bihar, Chhattisgarh, Delhi, Gujarat, Jharkhand, MP, Manipur, Meghalaya, Mizoram, Nagaland, Odisha, Rajasthan, UP and UK reported having dedicated ASHA programme staff at state and district level. In state of Tamil Nadu the programme is managed by designating existing staff at all levels. Dedicated block level programme officers are available in Bihar, Chhattisgarh, Jharkhand, MP, Nagaland, Rajasthan, UP and UK.
- ASHA facilitators are the most important link in the support chain for ASHAs. A dedicated ASHA facilitator, selected from among the group of ASHAs, is in place in Bihar, Chhattisgarh, Gujarat, Jharkhand, MP, Manipur, Meghalaya, Mizoram, Odisha, UP and UK. In the remaining states, this role is played by an existing official such as PHC Supervisor in Rajasthan, Public Health Nurses (PHNs)/ Lady Health Visitors (LHVs) in AP, ANMs in Delhi and Block ASHA coordinators in Nagaland. In addition to training of supportive supervision, ASHA facilitators have been trained in Participatory Learning and Action (PLA) in Jharkhand and Meghalaya. Sahiya Saathis (ASHA Facilitator) in Jharkhand, continue to play the dual role of ASHAs and AF, which affects their performance in both roles. Report from Jharkhand also highlights the variance in number of ASHAs linked with ASHA facilitators and is being addressed through GPS mapping to re-organize clusters of ASHA facilitators.
- Limited capacities of the support structures in providing mentoring support to ASHAs is reported from Andhra Pradesh, Bihar, Gujarat, Meghalaya and Mizoram. In Bihar, high percentage of vacancies and in Gujarat creation of a post equivalent to data entry operator for

managing the ASHA programme at district level affected the programme implementation. In Nagaland, the expectation from Block ASHA coordinators to provide mentoring support to nearly 40 ASHAs spread across difficult geographical terrain with limited mobility support has resulted in poor performance. Performance monitoring system based on ten functionality indicators is reported only from states of Jharkhand and Meghalaya.

- Regular review meetings for support structures are held only in Delhi, Jharkhand, Meghalaya and Uttar Pradesh while irregular meetings are reported from Bihar, Mizoram and Nagaland.
- Despite ASHA involvement in tasks and related training for the delivery of CPHC through HWC, the limited coordination between CP and CPHC teams is noted in Gujarat and Meghalaya. E.g. Training of ASHAs in NCD is conducted through the NCD cell, without involvement of the State ASHA nodal officers in Gujarat. Lack of commensurate training of ASHA support structures on CPHC is another area of concern as this further limits their capacities to provide on the job-mentoring support to ASHAs in new areas.

Drug and Equipment Kit

- Drug and HBNC kits have been provided to ASHAs in all states but timely replenishment to address stockout continues to be a persistent unresolved challenge in most states.
- Regular replenishment of medicines is observed only in six states - Gujarat, Jharkhand, Meghalaya, Odisha, Uttar Pradesh and Uttarakhand. Adhoc replenishment leading to frequent stockouts is reported from Andhra Pradesh, Rajasthan, Nagaland and Bihar. State of Meghalaya has not provided cotrimoxazole to ASHAs due to state level policy decision.
- Functional HBNC kits are available with ASHAs in Delhi, Gujarat, Jharkhand, Meghalaya. Odisha, Uttarakhand and Uttar Pradesh. Faulty HBNC kit equipment are reported by ASHAs from Andhra Pradesh, Chhattisgarh, Bihar, Nagaland, Rajasthan and Meghalaya. In two states (Rajasthan and Jharkhand), ASHAs met have used VHSNC funds to purchase few items of HBNC kits.

Incentives

Monetary Incentives

- The monthly incentive earned by the ASHAs ranged from Rs. 1700 in Meghalaya and Uttarakhand to Rs. 10,000 in Andhra Pradesh. In addition to the incentives provided under NHM, seven of the visited states reported providing incentives to ASHAs from state funds. These states are - Andhra Pradesh, Delhi, Gujarat, Odisha, Meghalaya, Chhattisgarh, Uttarakhand and Rajasthan (through ICDS).
- Payments linked with PFMS via DBT have become a norm in all states except in few where availability of banking services is limited. Timely payments of ASHA incentives is reported from eight states - Andhra Pradesh, Delhi, Gujarat, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh. Delay in payment of incentives linked with family planning activities is noted in MP. In UP and Jharkhand payment process of urban ASHAs is yet to be streamlined.
- Delays in payments of ASHA incentives are reported from Manipur, Mizoram, Meghalaya and Nagaland. In Meghalaya, backlog of payments of rural ASHAs is observed since 2013-2016 varying for different incentives, for e.g. VHND and HBNC incentive is pending since 2013 and VHSNC incentive since 2017 while in Manipur up to 6 months delays are noticed. In Nagaland, community members shared that they provide money to ASHA for JSY services since her incentive payment is delayed and ASHAs return the money when they receive the incentive. The motivation of ASHAs to continue working despite significant payment delays is indeed impressive.
- Few states like Chhattisgarh, Delhi and Rajasthan are using existing software to facilitate payments. UP has developed MIS application for Block Community Mobilizers, which has

reduced payment delays for rural ASHAs while Odisha is in process of development of an ASHA Software to further streamline payments.

Non-Monetary Incentives

Social Security Measures-

a) ASHA benefit package is introduced last year which included extension of life insurance, accidental insurance and pension benefits to eligible ASHAs and ASHA facilitators by enrolment under Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY) and Pradhan Mantri Shram Yogi Maandhan Yojana (PMSYMY) respectively.

b) However, enrolment of ASHAs under these schemes is reported to be low in eight states. Enrolment has not begun in AP and is reported to be slow in Bihar, Gujarat, Jharkhand, Odisha, Meghalaya, Nagaland and UP. Progress is better for enrolment of ASHAs under PMSYMY in states of Meghalaya, UP and Odisha compared to enrolment under PMJJBY and PLSBY. In Meghalaya, lack of clarity about guidelines on PMJJBY and PMSBY and non- availability of ADHAAR card for PMSYMY and in Nagaland, non availability of funds are cited as the main reasons for delay.

c) In addition, several states continue to support ASHAs through existing state specific schemes – a) Enrolment of ASHAs in state specific health insurance schemes in AP and Meghalaya b) Life insurance benefits in Bihar c) Financial assistance in case of death, disability, serious illness and education support in Jharkhand d) Financial assistance in case of death and disability – Odisha e) Maternity benefits in Odisha, Meghalaya and Delhi. Delay in settlement of claims and in accessing maternity benefits is reported in Gumla district of Jharkhand and in Meghalaya respectively.

Additional non-monetary measures-

a) In Odisha and Rajasthan, enrolment of ASHAs in Education equivalency programmes is sponsored. A total of 6319 ASHAs have been enrolled for completing matriculation in Odisha. In addition, Odisha has enrolled 5893 ASHAsin courses like Certificate in Food and Nutrition (CFN) and Certificate in Guidance (CIG) through IGNOU.

b) 'ASHA Rest Rooms'/ 'ASHA Transit Homes'/'ASHA Gruha' have been created in high case load facilities in Bihar, Delhi, Jharkhand, Odisha and Meghalaya (in rural PHC and CHC). Jharkhand (DH, Gumla) is not being used by Sahiyas as it is built in an attic with no ishroom facilities. No rest rooms are not reported to be available in AP,Gujarat, MP, Rajasthan and UP. However, ASHAs in Surat district of Gujarat reported that comfortable spaces have been earmarked for their use in few health facilities and in Bahraich district of UP, 15 ASHA rooms have been developed through CSR support.

c) Help desks are found to be functional only in Delhi and Jharkhand.

d) In Meghalaya, health Screening for ASHAs is conducted annually on International Women's Day (IWD). State also provides awards to ASHAs on annually as a measure to felicitate them for their contribution.

Grievance Redressal

- Grievance redressal committees have been set up in AP, Delhi, Jharkhand (present at state

level and in West Singhbum), Manipur, Odisha, and UP. However, the committees are not found to be fully functional in AP and Manipur while in Odisha and AP, ASHAs are not aware about the grievance redressal committees.

- Few states have created alternate mechanisms to address grievances of ASHAs such as toll free number 104 used in Jharkhand, grievances being directly submitted and addressed by district nodal officers in Manipur and Madhya Pradesh and placement of complaint boxes and grievance registers for ASHAs at PHC/ CHCs in Meghalaya.
- No formal or informal grievance redressal mechanism is reported from states of Bihar, Gujarat, Mizoram, Nagaland, Tamil Nadu and Rajasthan.

ASHA Functionality

- Overall findings reflect high levels of functionality of ASHAs with regards to improving access to services related to maternal, newborn and child health, communicable diseases and to some extent non communicable diseases. Community members valued ASHAs for their contribution and acknowledged the help provided by them to navigate the health system.
- ASHAs are reported to be actively undertaking activities related to antenatal care, institutional delivery, immunization, home based newborn care, diagnostic and treatment services for malaria and TB. In AP and Bihar, ASHAs are reported to be undertaking HBNC visits but the complete schedule of the visits is not being followed.
- In most states, ASHAs had good technical knowledge and skills related to routine RMNCH+A services as reported from states of Delhi, AP, Gujarat (Surat and one block of Dahod), Jharkhand, MP, Meghalaya, Aizwal district of Mizoram, Rajasthan and UP. Low level of skills is reported from Bihar, Mamit district of Mizoram and Manipur.
- Reports from Manipur and Gujarat highlight limited understanding and role of ASHAs in identification of danger signs of pregnancy

and follow up of SNCU discharged newborns respectively. In UP, ASHAs have limited coverage of marginalized population and they had limited understanding of marginalization and vulnerability

- In areas where HWCs have been operationalized and universal screening of NCDs has been initiated, most reports have mentioned that ASHAs have started undertaking additional tasks such as filling of Community Based Assessment Checklist, Counselling on risk factors for NCDs and Mobilising community for NCD screening. These include states of AP, Jharkhand, Gujarat, Madhya Pradesh, Meghalaya, Rajasthan and Uttar Pradesh. Findings from AP showed that ASHAs have started maintaining follow up records for NCD patients. Gujarat indicated that ASHAs required additional support to perform new tasks.
- Allocation of additional tasks to ASHAs like registration of AADHAR card, Voter ID etc. affected ASHA's performance on her routine tasks in Uttarakhand.
- Performance monitoring using ten functionality indicators combined with regular feedback is being followed only in Jharkhand and

Meghalaya. Both the states have been able to utilize the assessment to identify poor performing ASHAs who need additional support.

- In Meghalaya and Nagaland, difficult terrain with limited mobility access and high travel cost combined with systemic challenges such as non-availability of functional kits, delayed payments and poor availability of infrastructure and trainers to organize quality trainings have a strong impact on functioning of ASHAs, undermining their dedication and efforts. In Gujarat, analysis of average incentive earned by ASHAs, showed that nearly 40% ASHAs are earning an average of Rs. 3500 pm. This suggests that ASHAs are primarily performing only routine and recurring activities leaving out other important tasks like follow up of high risk and SNCU discharged newborns.

Village Health Sanitation and Nutrition Committee (VHSNC)

- Of the 16 states visited, fourteen states have constituted VHSNCs at revenue village level. Andhra Pradesh and Bihar are the only two states which have VHSNCs at Gram Panchayat level. Constitution of VHSNCs is near completion in all states except in UP(with 77%) against the target and almost all VHSNCs have bank accounts.
- Restructuring of VHSNCs has been completed in all states except in Andhra Pradesh, Bihar, Gujarat and Tamilnadu. ASHAs are currently not reported to be a member secretary of VHSNCs in AP, Bihar, Gujarat and in Nagaland for VHSNCs under HWCs. In Jharkhand, chairperson of the VHSNC is selected by the committee, who can be any community person and not necessarily the panch of that village. This is also noted in one of the visited villageswhere theMahilaPanch is not aware about VHSNCs while one male community member is holding the position of Panch since eight years.
- With regards to capacity building of VHSNCs, only Mizoram reported training of VHSNCs recently, in 2018. States of AP had last conducted training of VHSNCs in 2015-16 while in Meghalaya, last training is done in 2017. However, VHSNC members in Ri Bhoi have not received training. State of Gujaratreported completion of training of VHSNCs but in Dahod, members shared that only a brief orientation isconducted.
- Such limited investment in training of VHSNCs, has translated in low levels of functionality of VHSNCs across almost all visited states. Regular VHSNC meetings have been reported only from states ofGujarat, Manipur, Mizoram, Meghalaya and Rajasthan. Irregular meetings have been reported form states of AP, Bihar, West Singhbhum in Jharkhand and MP. In Rajasthan, lack of regular participation of PRI members and Sarpanch in VHSNC meetings is reported. In Manipur, regular monthly meetings are organized with active participation of ASHAs but except village chief, the participation and motivation of VHSNC members is low. Delay in the release of untied fund to the VHSNC also affects functioning of VHSNC.
- Of the states visited, active participation of VHSNC members is reported from Odisha, Nagaland and Meghalaya. Despite delays in fund release and lack of training, active participation of VHSNC members is noted in Meghalaya and Nagaland. In Meghalaya, regular VHSNC meetings are conducted under active leadership of ASHAs and members reported undertaking collective efforts for

sanitation related activities and supporting service delivery at AWC. In Nagaland, active involvement of VHSNCs is noted in HWC related activities. In Odisha, VHSNC members have played active role in distribution of LLIN and shared the annual plans prepared at village level.

- Irregular fund release has been reported in states of AP, Manipur, Meghalaya and Nagaland which hampers the functioning of VHNSCs. Mizoram is one state, in which regular fund release has been reported, with high levels (80-90%) of fund expenditures. In states of Jharkhand and Rajasthan, untied fund of Rs. 5000 is provided in this financial year as top up amount based on utilization pattern. In Rajasthan the untiedfund is released with the instruction to spend it on Yoga Day.
- Good practices reported from states - a) Sisthya Kantha in Odisha is an interactive health bulletin board (on some prominent village wall) maintained by GKS and updated by ASHAs b) Award of Rs. 10000 is provided best VHSNC in Meghalaya and c) Family planning mentor i.e. one active male member of VHSNC has been identified to promote adoption of vasectomy in the community.
- Given Gujarat state's successful experiences in behaviour change communication efforts such as Saptadhara, the state should now consider integrating such efforts into community platforms –such as VHSNC, MAS and PRI: as a routine for overall community awareness, community empowerment and behaviour change.
- **Village based Initiative for Synergising Health, Water and Sanitation Campaign-** Of the sixteen states visited, roll out ofVISHIS campaign is reported only from four states. Training on VISHWAS has been conducted in Meghalaya, Mizoram and Jharkhand.
- VISHWAS campaign roll out is reported in Mizoram, Odisha and in 16 selected blocks across districts in Meghalaya. In WGH - Meghalaya, 590 VHSNCs and ASHAs have been trained in VISHWAS in 2018-2019 and are actively involved in conducting campaigns

Community Action for Health (CAH)

- CAH activities have been reported only from states of Madhya Pradesh, Meghalaya and Rajasthan.
- In MP, CAH interventions are planned in 10 districts, with activities at all levels i.e. State, District and Block. Training of a range of stakeholders (CMO/CS, DPMs, DCMs, BCMs, & BPMs) on CAH programme has been completed in Chindwada district. CAH activities including Jan Samvads are conducted with active participation of VHSNC members and with support from MGCA members in the district.
- Meghalaya has reported CAH being implemented as a pilot in 5 districts, in selected villages of intervention block. Training of VHSNC & RKS, community members and ASHAs/AFs has been completed and public hearing/ Jan Samvad has been conducted on issues like denial of health services, maternal death, behaviour of health providers, sanitation, lack of basic amenities in health facilities etc. In WGH, Selsella block is the intervention block for conducting CAH activities (21 villages). In 2019, three public hearing/ Jan Samvad have been conducted.
- In Rajasthan, six districts are currently implementing CAH while eight more districts are planned for scale up. District trainings have been conducted in 4 districts during 2018-19 and 4 Jansamwads have been organized in one district so far.

Mahila Arogya Samitis (MAS)

- More than 90% MAS against target have been formed in Andhra Pradesh(91%), Gujarat(98%) and Jharkhand (100%). On the other hand, around 65% MAS are formed at Nagaland and 87% at Meghalaya.In Delhi, 98 MAS have been formed on pilot basis and additional 2500 are planned for current FY. Tamil Nadu does not have Mahila Arogya Samitis (MAS) in place as yet but has engaged SHGs in urban areas to perform similar activities related to health promotion and disease prevention.
- Training of MAS is reported from states ofGujarat, Jharkhand, MP and Meghalayawhile

in Bihar only one day orientation is done. Non-availability of MAS members for training during routine hours is reported as a challenge in organizing training in MP. In Dahod district, status of MAS training is found to be incomplete.

- Issues with transfer of untied funds are reported in AP and Meghalaya. Difficulty in opening of bank account is quoted as the reason for delay in fund release in Meghalaya.
- In Jharkhand untied fund of Rs. 5000 is provided to MAS and regular meetings of MAS are reported with adequate utilization of untied funds. However poor engagement of ULBs with MAS is reported in Jharkhand. In Delhi, MAS has facilitated organization of eye camp through Tata power mobile van and has undertaken activities like sanitation drives, operationalization of community toilets, health camps etc. but untied fund has not been utilized in North East district. In Gujarat, MAS members are aware about their roles and actively participated in activities but are unaware of the untied funds. In Madhya Pradesh, MAS in Khandwa is reported to be more functional than MAS in Chindwara. In one instance, due to efforts of MAS members regular doctor is posted at PHC.

Rogi Kalyan Samiti

- RKS has been formed as per recommended guidelines in Andhra Pradesh, Madhya Pradesh, Bihar, Mizoram, Manipur, Rajasthan and UP.
- In absence to training of RKS members, which leads to low level of participation of RKS members, the RKS has not emerged as an effective community- based platform at heath facility level. Training of RKS has not been reported from states of Bihar, MP and Rajasthan,
- Regular meetings are reported from the states of Andhra Pradesh, Mizoram and Manipur. Despite functional RKS and regular meetings in Manipur, it is observed that RKSis largely managed by MO I/C with limited participation of PRI members. The effectiveness is further hampered due to late receipt of untied funds in the last quarter of Financial year. Participation of PRI is also noted to be low in MP and Rajasthan, where RKS is being managed mainly by office bearers at the visited health facility.
- In some states, such as Bihar andMizoram, record keeping of meeting minutes and fund utilization have shown major gaps. On the other hand, despite irregular meetings in MP and Rajasthan, documentation of RKS on fund utilization is found to be updated.

Gender

- Ensuring that the health system is sensitive and responsive towards gender based and sexual violence is a low priority area across all states visited. Even the measures required to safeguard female health workers, who constitute a high proportion of the workforce,

have not been taken. This is evident from sporadic efforts being made to create safe rest rooms for ASHAs at health care facilities in most states and no or partial implementation of VISHAKHA guidelines at all levels.

- Reports from Andhra Pradesh, Gujarat and Madhya Pradesh depict that ASHAs and ANMs are sensitizing the community regarding gender based violence and discrimination. This could be linked with training of ASHAs on "Mobilizing for action on violence against women" as part of Round 4 of Module 6 and 7. In Gujarat, ASHAs and ANMs encouraged women to call 108 Abhyam helpline in Dahod district in a crisis situation.
- Domestic violence and gender-based violence is, however reported to be high during community interactions in many states including Chhattisgarh, Delhi, Gujarat, Odisha and few areas in Madhya Pradesh.
- One good practice noted from Delhi is the introduction of topics related to sex education in Delhi, which has led to increased awareness among school children and adolescents on such issues.
- Protocols for treatment and management of sexual violence cases are in place only in four of the 16 states (Andhra Pradesh, Gujarat, Tamil Nadu and Nagaland) including provision of medical and psychological support to victims. Such protocols are not available at visited facilities in Jharkhand while gaps are noted in implementation of the available protocols at facility level in Dahod district of Gujarat.

- Training of service providers in such protocols has been conducted only in Jharkhand while no training is reported from Meghalaya, TamilNadu, Nagaland and Mizoram.
- One Stop Crisis Centres (OSCCs) for domestic and sexual violence are seen in only few districts like Dahod district of Gujarat, Mayurbhanj district of Odisha, Nagaland and Tamil Nadu. In Meghalaya, OSCC is established by Women's Economic Development Society (WEDS) which is a registered NGO while in Nagaland the OSCC is linked with women Helpline 181and the Family Counselling centre.
- The VISHAKHA guidelines for prevention of sexual harassment at workplace is reported to be implemented only in Tamil Nadu as committees are formed at state and district level. They are not being implemented in Andhra Pradesh and Jharkhand, whereas in Nagaland there is lack of awareness about VISHAKHA guidelines in both the districts.
- State of Manipur reported favourable sex ratio while in Tamil Nadu the sex ratio at birth has dipped below 900 to 896 girls born per 1000 boys for the first time. Violations in the PCPNDT act are reported in both Manipur and TN.
- In Tamil Nadu, increased monitoring and inspections are reported with regards to PCPNDT act. State has also proactively brought within the purview of the implementation the PCPNDT Act, genetic counseling clinics and clinics providing Assisted Reproductive Technologies.

Recommendations

- As the ASHA programme transitions into the next phase, where ASHAs take on more complex tasks which require higher level of skills and close coordination with the health systems, it is essential that the core components of the programme are strengthened. This would mean ensuring *timely, skill based and quality training*, *eliminating stockouts of equipment / medicines*, *timely payments, safe working conditions with rest rooms at all high case load government health facilities and stringent grievance redressal mechanisms*.

- Role of support structures also needs to evolve at a commensurate pace by regular training on supportive supervision for newer tasks and working as a team with CPHC nodal officers at all levels.
- Experiences from Jharkhand demonstrate effective use of the performance monitoring tool to provide additional support to ASHAs while findings from Gujarat reflect the need for a robust monitoring mechanism for ASHAs functionality. In the current context of primary health care where new tasks are being allocated to ASHAs, there is an urgent need to revise and institutionalize the performance monitoring system for ASHAs. Digital technology should also explored to facilitate the implementation of such system, wherever feasible.
- Most states have either completed or are near completion for selection of rural ASHAs. However, CRM reports have consistently highlighted the gap in terms of areas that have been left out while setting target for ASHAs or due to inability to adapt the guidelines as per local context. Such left out areas in majority of the cases are also the most vulnerable and difficult areas. It is recommended that detailed mapping should be done to identify the areas which constitute the 5-10% gap in ASHA selection in states and prioritize selection of ASHAs in such areas.
- Selection status in urban areas has been relatively poor owing to inability to select a suitable candidate and/or high attrition due to better employment opportunities. Such findings warrant the need for a comprehensive review and, if required a revamp of the existing programmedesign to address the health needs of the urban poor.
- Though the training structures for ASHAs are well established, mechanism to manage the attrition of trainers and strengthen the infrastructure for quality training on a regular basis needs to be created. ASHA certification can be utilized as an opportunity to standardize and strengthen the quality of all training components for ASHAs. This would also facilitate planning and roll out of training of ASHAs planned on newer areas like HBYC, NCD etc.
- Findings also mention the need for refresher training of ASHAs on key skills on an ongoing basis. Given the requirement of refresher training along with training in new skill areas,this could prove to be a significant logistic challenge. States should invest in building the platform of PHCmonthly meetings for capacity building of ASHAs on a regular basis as per the guidelines.
- Despite several initiatives to streamline payments of ASHAs, delays still persist especially in areas where either banking services are limited or fund flow to districts is not regular. Such delays, after 15 years of roll out of programme are not-acceptable and require immediate intervention of the state and district administrators.
- Slow pace of enrollment of ASHAs and ASHA facilitators in the three schemes – PMJJBY, PMSBY and PMSYMY, which is launched by Central government as entitlement for ASHAs and ASHA facilitators, also needs to be addressed.
- Health systems readiness to provide sensitive and high qualityservices to victims of sexual offences and even to provide a safe working environment to our women health care providers and community health workers needs strengthening. Systemic review and time bound plan needs to be developed by states to address this gap.
- Community based platforms of VHSNCs, RKS and MAS are yet to evolve as avenues where the voices of the community in planning and monitoring for service delivery, accountability mechanisms and addressing social determinants on health is heard and taken care of. Efforts are needed at all levels to build capacities of these platforms and for providing handholding support. Better integration with decentralized structures such as PRIs and ULBs needs to be done.

State Specific Findings

Andhra Pradesh

- State has selected 99% (39,009) rural and 81.5% (2609) Urban ASHAs.

- ASHAs are active in facilitating services for NCDs, immunization, institutional delivery, referral of malnourished children and creating awareness about health care entitlements in community.
- State has increased the honorarium of ASHAs from Rs.6000 per month to Rs.10000. Payment of incentive being done via DBT through Comprehensive Financial Management System (CFMS) and there is no pendency in ASHA payments.
- ASHAs have been provided with one day orientation on NCDs due to state's priority to complete training of ASHAs in 3 and 4 rounds of Module 6&7 which is currently around 70%.
- RKS have been formed at all levels and regular meetings are reported.
- ASHAs and other female health staff are aware regarding sexual harassment and domestic violence and make special efforts to identify victims and help them.
- Most ASHAs undertake HBNC visits but it is reported that visits are not completed as per schedule.
- Replenishment of medicine kits has not been done since 2015-16 and faulty HBNC equipment have not been refurbished.
- At sector level, Public Health Nurses/LHVs/ CHOs are designated as Nodal Officers to play the roles of ASHA facilitators. However, their interaction with ASHAs is found to be limited to PHC monthly meetings.
- VHSNC have been constituted at Gram panchayat level. As per state reports ASHAs are member secretary of VHSNCs, but during the village it is found that the village's panchayat secretary isthe member secretary of VHSNCs and not the ASHAs. Low utilization of untied funds is reported in both the districts.
- State has total 91% (9015) MAS formed against the target. However, funds have not been transferred to the MAS accounts since last year.
- VISHAKHA guidelines have not been implemented.

Bihar

- ASHAs are very active in facilitation to provide services for immunization, institutional delivery, identification and referral of malnourished children.
- State has more 90% ASHAs positions filled in rural areas but in urban areas about 50% ASHAs positions are filled.
- State has introduced fixed performance-based incentive of Rs. 1000/- per month and life insurance support to ASHA with a benefit of Rs. 4 L from State Funds. Pace of enrolment in the three social benefit schemes is very slow.
- Incentives for ASHAs are paid on time through PFMS and statements are displayed at PHC for the benefit of ASHAs and to ensure transparency. ASHAs are not aware of their VHSNC entitlements.
- CUG SIM has been provided to ASHAs for better communication with districts health teams and for block level reporting.
- Pool of ASHA trainers has shrunk from 803 to 180 over last three- years and pace of training has been slow with only 69% ASHAs trained in Round 3 and 28% in Round 4. Long gap in trainings has affected the functionality of ASHA. Training of Urban ASHAs in Module 6&7 has not been initiated yet.
- 37% ASHAs are covering a population of above 1500 and 14% ASHAs are doubling for positions that are vacant, thereby serving double the population they are supposed to i.e. 3000.
- ASHAs are found to be overburdened and not skilled enough to meet the current reporting requirements.
- Dedicated divisional review of ASHA Programme with DCM/BCM not undertaken for last two-three years.
- None of the ASHAs had a functional HBNC kit. As part of medicine kits only ORS, Zinc, Condoms and OCPs have been provided to ASHAs.
- ASHA help desk and grievance redressal mechanism are not in place.

- 8384/8406 VHSNCs formed at the Gram Panchayat level.
- VHSNC meetings and RKS are found very irregular and members are not aware of their roles and responsibilities.
- MAS members have been given only one day orientation.

Chhattisgarh

- Mitanins are diligently undertaking their tasks related to raising community awareness, demand generation and social mobilization, but gaps in the health system nullify their efforts.
- Mitanins knowledge on family planning is good, but they need a better understanding of client selection
- Rest rooms for Mitanins are found to be inadequate.
- Mitanin kits had damaged thermometers.
- Pace of Population enumeration and CBAC filling is slow.

Delhi

- 6035 ASHAs are in place against a target of approximately 6258 (96.4%).
- ASHAs are dedicated, motivated, hard-working and well accepted in community.
- ANM and ASHA have good skills and knowledge about mother and child care practices including the danger signs in pregnancy and newborn period.
- Ten days ASHA certification refresher training has been provided to 2216 ASHAs.
- Web based system captures performance and also estimates incentives. Payment of incentives is transferred to ASHAs account through PFMS by 10th of every month.
- ASHA rest rooms and help desk are provided inthe facilities across the state.
- Grievance redressal mechanism is in place (in 2018-19, 122 cases resolved out of 123)
- 98 MAS have been formed in both districts as pilot. However, formal training of MAS has not been done.
- Regular monthly meetings of MAS are being organized. Special eye camps have been organized in the Todapur community by MAS. Untied funds had not been utilised in East Delhi District.

Gujarat

- 38,213 Rural ASHAs and 4058 Urban ASHAs in position i.e. 97% and 98.63% respectively against the set target.
- Equitable representation of ASHAs from all the communities is observed in state, especially in Surat district. In Surat 69% ASHAs are from SC/ ST community against 72.68% of the total rural SC/ST population of Surat (Census 2011).
- ASHAs are valued for their contributions in the community and are seen as an integral part of the health system.
- State provides Rs.1000/ (50% top-up) to ASHAs from state funds. ASHAs reported timely payment of incentives without any backlog.
- State has enrolled 66% ASHA in PMSBY, 33% in PMJJBY, 55% in PMSYMY, 7% in MAA (Govt. of Gujarat). This figure is lower in Dahod with 56% in PMSBY, 23% in PMJJBY and none reported for PMSYMY.
- Average time spent on ASHA work is reported to be up to 04 hours a day on their activities. However, in Dahod, low coverage of key MCH services such as ANC care (48.8%), Immunization (33%) etc. raise concern about the adequacy of the outreach and home visits.
- ASHA training in Module 6 &7 is over 90% in both districts. However, limited knowledge and competencies are observed in key health topics. This could be on account of poor quality of training as training is often planned on directions of THOs/MOs/FHVs in an ad hoc manner.
- ASHA Drug Kits are regularly replenished from SHC and PHC levels in both the districts.

- No ASHA grievance redressal mechanism is in place and rest room at DH levels is not institutionalised.
- Inadequate support provided for field monitoring of ASHAs since state has deployed district nodal officer equivalent to a Data Entry Operator. Hence ASHA Facilitators (01 for every 10 ASHAs in Dahod) are the only support structure for the ASHA, given the ineffectual nature of district support and lack thereof at the block level.
- State has the system of SATCOM (TV) where every Saturday session for ASHAs on various subjects/issues is taken. This is an effective means of updating ASHA on current priorities, but needs to be evaluated as to its efficacy in building capacity.
- 17646 VHSNCs (Gram Sanjivani Samiti in Gujarat) have been formed (100% against the target). All the VHSNCs have joint bank accounts with MPHW-F as the Member Secretary.
- Though, a total of 16410 VHSNC members have reportedly been trained in the VHSNC Handbook in the entire State, but in Dahod district mere brief orientation is given to the members.
- A total of 7847 MAS (Mahila Arogya Samiti) have been formed (98% against target). Similar to VHSNC, a total of 3441 MAS have been trained but status of MAS training is found incomplete in Surat district.
- Interaction with MAS members show lack of clarity on utilisation of the untied fund of (Rs.5000).
- In Dahod district, Sub Divisional Hospital has been designated as One Stop Crisis Centre for Gender Based Violence cases whereas Surat district does not have any designated centre.
- ANMS and ASHAs are encouraging women to call 108 Abhyan helpline in Dahod district in crisis situation.

Jharkhand

- Selection of rural Sahiya is around 98%. Selection process is community led, both in rural and urban areas. In urban areas, MAS members are involved in selection of Urban Sahiyas.
- Target of urban ASHAs is found to be insufficient in both districts. In Gumla, target of Sahiyas sanctioned is 9 for the population of 65,000.
- Training status is satisfactory for rural Sahiyas in both the districts with regards to Module 6&7. NCD training is completed for all the rural Sahiyas in Gumla and for rural as well as urban sahiyas in West Singhbhum. In Gumla, urban Sahiyas are yet to be trained in Module 6 and 7 and NCDs.
- Quality of training is monitored at each level by state and district trainers, state training co-ordinators, SPMUand DPMU
- Sahiya sathis are also functioning as Sahiyas which affects their performance in both roles. To address the issue of variable coverage of ASHAS by Sahiya sahthis, state has mapped clusters and villages using GPS to rationalize the distribution.
- In addition to two-days training on supportive supervision, Sahiya Saathis in rural areas have also received training in PLA module.
- Performance monitoring system is being implemented effectively. The non-performing Sahiyas are closely monitored and supported for 6 months and declared dropped if scores poorly in performance monitoring system.
- Regular monthly review meetings of support staff conducted at both district and block level.
- HBNC and drug kits available with Sahiyas in rural areas
- HBNC visits in both the districts are satisfactory.
- Sahiya Sahayta Nidhi, a financial assistance scheme for Sahiya, Sahiya Saathi, STT and BTT for death, disability, accident, education and serious illness is functional since March 2018.
- Enrollment in PMJJBY, PMSBY and PMSYMY is under process.

- Payment process has been streamlined and sahiyas visited had received timely incentive for last month.
- Help desk is functional at both district hospitals with 2 Sahiyas present on a rotational basis and rest rooms are available at DH and CHCs.
- Of the two visited districts, grievance redressal committee is formed at West Singhbhum.
- VHSNCs are formed at Revenue Village level in the state. In Gumla district, 943 VHSNCs have been constituted out of 948 villages. The chairperson of the committee is selected by members and may not necessarily be an elected PRI member. In one of the visited village, elected female PRI member is not aware of the VHSNC, while the chairperson is a male community member who is holding the chairperson position since 8 years.
- Training of MAS members is completed in both the districts and MAS members had good understanding about their roles.
- MAS is receiving untied funds of Rs. 5000 regularly and funds are being used appropriately, for conducting meetings, sanitation activities in the ward and records are maintained by Sahiyas.
- Service providers at Gumla are reported to be trained in protocols for treating women who are victims of sexual violence. However, no protocols are available and service providers are not aware about medico-legal protocols for sexual violence cases

Madhya Pradesh

- Community members shared that ASHA played a major role in helping the community provide better contact with the health system.
- ASHAs are mostly involved in institutional deliveries, followed by HBNC, Immunization and Family planning and then followed by other services.
- No formal grievance redressal mechanism is in place but in general District and Block Community Mobilizers attended and solved the grievances of ASHAs.
- No rest rooms for ASHAs are found at any of the health facilities.
- A total of 2677 VHSNC are in place for both the districts. Frequency of VHSNC meeting is not regular while all VHSNCs met have utilized funds for this Financial Year.
- Community Action for Health (CAH) is being implemented at all levels (State/ District and Block). CAH programme has made strong foothold at Chindwara district with equal participation from Village Health Sanitation Nutrition committee members at village.
- In Khandwa, 68 MAS have been formed against 72 and 26 MAS have been provided training. Funds have been provided to 40 MAS in Khandwa so far.
- RKS members have not been trained but are aware of the responsibilities as a RKS member. RKS meetings are held infrequently.

Manipur

- ASHAs have good rapport with community members.
- Training on module 6& 7 has been completed for all ASHAs except for the newly selected ASHAs.
- ASHA is supported by ASHA Facilitator at the cluster level and by District Community Mobiliser (DCM) at the district level
- Grievance redressal committees have been formed and are functioningproperly.
- On an average ASHA receives incentive amount upto 2000 and in exceptional cases upto Rs 4000. Delay in the release of ASHA incentives is of about 6 months generally.
- VHSNCs have been constituted at all villages and regular monthly meetings are organized. Delay in the release of untied fund to the VHSNC hampers the activities at the village level.
- RKS is functional at most of the health institutions with regular meetings being done. However, there is a need of capacity building of RKS for effective utilisation of untied funds and generation of resources on their own. RKS

has not emerged as an effective institution as members are not active and largely managed by MO I/C and the Chairman. The effectiveness is further hampered due to delay in funds released in the last quarter of the year

- PCPNDT Act is not displayed at health centres and villages.

Meghalaya

- 6568 rural ASHAs (100.8%) and 177 (84.3%) urban ASHAs are in position
- ASHAs in both districts are reported to be active and motivated to carry out their functions.
- In addition to Module 6 &7, ASHAs have undergone 5-days training in universal screening in common NCDs while HBYC is being implemented in Ri Bhoi district.
- 30 ASHA Facilitators of Ri-Bhoi have also been trained in Participatory Learning and Action (PLA)
- Quality of training is reported to be affected due to non- availability of adequate infrastructure, high attrition rate of trainers and drop-out of ASHAs during trainings.
- ASHA Certification programme in the state is initiated in 2018.
- State has effectively rolled out performance monitoring system; ASHAs are monitored on 10 functionality and blocks are graded based on their performance.
- About 5016 rural ASHAs have drug kits and 5442 rural ASHAs have functional HBNC kit. In urban areas, drug kit is available with 177 ASHAs and 167 ASHAs have functional HBNC kit.
- No grievance redressal committee is formed at state or district level. ASHA complaint boxes/ drop box are available in some PHCs/CHCs in rural areas. Grievance registers are available at health facilities in WGH for ASHAs and their queries are noted by any PHC/CHC or BPMU staff members.
- All 39 blocks in the state are making online ASHA payments linked with PFMS, subject to availability of fund. Irregular payments have been reported in both districts. Huge backlog of payments of rural ASHAs (backlog varying block-wise in WGH) - routine and recurring incentives are due since 2015/2017; JSY (also for beneficiaries) since April 2016/2018-19, HBNC since 2013/2016, VHND since 2013, VHSNC since 2017-18 and Meghalaya Maternity Benefit Scheme (also for beneficiaries) since 2013/2017.
- ASHA Benefit Scheme (ABS)- State scheme functional since 2011-12. ASHAs are paid same amount of incentives (as the contribution from the scheme) that she earned during a particular year from all NHM programmes.
- Cash award is provided to best performing ASHA (1 ASHA) both at district and block level. Rs. 5000 for best ASHA of the Block and Rs.10000 for best ASHA of the district in a year.
- No ASHAs and AFs have been enrolled till now in PMJJBY and PMSBY but 100% ASHAs and AFs have been enrolled under the Universal Health Insurance Scheme (UHIS) to provide health insurance.
- ASHA transit homes are available in few PHC/ CHCs.
- Health Screening for ASHAs is conducted annually and on International Women's Day (IWD) and physical activity sessions for front-line workers is being undertaken at HWCs.
- VHSNCs re-constituted as per 2013 GOI guidelines but untied funds have not been received in WGH since 2015/2017-18.
- Training of VHSNC members is conducted in 2014/2017 in WGH while in Ri Bhoi VHSNC members have not received training.
- Theme-wise VISHWAS campaign is being conducted on a monthly basis in the selected 16 blocks in all districts. In WGH, 590 VHSNCs and ASHAs have been trained in VISHWAS in 2018-2019 and are actively involved in conducting campaigns.
- Ninety-two MAS have been formed and trained against the state target of 105 MAS. MAS untied funds have not yet been released due to issues in opening bank account.

- CAH-Community Action on Health is a pilot project implemented only in 5 intervention districts (West Jaintia Hills, East Jaintia Hills, East Khasi Hills, West Garo Hills and South West Garo Hills).
- No gender-related training of health service providers and no specific protocols for genderbased violence is available at healthcare facilities in both districts.
- In WGH in Tura, Hawakhana, a one-stop crisis centre is established by Women's Economic Development Society (WEDS) which is a registered Non-Governmental Organization (NGO) specially working for economically and socially deprived women of Garo Hills.

Mizoram

- State has 100% ASHAs in position as against the State's target. Most ASHAs have clarity on their roles and skills and are well rooted in community with good empathy and rapport.
- All ASHAs in rural areas have been given training in four rounds of module 6 & 7 and have subsequently been given refresher training.
- NCD training for ASHAs has been conducted and 258 ASHAs and 109 Facilitators have been trained. Limited trainings have been undertaken for urban ASHAs where only the induction module training has been done for urban ASHAs.
- ASHA's knowledge about her roles and programme activities, including HBNC, is satisfactory in Aizwal but not in Mamit.
- ASHA incentives payments are irregular with substantial delays.
- State is yet to enroll ASHAs and ASHA facilitators in the three schemes
- Grievance redressal system and ASHA restrooms are not found operational.
- Support structure for ASHAs are available at state and district levels but it is not working well due to absence of a regular review system.
- State has RKS constituted and functional in all of its 77 facilities.
- VHSNCs have been constituted as per the target (830) and all have bank accounts. Un-tied funds is given to VHSNCs on regular basis and fund utilization is good. Training for VHSNCS has been conducted in 2017. In 2018, VHSNCs and ASHA have been trained on VISHWAS campaign, initiated by MOHFW.
- Record keeping systems and minutes of the meetings of VHSNCs and RKS have shown major gaps.

Nagaland

- Overall, level of functionality of ASHAs is observed to be higher in Phek as compared to Kiphire. Community members mentioned seeking care and advise from ASHA on a routine basis. ASHAs are reported as a great support to the community and performed her duties with full determination.
- State has 100% ASHAs in position against the sanctioned 1917 in rural areas, and 74 ASHAs (82.2%) in position against the sanctioned 90 ASHAs in urban areas.
- Despite 100% ASHAs in position against the target, there are villages which are not covered by any ASHA as newly formed villages in Kiphire district have not been recognized.
- The process of ASHA selection in state is not community led as nepotism exists wherein the Village Council and Village Head in consultation with "Gamboora" (Village Elderly) identify ASHA, who is mostly related to Village Head.
- Absence of district trainers conversant in local dialect and adhoc planning of training affects the quality of training.
- Functionality of ASHAs and support structures is also affected by poor road and internet connectivity, lack of mobility support, infrastructure and administrative issues.
- ASHA ghars and ASHA help desks are not available at facility level
- Drug kits and equipment supplied to ASHAs are not refilled on a timely basis.
- Grievance Redressal Committees are not functional across the state.

- Delays in disbursement of incentives demotivated ASHAs to continue working for the community. In order to support the ASHAs, community members reported providing money to ASHA for JSY services, which she returns after her remuneration is received.
- State is yet to implement the recently launched schemes i.e. PMSBY and PMJJBY due to unavailability of funds under this scheme.
- On-job field support is provided by the Block ASHA Coordinators (BAC), who shared that lack of mobility support and difficult terrain limits their functionality to support ASHAs.
- ASHA meetings are not conducted regularly in either of the districts but District Community Mobilizer (DCM) and BAC communicate with ASHA over phone for monthly progress reports. The communication is limited to selected ASHAs due to poor connectivity.
- 100% Village Health Sanitation and Nutrition Committees (VHSNCs) with functional bank accounts against the target of 1,346 have been formed.
- VHC members have not been trained on 'Handbook for VHSNC members'. Lack of clarity is observed regarding VHC's roles and responsibilities amongst VHC members and BPMU staff. VHC members mentioned funds as the main constraint in their functionality. However active engagement of VHC members is noted in functioning of Health and Wellness Centres.
- In urban areas, the state has formed 64.6% Mahila Arogya Samiti (MAS) with functional bank accounts against a target of 113.

Odisha

- Against the target of 47147 ASHAs, 46347 are in position (i.e. 98% position filled; Mayurbhanj - 99% and in Kandhamal - 98%)
- Module 6 &7 training has been undertaken for most ASHAs and they have received HBNC kit.
- A total of 3881 ASHAs have been trained for HBYC in 14 aspirational districts.
- Medicine kit with ASHAs are replenished as required by SC/PHC.
- ASHA Gruha (staying arrangements) is available at health facilities.
- ASHAs payments are made timely, generally made by 10-15th of next month.
- State has developed software to monitor performance and payment of ASHAs. However, this is only in its initial stages.
- State provides Rs. 1000/- as an assured amount pm to ASHAs from state funds.
- An amount of Rs. 6,000/ @ Rs. 1,000/- per month is being given for a period of 6 months during the pregnancy/post-pregnancy period.
- Compensation is given to the family under ASHA Kalyan Yojana as compensation for death and disability.
- 11,422 ASHAs have been enrolled PMSMY till August, 2019 while enrolment is underway for PMSBY and PMJJBY.
- 785 ASHAs have been enrolled under this to complete their matriculation. ASHAs have also been enrolled in courses like Certificate in Food and Nutrition (CFN) and Certificate in Guidance (CIG) under IGNOU. Total no. of ASHAs enrolled till September 2019 in the state are 5893.
- VHSNC known as Gao Kalyan samitis (GKS) have been formed and provided one day training. The members are aware about the VHSNC activities and also shared details of annual plans along with the fund distribution.
- Each of the GKS maintains an interactive health bulletin board called "Sisthya Kantha" which is the hall mark of GKS at the village level. ASHA writes important information and messages for the information and awareness of the people.
- GKS have played a major role in distribution of LLINs and reduction of diarrhoea and scabies at community level.
- One stop centre at Mayurbhanj district is functioning well but there is no One stop centre in Kandhamal district. Overall state has 22 one stop centres.

Rajasthan

- Overall, in the state 51743 (92.53%) ASHA Sahyoginis are selected by the joint collaboration of Women and Child development department. However, in Sirohi district gap is noted in selecting ASHS in tribal areas on account of state's strict adherence to the education criterion of 8th standard despite the flexibility provided in guidelines
- Remuneration to the ASHA Sahyoginis is made on time, through ASHA Soft.
- In rural areas ASHA PHC Supervisors and Block Supervisors are supervising the work and in urban areas ANMs perform this task.
- Drug kits of ASHAs are not replenished regularly and HBNC equipment like thermometers, hand watch and weighing scale have also not been replenished.
- ASHA Sahyoginis are provided with an amount of Rs 2700/- pm from WCD in addition to regular incentives from Health Department.
- Grievance redressal mechanism has not been created.
- State supports ASHA Sahyoginis for their education through NIOS (Open schooling).
- Enrolment of ASHAs Pradhan Mantri Jeevan Jyoti/Suraksha Bima Yojna, Shram Yogi Maandhan Yojana is underway.
- VHSNCs meetings are being conducted but public representatives like Panchayat members or Sarpanch do not attend the meetings. Only ASHA, AWW and sometimes ANMs attend the meeting.
- A sum of Rs.5000/ for this year has been transferred to VHSNC untied fund, but with a rider to spend it on Yoga day (21st June). Training for the VHSNCs is not being provided for the last 4 years now.
- RKSs have been found to be registered under Society's Registration Act.Records of Funds utilization have been found in the facilities but participation of PRI members is low.
- Six Districts have been selected for CAH. District trainings have been completed in Dhaulpur, Bundi, Bikaner and Baran district during 2018-19.

Tamil Nadu

- State has selected ASHAs only for tribal and inaccessible areas. Although the state's records show that 81 % of ASHAs are in position against the revised target, the actual numbers indicate a decline (364) in the number of in-positionASHAs.
- 90% of them have been trained up to module 7.
- On an average an ASHA earns Rs. 3000-6000 per month and are enrolled in 3 social benefit schemes.
- No formal mechanism for ASHA grievance redressal has been set up
- State has selected Woman Health Volunteers (WHV) are recruited through the Department of Women and Child Development, as part of the SHG programme for provided community based NCD services.. The performance based incentive of Rs. 3500 pm is provided to WHVs by health department,. All the recruited WHVs had undergone the induction training.
- State has 15,015 VHSNCs which are not fully functional and do not meet regularly.
- Tamil Nadu does not have Mahila Arogya Samitis (MAS) in place as yet. Instead, state has engaged women's Self-Help Groups (SHGs) in urban areas to perform functions similar to MAS especially for initiatives related to health promotion and disease prevention.
- With regards to PCPNDT Act, increased monitoring and inspections are reported. State has also proactively brought within the purview of the implementation the PCPNDT Act, genetic counseling clinics and those clinics providing Assisted Reproductive Technologies.
- At present there are two OSCCs operational in the State for gender-based violence cases. Medico-Legal Care Protocol for cases is present only at Government Hospital level. Written SOPs are available for taking informed consent for medical examination, evidence collection, reporting to the police etc. Psychological and

medical treatment is being provided to the survivors.

- VISHAKA Committee has been formed in 2018 with the prescribed members for complaints against any sexual harassment at workplace.
- Citizen's charter of rights and entitlements is displayed at all public health facilities at all levels and the procedure for recording complaints is also available for public access.

Uttar Pradesh

- ASHAs are motivated and dedicated. Interaction with community members revealed that ASHAs regularly visited households
- Against a target of 159307 rural ASHA, 152667 (96%) ASHAs are in position.
- Against the target of 8336 urban ASHAs, 6426 (77%) are working. The reason cited for gap in selection in urban areas are low incentive in urban areas and possibility of better opportunities.
- In state, 95% rural ASHAs in round 1, 92% in round 2, 86% in round 3 and 74% in round 4 have been trained in module 6 & 7. The technical knowledge and skills to be satisfactory.
- However, none of the urban ASHAs have been trained in Module 6 & 7.
- Around 13662 ASHAs (59 % associated with HWC) have been given 5 days NCD training. HBYC Training has been initiated.
- Average monthly incentive is Rs 3672/- ASHA's (Rural) and payment for rural ASHAs is processed through BCPM-MIS application. Development of MIS application is under way for urban ASHAs.
- Most of the ASHAs had a kit with all the essential drugs and equipment with regular replenishment. For replenishment, a separate fund has been allocated to Districts and it is done on the basis of requirement sent by BPHC/CHC.
- State has a good support structure in place from state to block level supported by SPMU, regional coordinators, district and block community process managers. However, some ASHAs reported that they directly contact to their Medical Officers In-Charges for support and grievance redressal.
- Rest rooms are not available in the observed facilities but in Bahraich district under CSR funds 15 ASHA rooms are sanctioned.
- Asha Bima Yojana (accidental insurance) is in place since 2016, however the scheme is till November 2019 as state has already rolled out PMSYMY and will be rolling out PMJJBY and PMSBY.
- ASHAs have limited coverage of marginalized population as the services provided by them are not inclusive and they had limited understanding of marginalization and vulnerability.
- 60523 VHSNC have been constituted against a target of 79032 at the revenue village having population of more than 500. VHSNCs and MAS members are not familiar with roles and responsibilities. VHSNCs do not have 50% female members. The untied funds are being used for infrastructure like weighing machine, carpet for AWC, Water campo etc. There is no involvement of VHSNCs in Community Action for Health.
- In some VHSNCs there is one active male member who is a family planning mentor at the panchayat level. Their main role is to counsel men on undergoing vasectomy.

Uttarakhand

- Average time spent by ASHA in community work is 7-8 hours.
- ASHAs have been given HBNC kits which include weighing machine, thermometer and warm bag.
- Training of ASHA on different aspects of Health, Nutrition and Sanitation is found to be inadequate.
- ASHAs are supported and reviewed by ASHA facilitators with regular visit the field with ASHAs.
- ASHAs are not aware of benefit schemes like PMJJBY, PMSBY and PMSYMY.


ભાઈઓ
MAY I HELP YOU ?-પૂછપરછ વિભાગ
બહેનો
શાંતિ જાળવો.
ઓ.પી.ડી. સેવાઓ - બહારના દર્દીઓનો વિભાગ
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TOR 7
QUALITY ASSURANCE

National Overview: National Quality Assurance Standards (NQAS)

Delivery of equitable, efficient, effective and safe care will ensure improved health outcomes under the Universal Health Coverage (UHC) and other programmatic interventions in the country. It is essential to coalesce various quality interventions into a system based approach. Implementation of National Quality Assurance Standards (NQAS) strives to inculcate the component of "Quality" in every aspect of service that is delivered at the health facilities.

NQAS provides an objectively monitor able framework of quality measures for administrators, programme managers, district managers, and service providers to promote safety, efficiency, timeliness and equity in delivery healthcare that is patient centric. National Quality Assurance Program (NQAP) has laid out a systematic process for building both institutional and clinicalcapabilitiesin delivering the same.

In comparison to previous years, this years' experience reflects remarkable progress, both in terms of efforts and outcomes. Numbers of state and nationally certified health facilities have increased significantly. While the number of nationally certified health facilities have increased from 224 in 2018-19 to 536 by December 2019, the number of state quality certified facilities have risen from 503 to 941 during that period.

Key Findings

Organizational Framework

- Most of the states had well establishedState Quality Assurance Committee (SQAC) and District Quality Assurance Committee (DQAC). However, except Delhi, Odisha and Tamil Nadu, regular meetings of SQAC and DQAC are not being conducted in any of the states.
- Quality teams have been formed and are functional at the district hospital level, but are yet to be operationalizedat the PHC/CHC level.

NQAS Certification

- Most of the states made significant progress in term of number of health facilities getting NQAS certified. While Andhra Pradesh leads other states with 67 facilities NQAS certified, states of Bihar, Jharkhand, Manipur and Nagaland have no NQAS certified facility.
- Slow pace of implementation of quality assurance programmes at urban health facilities has also been observed across all visited states and UTs.

LaQshya Certification

- Pace of certification of labour room and maternity OT under LaQshya has remained slow in most of the states. Few states such as Delhi,

Manipur, Meghalaya, Mizoram and Nagaland don't have a single LaQshya certified facility.

Safety Protocols & SOPs

- Adherence to six steps of hand ishing is observed in most of the states. The staff handling biomedical waste have been provided with PPE in most states except in Bihar, Chhattisgarh and Odisha.
- In most of the states visited, staff is not vaccinated for Hepatitis B and Tetanus Toxoid except in the states of Jharkhand and Tamil Nadu.
- NOC for Fire Safety is available in the NQAS certified facilities. Many states had gaps in fire safety trainings and disaster preparedness.
- Standard Operating Procedures for care are available and implemented in the states of Andhra Pradesh, Madhya Pradesh, Odisha, Tamil Nadu and Uttar Pradesh only.
- Irrational use of antimicrobials had been observed across visited states and UTs.

Patient Experience

- In most of the visited states, the community had a sense of trust in government services and are satisfied with the quality of care and services provided, but did complain about staff behaviour in few facilities.
- Most of the visited health facilities had basic amenities for patients like separate toilets for men and women, running water, sitting arrangements,etc.

Grievance Redressal System

- Absence of a robust Complaint Resolution System is observed in most of the States except in Uttar Pradesh.

Bio-medical Waste Management System

- Common Bio-medical Waste Treatment Facility is available in most of the States except Mizoram.
- In most of the visited States, working staffdid not have knowledge about latest BMW rules

2016 (as amended) except that of Delhi, Gujarat and Tamil Nadu, leading to non-adherence to the BMW management protocols.

- Though colour coded bins are available in all the states but mixing of wasteis observed in Andhra Pradesh, Bihar, Nagaland, Odisha and Uttarakhand.
- Pre-treatment of laboratory and highly infectious wasteis being done however liquid waste management (ETP/STP) is not in place in all the States.

Audits

- Audits such as Prescription, Death Audits, Maternal Death audit and Child Death Audits are being done in few states namely AP, Chhattisgarh, Meghalaya, Odisha and Tamil Nadu.
- The staff is not aware of Quality tools and methods like PDCA, 5S, Mistake Proofing, Pareto analysis, etc. in most of the states except Odisha, Rajasthan and Tamil Nadu.
- Reporting and recording of Key Performance Indicators is practiced in Andhra Pradesh and Tamil Nadu only.

Mera-Aspataal integration

- Integration of District Hospitals under Mera-Aspataal has been completed in most of the stateshowever; integration with lower level

facilities is yet to happen. Moreover, the data recorded through PSSs or MeraAspataal portal is not analysed for quality improvements.

Statutory and Regulatory Compliances

- Non-compliance to the statutory requirements viz. Authorization for BMW, AERB authorization for radiology set-up, blood bank license is a commonly seen.

Recommendations

NQAS Implementation-Mentoring and Review

- The states need to conduct meetings of all QA institutional structure (SQAC, DQAC, Quality teams and Quality circle) at regular interval, as recommended.
- Almost all the states have substantial numbers of NQA internal assessors and external assessors and also quality trained professionals, who have attended one year PG Diploma in Health Quality at Tata Institute of Social Sciences (TISS) Mumbai. The states need to utilise these professionals by deputing them to undertake continual assessment and gap-closure action. Experienced personnel may be allocated mentoring role in guiding the health facilities in meeting the NQAS norms and certification.

NQAS and LaQshya certification

- Though visited states had few facilities NQAS and LaQshya certified, the experience gained in NQAS implementation had not been utilised in getting other health facilities certified. The states need to devise an effective strategy for getting this done.
- Most of facilities have SOPs in place for clinical and administrative processes and sub-processes. However they are not followed in day to day practice. There is also a need of regular trainings and robust supportive supervision. This would also go a long way in sustenance of the gains, made during NQAS certification.
- States to provide required support e.g. provision of vehicles to the officers involved in monitoring in NE states owing to poor public transport facilities and difficult terrain.

Patient Safety

- Awareness on different dimensions of patient safety has been woefully inadequate, be it infection control, antimicrobial resistance, drug safety, safe surgery, patient fall etc. The States QA Committees should draw a plan to implement National Patient Safety Implementation Framework, which is launched by the Ministry of Health & Family Welfare in April 2018.

Patient Experience

- Poor behaviour of the staff being one of the key findings, across many states, training ofmedical and paramedical staff to build soft communication skills and better interface would go a long way in improving the patients' perception about the public health system.

Mera-Aspataal Integration

- Implementation of Mera-Aspataal initiative below the District Hospitals (HSC/APHC/Block PHC) needs to be done in all the statesacross in all health facilities.

Bio-medical Waste Management

- Training of staff on Bio-medical waste management rules 2016 (as amended) and strong linkages of peripheral health facilities with the Common bio-medical waste treatment and disposal facility (CBWTF) for timely transport, treatment and disposal of waste needs to be established.
- The states, where there are either no CBWTF or number of CBWTF is far less than required, should plan to establish more CBWTF, as recommended BMW Rule 2016 and central pollution control boards guidelines.

Audits

- Practice of medical audit needs to be introduced at all level of facilities for continually improving

the quality of care. Initially, a beginning could be made by introducing the prescription audit and death audits. Later clinical audit may be started against simple criteria. After the audit mechanism progresses and gets embedded in the hospital functioning, higher level criteria may be introduced for the audit.

Regulatory and Statutory Compliances

- SQACs should monitor compliances to following regulatory and statutory requirements by each of the health facility:
  - Authorization from the competent authority under BMW Rules
  - NOC for fire safety at health facilities
  - License for Blood Bank/ Blood Storage Unit
  - Electrical Safety Audit
  - Licence for operating lifts (if installed)
  - AERB Authorisation

Key Performance Indicators

- SQACs and DQACs are requiredto put a system in the place where all healthcare facilities capture, measure and report the Key Performance Indicators (KPI).
- Focus should now be shifted from curative to preventive (NCDs etc.), promotive and wellness services in the state.

State Specific Findings

Andhra Pradesh

The State has achieved National Certification of 67 facilities under NQAS, which includes 09 DHs, 12 AHs, 20 CHCs, and 26 PHCs. However, sustenance of the improvement at NQAS certified facilities is an area of concern.

- 13 DH and 28 SDH are integrated with 'Mera-Asptaal'. The community felt that after NQAS certification, quality of services had improved both in terms of infrastructure and behaviour of staff.
- However, only one facility – a DH is LaQshya certified. Medical college hasn't been included under LaQshya.
- Kayakalp winners and NQAS certified facilities are yet to receive their award money. Although, approved and released from centre.
- Well constituted SQAC, DQACs and SQAU and DQAUs. However, meetings are not being held on a regular basis.
- Many good practices like Prescription Audits, KPI Monitoring, Patient satisfaction surveys are seen. Most of the Prescription audits show that handwritings being not eligible, drugs are prescribed by brand name, diagnosis is not written.
- External Quality Assurance Programme for Laboratories and pest control measures are found at the facilities selected for NQAS certification. Fire extinguishers are also installed but the staff lacked training on its usage.
- All the drugs, diagnostics and dialysis services are free for all. Patients suffering from End Stage Renal Disease (ESRD) also get financial assistance of Rs. 10,000. drugs are found systematically arranged. However, OOPEs are incurred on transport of patient from home to hospital as pick up facility is ubiquitously missing in the state
- EDL list, Citizen's Charter and IEC are displayed in almost all level of the facilities. Use of Radio Frequency Identification (RFID) tags with complete details of the newborn to prevent baby swapping is a good practice observed.
- Patient amenities like safe drinking water with RO, toilets, clean linen are found in almost all the facilities visited. Though complaint boxes are found in most of the facilities, grievance redressal system is not in place.
- Staffs are not aware about Quality tools- like PDCA, Pareto or mistake proofing.
- Staff members are not vaccinated for Hep B and TT in many facilities.
- Quality Consultants at the districts are found to be lacking in knowledge, and capacity to support the program.
- The staffs are aware about processing of equipment like disinfection, cleaning and sterilization. But sterilization timing, recommended temperature and pressure are not known
- BMW management is outsourced.Adequate bins, liners, and hub cutters are available. However, mixing of various categories of istes is observed. The staff is not aware new rules of 2016 and its amendments in 2018. No mechanism for liquid waste management is found in places visited.

Bihar

- Progress made by the state under the NQAS implementation is in nascent stage as the state had only two LaQshya certified district hospitals namely; DH Purnia& DH Begusarai.
- The state has functional SQAC, DQAC and Regional Committees in line with the requirements of NQAS institutional framework. No quality committee for APHC, Block PHC/ CHCs. But no baseline assessment is conducted in the state and the staff is unaware of any quality initiatives in the facilities visited.
- Maternal Death Surveillance & Response (MDSR) and Child Death Review (CDR) meetings are taking place regularly at Bhagalpur under the Chairmanship of District Magistrate
- Essential Drug List (EDL) is displayed within the visited health facilities and drugs are prescribed in the generic name. However, many instances of illegibly written prescriptions or other records are observed.
- Most of the patients are satisfied with the quality of care and service delivery provided under Reproductive, Maternal, New-born,

Child health. No out-of-pocket expenditure and informal payments are reported during interactions with the patients.

- Registers like OPD, RCH records, etc. are maintained well.Partograph is recorded and filled-in completely in the labour rooms of visited health facilities.
- Visited facilities had basic amenities for patients like separate toilets for men and women, running water, sitting arrangement, etc. Facilities are patient friendly as ramps/side grills are available. Also, Colour-coded directional signage on the floor is used in various HCF for helping people reach the respective room/area as needed.
- HCFs are following colour coded bed sheets practice to ensure that these are changed on daily basis.
- The facilities had an arrangement for liquid waste management. However, the staff is not aware of sodium hypochlorite proportion and its duration of contact for neutralization of liquid waste.
- Periodic review of the progress of Quality Assurance programmes by DQAU or Quality Teams at facility not done. Only 01 SQAC meeting and only 25% DQAC meetings had been conducted in the FY 2019-2020. Non-utilization of available human resource pool [like internal assessors (177) and empanelled National External Assessors (8)] is seen.
- Under LaQshya, 426 facilities have been identified, out of which only 19 labour rooms & 5 Maternity OTs have achieved State Certification, whereas only 2 labour rooms & 1 Maternity OT are nationally certified. Quality Improvement cycles not initiated in all LaQshya facilities. Monthly reporting of LaQshya Indicators not being done.
- Quality Nodal Officer and one Quality Consultant are available at the state level, but posts are vacant at District level.
- Non-compliance to statutory requirements viz. Authorization for BMW, NOC for fire, AERB for X-rays, etc. is observed in most of visited healthcare facilities.DH Begusarai, didn't have a valid blood bank license for many years.
- Other gaps like- poor knowledge of quality tools and methods like PDCA, 5S, Mistake Proofing, non-adherence to SOPs, non-monitoring of KPIs, lack of audits or PSSs, weak GRS and poor training on infection control practices, fire safety & use of fire extinguishers, disaster management, basic life support (BLS) are uniformly seen across the state.
- All DH are integrated with Mera-Aspataal initiative but Patient Satisfaction Score are found to have declined from 48.09% to 43.06% at DHs. There is to need to examine this trend and take follow-up action.

Chhattisgarh

The State had achieved National Certification of 06 facilities under NQAS. It has also constituted the SQAC and DQAC, but regular meetings do not take place. No mentoring visits are conducted by the District Quality Assurance Team. Also, medical colleges in the state don't have any quality assurance programme.

- The state has a pool of 53 internal assessors and 3 external assessors.
- Signage, citizen chatter, layouts are displayed at most of the facilities. Programme specific IEC visibility is good all across the state and in the facilities.
- Liquid waste management system, Deep Pit and sharp pit seen across facilities.
- Authorization by Pollution Control Board exists for 57 out of 63 facilities in Rajnandgaon
- IEC about entitlements, BMW management, SOPs are found adequately on display in the facilities.
- Non-compliance of infection control practices is generally observed in all visited health facilities.
- Medical and death audits are seldom conducted at the visited district hospitals. Similarly, MDSR & Child death reporting and review is not being done.

- Non- utilization of funds received by Jeevan Deep Samiti (JDS) under the PM-JAY for quality improvement.

Delhi

- Strategic Information Management System (SIMS) is being used for reporting and Monitoring & Evaluation.
- Patient had very good experience in Mohalla clinics as the services are available at doorstep but ANMs drawing blood there is a wrong practice observed.
- In general community perception, about quality of care is found satisfactory. The State has also achieved NQAS Certification of four facilities.
- Quality assurance committees had been constituted in both visited districts. The state had recently hired 6 quality coordinators supporting various quality initiative programmes. The state had a pool of 95 internal assessors and 46 external assessors.
- Mera-Aspataal had been implemented in 31 public hospitals (28 GNCTD, 3 MCD) across 11 districts. The state had initiated 'Mera Sisthya Kendra app' wherein, patients can scan the QR code and can post their real-time experience at the health facility. Patient satisfaction surveys (PSS) done through MeraAspataal and "MeraSisthya Kendra" apps showed that he total time spent on consultation, examination and counseling is fair.
- Quality-circles are formed in all PUHCs (GNCTD), district hospitals and tertiary care centres in both districts. Internal and peer assessment for visited health facilities had been completed under NQAS and LaQshya.
- In most of the facilities, Citizens Charter and other programme related IEC are displayed. However, entitlements under JSY, JSSK etc. are not found well placed everywhere.
- Bio Medical Waste management from onsite segregation to final disposal is according to the norms across the facilities; however training of the staff in latest protocols is required. Also, Daily records are maintained while handing over the waste to CBWTF.
- Nearly all the facilities had a fire extinguisher installed and protocols for fire safety displayed. However, no disaster response training had been conducted.
- No Standard record keeping because of different service providers e.g. MCD, NDMC etc. there by multiple UIDs are created for a single patient.
- MDR and CDR are done, but pending cases seen. Maternal deaths and death audits are conducted, it is analyzed but no action plan prepared. Prescription audits not done.
- The quality of outsourced services like that of diet, linen and laundry etc.is not being monitored.
- OOPE to the extent of Rs 500-2000 observed due to non-availability of USGs, ECGs at secondary care level. Also, during community interactions, it is learnt that in a few of the urban slums (Todapur), ambulance services are not functional because of absence of complete address beneficiaries and patients had to incur expenses on transportation.
- The RKS meetings are not held due to rearrangements in the composition of the committee. Assembly RKS is yet to be formed in the state. RKS not formed at PHC equivalent health facilities leading to difficulty in day to day activities.

Gujarat

- The State has strategic 'Mission NQAS 151 facilities' for FY 2019-20inclusiveof 3 DHs, 3 SDHs, 1 CHC, 14 UPHCs and 130 PHCs. Till date Gujarat has 82 State Certified NQAS facilities
- The state had achieved National Certification of 11 facilities under the NQAS until September 2019, which includes 4 DHs, and 07 PHCs.
- Gujarat is the first state to achieve LaQshya certified facility in the country. Till date 30 Labour Room and 28 OT are LaQshya certified in the State and 153 facilities are targeted for LaQshya certification for FY 2019-20
- SQAC & DQAC have been reconstituted in the State and all the districts & regular meetings

are being conducted. However, no meeting is held in Dahod district in FY 2019-20.

- The state had 77 qualified internal and 35 external assessors for assessing quality of services.But none of the staff from the state has undergone PGDHQM course at the Tata Institute of Social Sciences at Mumbai- training supported under NHM.
- EDL list, Citizen Charters and IEC displays are available at almost all level of facilities. Drugs are found arranged systematically in most of the facilities visited.
- RKS are functional and regular meetings are being conducted in all the visited facilities.
- Bio-medical waste management is found satisfactory in most of the facilities visited. The state has outsourced the management of BMW to ''SAMVEDANA'' Common Bio Medical waste treatment facility, authorized by Gujarat Pollution control board.
- Complaint boxes are available, but the GRS is not in place. Likewise, "May I help You Desk" is not observed in the visited facilities. None of the facilities have initiated Patient Satisfaction Survey manually or through ''MeraAspataal'', except CHC Bardoli.
- Basic patient amenities for e.g. safe drinking water with RO, Toilets, and clean linen are found in the facilities.
- No out-of-pocket expenditures and informal payments are reported by the inpatient on drugs and diagnostics.
- Most of the facilities had installed fire extinguishers but, the staffs are not trained to use these extinguishers. Pest control measures are not found in any of the facilities visited.
- None of the visited facilities had initiated measuring KOIs under NQAS. Also, staffs are not aware about the usage of Quality tools (like PDCA, Pareto, mistake proofing, etc.)
- No standard treatment protocols available, prescription practices varied between facilities. The staff knew six steps of hand ishing, but knowledge about 5 moments of hand-ishing lacked. Most of the staff members are not vaccinated for Hep B and TT.
- External Quality Assurance Programme for Laboratories had not been initiated in any of the visited facilities
- The staff is aware of equipment processing protocols, but sterilization timing, recommended temperature and pressure are not known to most of the staff. Disinfection of equipment using 0.5 to 1% hypochlorite solution is practiced in most of the facility.
- Fumigation of OTs is observed with ''FORMALIN' in Dahod district', a practice no longer recommended for the fumigation. Similarly, demarcation of OT into protective, clean, sterile and disposal zone is missing.
- Management of sharp wasteis an issue in the state as mixing of needle and syringes is found in Zydus hospital, Dahod while records on sharp waste management are missing in other facilities.
- The State had been receiving incentives/ grant funds under Kayakalp, NQAS and SSS; however, staff had no clue on how and where to invest the funds.
- 21% of the patients from 1886 integrated facilities in ''MeraAspataal'' have reported unsatisfied with the treatment. Out of which 32% cited staff behaviour, 21% cost of treatment, 16% cleanliness and 31% other reason for dissatisfaction.

Jharkhand

- The state has achieved National Certification of 2 LRs and 1 Maternity OT under LaQshya.
- The state has a pool of 143 internal assessors and 3 external assessors. But, pace of implementation of quality programmes seems extremely slow.
- Despite having won Kayakalp awards, the districts have not focused on LaQshya. None of the facilities visited had District Quality Teams identified, no meeting minutes available and no follow up of the LaQshya internal assessment

reflecting a weak institutional framework for quality that needs to be strengthened on priority.

- Service providers at DH and CHC are immunized for Hep B.
- The community is aware ofthe services providedat the public health facilities. However;awareness about entitlements under various NHM schemes like JSSK, Free Drugs and Free Diagnostics is not there.
- Free drug and diagnostic services have been started, but all the drugs mentioned in EDL are not available in the facilities. Ultrasonography services are also available only at the district HQ and women bear OOP expenses on travel to get the Sonography done.
- Pre-treatment of laboratory and highly infectious wasteis being done at all levels of facilities. Though, liquid waste management system is not in place.
- BMW collection had been outsourced to a private provider- 'Medicare'. Colour coded bins are available in some facilities and waste segregation is being done, but disposal of BMW through CBMWTF had been an issue in the state. For e.g. at DH- alternate day collection of wasteis being done. At CHCs, there is no fixed schedule for waste collection and the provider collected waste twice/thrice in a week. The other facilities had deep burial pits for waste disposal.
- There is no system in place to conduct patient Satisfaction Survey, Prescription Audit, Medical and Death Audit. Community leaders expressed unhappiness over the poor behaviour of service providers in few health facilities.
- Infection prevention control/Hospital associated infections committees had not been created.
- There are two fire accidents in Gumla District Hospital SNCU in a span of two months due to short circuit reflecting poor adherence to safety norms.
- AERB certification is not available at DHGumla.

Madhya Pradesh

- The state has two Nationally Certified District level hospitals under the NQAS. State certified facilities include 10 district level hospitals, one civil hospital and one CHC. Number of facilities planned for the National Certification in the FY 2019-20 are15.
- 10 Labour Rooms and 10 Maternity OTs are LaQshya certified. The state has taken up 79 facilities for the LaQshya national certification in the FY 2019-20.
- The state had a pool of 248 internal assessors and 7 external assessors. Total 30 trainings including Internal Assessors, Service Providers training, Kayakalp etc. had been provided along with sponsorship for PGDHQM, TISS course. Though the state has substantial quality trained professional, progress made by the state under the NQAS seems to be trivial.
- DQACs and DQAUsare yet to be constituted and made functional.Though, 51 Hospital Managers post had been approved in the NHM ROP 2019-20
- Total 86 facilities are integrated with Mera-Aspataal, including 1 medical college and 51 DHs. However, the reporting is negligibleand the staff is not sensitised for the same
- Free drugs and diagnostics are available, but the drugs are not available as per the EDL. There is no out-of-pocket expenditure as reported by the patients and visitors.
- The state had developed and implemented MP-AMR (Anti-microbial resistance) policy. SOPs and guidelines for strengthening hospital processes as per NQAS are available, but the same had not been customized as per the scope of services at the respective facility.
- Records of fire safety mock drill are available at DH Chhindwara but fire safety licence is not available. Similarly, no training for disaster management is conducted.
- Provision of Diet as per the condition of the patient like separate diet for Diabetic orhypertensive patients is not provided.

- The policy for management of records in Medical Record Department is not available. No condemnation policy at the facilities is found at the visited health facilities.
- The PHCs and U-PHCs are not having the authorization certificate from PollutionControl Board for the operation of the sharp pits at the facility premises.
- The staff is not aware of the Quality tools and no training pertaining to the same had been provided to the facility staff
- The collection and transportation for the BMW management is undertaken by the outsourced agency namely; Krupa Istages but it is not done as per the protocols. Liquid waste management is another area of concern.
- The management of sharps and needles is not being done as per the protocol. Collection of needles in the hypochlorite filled container is still being practiced at both the DHs. Practice of burning needles in hospital premises is reported.
- Linen and laundry management is not adequate at DH Chhindwara. No sluicing of the laundry is followed. Trolley for transportation of the linen and laundry is not used. However, in DH Khandwa the laundry is working well observing all protocols.

Manipur

- Till date, the state had conducted 10 Internal Assessor and Service Provider training for NQAS training, 5 for Kayakalp and one state level LaQshya Training. The state had a pool of 119 internal assessors and 3 external assessors
- LR and Maternity OT of DH Bishnupur are LaQshya certified at the state level.
- State Quality Assurance Committee is formed and functional. At present, 2 State QA Consultants, 8 District QA Consultants are in position in the state.
- District Quality Assurance Committee for both Chandel and Bishnupur Districts areformed in 2018, but no meeting had been conducted since the formation of these committees.
- Difficulty in preparation of Documents required for NQAS Certification, such asSOPs, Quality Policy and Objectives, Quality Manual, etc. is brought out.
- Difficulty in improving the score in Quality Management which includes use of Quality Tools is observed. Government to support state in training Health care providers in this regard.
- **Mera-Aspataal** is implemented in medical college only (RIMS). The state is in the process of implementing it in all DHs, all CHCs and selected PHCs and HWCs. A system of collecting and analysing patient feedback is established in DH Chandel since March 2019. The Patient Satisfaction Scores ranged from 52% to 72%.
- In the SHC-HWCs at Chandel District, there is no system of taking patient feedback. However, during community interactions, it is learnt that the patients are satisfied with cleanliness of health facilities and behaviour of the service providers; and also they did not make any informal payment for availing the services.
- Segregation at the point of generation, Collection, Storage and record maintenance of the biomedical wasteis being practiced as per BMW Rules. Colour coded bins and bags are available except in few facilities. KPIs not monitored.
- In DH Chandel, DH Bishnupur, CHC Moirang, CHC Chakpikarong, PHC Komlathabi and PHC Oinam, an agreement had been entered with Shija Hospital for collection and disposal of healthcare waste in September 2019. But zero collection is done in DH Chandel and CHC Chakpikarong. Service is also poorly given at other HCFs.
- In the SHC-HWCs at Chandel, there is no linkage with CBWTF for collecting and disposing the istes, sharp pits are also not available.
- Regarding dietary service, there are no Kitchen in CHC Chakpikarong and PHC Komlathabi. Amount of Rs. 100/- for purchase of foodis given

per day to the mothers who had deliveries in the facilities.

- Liquid waste management is not in place. Hub cutter is used for disposal for needles. Also puncture, tamper proof bags for disposal of sharps are not found anywhere.

Meghalaya

- As on October 2019, 02 facilities; PHC Umden (Ri-Bhoi) & PHC Nartiang (West Jaintia Hills) are NQAS certified. State hadpool 50of internal assessors &8 external assessors.
- Institutional arrangements for Quality Assuranceare in place. One state and two Regional level consultants are responsible for 11 DQACs in the state.
- Plans for quality action at various levels are available. The state had also prepared a Gannt chart for tracking progress.
- The prescription audit is done at CHC Patharkhmah (Ribhoi district). Generic prescription of medicines is being followed. Maternal Death Review (MDR) is conducted regularly in both facility and community.
- BMW while segregation and collection is good, final disposal needs streamlining, especially as per the rules 2018. The staff handling BMW should undergo annual check-up as well as receive Hepatitis injection.
- The state has a skill lab setup in the state hospital (Ganesh Das hospital) funded under the NHM, the facility is observed to have complied with the DAKSH guidelines
- Despite a mammoth list of EDL (1374), drug list is not categorized as per the facility level. Due to poor logistics management system (number of warehouses, vehicles available for transporting medicines etc.), many essential medicines are not available in the hospitals. The same problem exists for consumables as well.
- All the visited facilities are found to be clean and well maintained. The facility staffs are found to be courteous and motivated. The system for maintaining medical records is very good.
- Good System of Medical Records Management with retrieval facility is available. DVDMS is only used by NHM doctors, not by directorates.
- Most of the visited hospitals had not got fire safety clearance. Infection control practices are an issue too. Effluent Treatment Plant (ETP) is not operational in both districtsRunning water, electricity and power back up, internet connectivity affecting many IT applications aremajor concerns across the facilities.
- The state doesn't have a SIHFW but has a regional institute set-up during the period of undivided Assam. The regional institute currently provides training only to regular cadre health staff and not the NHM staff.
- Diagnostic services at HWCs-PHCs, CHC and DH are provided by the state in collaboration with Krsnaa diagnostics under Public Private Partnership (PPP). A total of 51 free diagnostic tests (including HbA1c) are available under PPP at HWCs-PHC. Usually laboratory results are available within 1-2 days but delays up to 3 days in delivering laboratory report by Krsnaa diagnostics is also reported.
- Dietary services are outsourced at Rs. 100/ day and they provide meals, three times. The DH Nongpoh had an in-house dietary service working in a limited space. Efforts are made to ensure that food is stored, prepared and served hygienically.
- Mera Aspatal is found to be in use. However, data analysis is minimal. Call centre and helpdesk for Grievance redressal had not been established in all facilities. 'May I help desks' are also not available across the facilities
- The infection control practices- Use of autoclave, Zoning in OT, CSSD and Mechanized laundry, SOPs, needs improvement. Could see wide use of Cheatle forceps holders, which is not recommended these days

Mizoram

- The State had achieved National Certification of 2 health facilities under the NQAS.

- Civil Hospital Aizawl & ITI UPHC are NQAS Certified. The state had a pool of 28 internal assessors and 3 external assessors
- The overall infrastructure of the facilities is as per protocol with clean and functional toilets, drinking water, branding, adequate space for conducting the examination in privacy, no cracks, seepage and water logging within the facility and outer premises.
- The IEC related to BMW management is well in place at the facilities. The staff is aware of the segregation rules of BMW, but other protocols like pre-treatment, use of personal protective Equipment and annual health check-ups are not followed
- The health facilities had sharp pits but for the disposal of other anatomical waste they are using locally designed incinerator the effectiveness of which is not known.
- The quality teams for quality assurance, BMW Management, etc. are not constituted. Even the meetings of quality teams that are formed or of RKS are conducted too infrequently, the last being in NOV 2018.
- Documentation throughout the facilities below district level is poor, standard registers are not being used. Unavailability of signage for guidance of patients to access the services seen.
- Biomedical waste authorization is not available for some health facilities under State Pollution Control Board
- Out-of-pocket expenditure is reported due to irregular supply of medicine and travel cost from village to HCFs. Any other kind of expenditure or informal payment is not reported.
- Facility wise Essential Drug List is not present, and the documentation related to dispensation is not maintained. Even citizen charter is not displayed at all the facilities.
- Continuity of care is a major challenge for all the facilities of District Mamit because of difficult terrain and road conditions as well as non-availability of transport facility.
- Referral mechanism is inadequate as National Ambulance Service (NAS) programme is not implemented in DH,Mamit. Only a BLS Ambulance donated by TATA Trust is there.
- The prescriptions are not as per Standard Treatment Guidelines and branded drugs are prescribed. No audits- prescription, medical and death are being conducted.
- Though health care workers are aware about the preparedness plan to manage disaster, the facilities are lacking the action plan or trainings to deal with emergencies.
- Staff is not aware about quality tools like PDCA and 5S.

Nagaland

- District Quality Assurance Committees (DQAC) had been constituted at District level in Phek and Kiphire, but quality teams are not constituted at CHC & PHC level.
- The state had a pool of 54 internal assessors and 3 external assessors. Internal Assessment score of DH, Phek is 35% as per NQAS and LaQshya.
- The cleanliness at all the facilities visited is satisfactory. All the visited facilities had a 'Complaint and suggestion Box' in place. But, an integrated call centre for the grievance redressal is not available in the State.
- Client satisfaction surveys are done monthly. Also, Kiphire District is conducting medical and death audits at District Hospital level but not below.
- EDL, Citizen Charter displayed at HWCs with OPD timings & contact details of PHC team. DVDMS not functional in state
- Colour coded bins for biomedical waste management are found in all the visited facilities
- Sharp pits and deep burial facility are available near the facilities. The staffs are not aware about the biomedical waste management rule at SCs and PHCs in both the districts. Most of the districts did not have linkage with

the Common Biomedical Waste Treatment facilities.

- Facility staff are not aware about the Quality improvement tools and methods including PDCA, 5S, Mistake proofing, Pareto etc.
- Awareness and practices of QA related activities like Patient Satisfaction Surveys, Prescription Audits, Standard Operating Protocols (SOPs) etc. are found lacking at all the facilities visited. None of the facilities are reporting its KPIs.
- Mera-Aspataal initiative had not been implemented in the State due to poor internet connectivity.

Odisha

- The State had achieved National Certification of 06 facilities under the NQAS. Five LRs and Maternity Operation Theatres had been certified under the LaQshya.
- The state had a pool of 97 internal assessors and 8 external assessors. DQAC meetings are being conducted regularly.Quality policy with all SOPs and minutes of meetings are available at Mayurbhanj District
- EDL, IEC &Citizen's Charter had been displayed outside the health facilities of all levels and Help Desk for addressing the concerns and complaints had been institutionalized in both the districts of Mayurbhanj and Kandhamal.
- Most of the facilities are clean, medicines and had separate male & female toilets. However at DH cleanliness is hampered by spitting behaviour of population, despite penalty imposition. Also, at CHC Barasahi, it is observed that there is community unrest regarding drinking water, toilet and non-availability of specialists
- Behaviour and attitude of staff towards patients is supportive and good. The total time spent on consultation, examination and counseling is fair and similar findings are reported from the Patient Satisfaction Survey (PSS)
- MeraAspataal is functional at the level of the district. Patient feedback is being taken and uploaded on the MeraAspataal.
- RKS is constituted, the meeting being done, and funds utilised properly
- The prescription audit had been done regularly and revealed that drugs are prescribed by generic names as per standard treatment guidelines from EDL only
- The managerial staff had sound knowledge on PDCA, Pareto principle, 5S, etc. However, except the managerial staff no one else could explain it.
- Maternal and Child Death reporting and audits are conducted regularly with the help of district officials in both the districts. However, data had not been analysed to identify the causable factors
- Laundry service at DH Mayurbhanj had implemented colour coded bed sheets that are changed daily. But overall, the laundry & dietary services needimprovement as these are not as per the GOI guidelines in both the districts.

Poor hygiene status of the kitchen is observed in DH Kandhamal.

- At district Kandhamal, BMW management segregation, collection, transport and storage is being followed as per the latest BMW guidelines. However, in Mayurbhanj the practice of common storage area is not being followed as per the guidelines.
- The Staff handling biomedical waste at PHC is not provided with puncture proof gloves and other protective equipment and are also not trained to manage the liquid waste in both the district.
- The District hospital and other facilities of Kandhamal had fire extinguishers installed with date of expiry and licensing; however, at Mayurbhanj the health facilities visited didn't have license. Training of health facility staff in operating the fire extinguishers or in Infection prevention protocols is not done.
- No user charge is being paid by the patients. However, drugs stockouts did happen that led to OOPE.Even USG services are not available at SDH of both districts, so patients are utilizing private labs for the same. OOPE also occurred for Thyroid tests during antenatal period.
- Overcrowding in medical, paediatric, obstetric wards and SNCU/NICUs seen with more than one patients per bed which needs urgent attention
- Key Performance Indicators are not being calculated and recorded periodically
- The visited health facilities lacked Geriatric and Divyaang friendly structures

Rajasthan

- The implementation of Quality Assurance program is weak as only 3% facilities have attained NQAS certification. The LaQshya certification of both the DHs remains conditional even after time gap. The state had a pool of 270 internal assessors and 8 external assessors
- Presently, NQAS is implemented in all DHs, SDHs, 108 FRU CHCs, 295 Adarsh PHCs, 6 facilities covered under Model Health District (3-CHCs & 3-PHCs) and in all Kayakalp award winning facilities. The state has a vision of NQAS certification of at least one facility in each district
- While SQAC and DQACs had been formed and meetings are conducted, the Minutes of the Meetings broadly suggest lack of much needed push from authorities to attain the required standards.
- Awareness and display of Quality tools and methods e.g. PDCA, 5S, Mistake proofing, Pareto etc. for quality improvement are observed at CHC Sahawa (NQAS certified facility in Churu).
- MeraAsptaal is being integrated in a phased manner. Visited districts, Churu and Sirohi are not part of first phase. Though, Patient feedback system had been implemented in both the districts.
- Key issues observed in certified facilities arelack of proper drug inventory system at Shivganj CHC, piles of garbage adjacent to Arathwada SC/HWCs and conduct of Family Planning counseling sectionamidst waiting area without any privacy and confidentiality.
- The facility records had several entries for an individual patient for various services, however as per the beneficiary feedback, no such services are being availed by the beneficiary.
- During the visit, it is observed that the facilities had limited outreach amongst the community, especially amongst the marginalized and vulnerable communities.

Tamil Nadu

- The State had a total of 50 quality certified facilities under the NQAS, which included 12 DHs, 05 SDHs, 12 CHCs and 21 PHCs. All CHCs and Additional PHCs in the districts had started undergoing baseline assessment for the NQAS.
- Likewise, State had identified 188 facilities for the LaQshya certification, of which 06 are nationally certified, 66 State certified and 20 had already applied for national certification.

- The state had a pool of 339 internal assessors and 30 external assessors.
- The SQAC and DQACs in the visited districts had been formed and meetings are held on a regular basis however dedicated quality assurance officials are not present in the districts.
- All patient centric facilities like clean surroundings, gardens, designated areas for meditation and yoga, clean linen on the beds, clean toilets and safe drinking water are available.
- In both visited District Hospitals “May I Help You” boards, Citizens charter and information regarding services is displayed in the hospital.
- “MeraAspataal” (My Hospital-My Pride) had been implemented in all District headquarters hospitals in the State. The Suggestion Boxes are available in visited health facilities but are not opened at regular intervals in some PHCs.
- Support services like Linen, Dietary, Housekeeping and Security services are in place and are outsourced. As a good practice, apart from serving three meals a day, a special diet of egg and milk for antenatal patients and kunjee for fever patients is also given in Virudhunagar DH.
- Fire Extinguishers are available in all HCFs. Protocols for fire safety and fire exit signage are prominently displayed in the DHs. Mock drills for disaster and fire had been conducted.
- Need based trainings like Bio-Medical Waste Management, Infection Control, etc. are conducted regularly. Prescription audit are conducted regularly and analysed.
- Patient Satisfaction Survey is conducted in prescribed format for Indoor patients only, and the feedback is analysed at regular intervals to enhance patient satisfaction

- In both districts, maternal and infant death audits are being conducted and the District Collector reviewed the maternal death audit every month. Child Death/ Stillbirth review is done by representative sampling assessment at the State and all female deaths are treated as foeticide.
- SOPs are available and followed in DHs and records of the same are maintained.
- Report on KPIs as a part of Quality Assurance programme is maintained and updated every month in visited DHs. There is a regular review on all indicators for further improvement
- Bio Medical Wasteis segregated at source, collected and kept in the BMWM room daily. Outsourced Common Treatment Facility (CTF) collected the biomedical waste from BMW room under the supervision of Nursing Supt. and Hospital worker.
- All the personnel handling bio-medical wasteare provided with the protective equipment, immunization (against Hepatitis B, Tetanus and Diphtheria). Annual reports of BMW are being sent to the SPCB/PCC (by July-October). The facility had not started using bar-coded trash bags as they are not being provided by the operator yet.
- The RKS (Patient Welfare Society) registration had not been renewed for years in most health facilities visited; the last renewal ofVirudhunagar DH is done in 2007. The involvement of the community as representatives of the RKS is inadequate.

Uttar Pradesh

- The State had7 NQAS certified district hospitals. 03 Labour rooms and 2 Maternity Operation Theatres had been certified under LaQshya. 40 facilities for NAQS certification and 80 for state level assessments had been targeted in financial year 2019-20.
- The state had a pool of 295 internal assessors and 28 external assessors.
- Facility based grievance redressal mechanism (Suggestion/complaint box, register, online complaints, patient feedback form, help desk at DH) is functional which is commendable. Community/Patient reported no expense for availed services such as drugs, diagnostics and consultations in the public health facilities at all levels- DH, CHC, PHC, UPHC. However, USG facility in public health sector is available at DH level in both the districts
- However, ASHAs in Bahraich claimed that the duty sister charges an amount up to Rs 400/- for delivery and support staff charges Rs 100/- per patient in the district hospital.
- Uncourteous and rude behaviour of the district women hospital Bahraich had been an area of concern. The hospital is trying to improve the situation by organising regular orientation and through individual tracking using an online google application.
- Most of the policies andSOPsunder quality assurance are available at the facilities but their implementation had been an area of concern especially in Bahraich.
- Applications for fire safety licence for all public health facilities in Meerut and Bahraich are pending except for the DWH, Bahraich. Calibration of the new equipment is yet to be done at the DWH Bahraich.
- The infection control practices at the critical areas of the hospital like labour room and OT needed improvement.In Urban PHC Bakshipura (Bahraich), placenta is being transported to other urban PHC for disposal. A support staff carried the waste on bicycle as and when the delivery is conducted.
- The contract for collection of the biomedical waste done for District hospital and Community Health Centres only.The BMW vehicle collected waste once in 2 days in the district hospital Bahraich, where around on average 28 deliveries are conducted daily.
- Rogi Kalyan Samitis are not constituted and registered at the PHC level in rural areas. The untied fund for the concerned PHCs is received by the RKS of the adjoining CHC. The RKS of DH, Bahraich is not functioning due to change

in its governance and institutional mechanisms as the hospital had been taken over by the medical colleges

Uttarakhand

- The State had 1 nationally certified facility namely; Chain Rai Women District Hospital under NQAS and LaQshya program. Baseline assessment of all PHC's is done and submitted to the state.The state had a pool of 112 internal assessors and 3 external assessors.
- District Quality Assurance Committee operated on adhoc basis. As per the Minutes of Meeting recording, discussions during the DQAC meeting focused majorly on FP.
- EDL, Citizen's charter and IEC display are observed at all levels of care and 'Help Desk' for addressing the concerns and complaints had been institutionalized in both the districts
- Laundry and dietary services are not as per GOI norms in almost all the facilities. Lack of standard BMW management practices seen at HWCs, PHCs and CHCs.
- Significant Out Of Pocket Expenditure (OOPE) is borne by patients across all facilities at all levels. User fees on OPD slips, admissions, diagnostics, investigations (CXR), referral transport are considerable. Urine pregnancy test (UPT) is chargeable too. Pregnant women bore non-medical costs (travel costs up to INR 1000) for getting the free compulsory USG prescribed once during the ANC period
- The perception of the community regarding health services is found to be non-satisfactory.
- The patient feedback form is either not filled or available at the facilities visited. Also, there is no provision of internal analysis of the duly filled forms and plan of action for the same.

National Overview: Kayakalp

Kayakalp is a scheme for recognition of those health facilities, which demonstrate excellencein upkeep, infection control, waste management, support services, hygiene & sanitation and

cleanliness beyond boundary wall. Started with DHs level facilities in the year 2015-16, Kayakalp is extended to Health & Wellness centres in all States/ UTs in the year 2019-20. Since cleanliness of the health facilities has a major bearing on the overall patients experience and treatment outcomes, 15% weightage has been allocated to patient's feedback on cleanliness in the DH category facilities (as captured on the 'Mera-Aspataal portal) and it is used while deciding overall ranking of the facilities.

Number of facilities participating under Kayakalp has increased from 750 in year 2015-16 to over 26,000 facilities in Year 2018-19. Number of facilities getting Kayakalp awards has also increased from 97 in the year 2015-16 to 4820 in the year 2018-19 which includes 395 District Hospitals, 1140 Sub-divisional hospitals/Community Health Centres, 2723 Primary Health Centres and 562 Urban Health facilities.

Key Findings

- Although, the states are participating in the Kayakalp scheme every year from DH to PHC level, it is observed that all UPHCs/PHCs are still not participating and working towards achieving minimum 70% Kayakalp score on external assessment.

- The states of Mizoram (78%), Gujarat (45%) and Delhi (32%) have made significant progress under Kayakalp.
- The states of Bihar (1.3%), Uttar Pradesh (3.53%), Madhya Pradesh (5.19%) and Jharkhand (5.64%) should undertake more efforts to get more health facilities, scoring 70% or above under the Kayakalp scheme.
- Incentivized money awarded to winner health facilities under Kayakalp scheme is not given in some states like in Andhra Pradesh
- Out of 16 CRM States, states of Meghalaya and Uttarakhand did not extend Kayakalp initiatives to urban health facilities.

Recommendations

- Inclusion of Health & Wellness Centres in the scheme needs to be ensured.
- All health facilities need to be integrated in the 'Mera-Aspataal' portal and users' feed-back in terms of level of cleanliness needs to be analysed for addressing concerns of the patients and their attendants. Kayakalp score of DH level facilities should have 15% weightage ofthe cleanliness.
- Kayakalp winner facilities in 2018-19 may be targeted for the NQAS certification.
- All states are required to ensure that every facility undergoes at least one peer level assessment in a year.
- Ensuring sustenance of the gains achieved after attainment of Kayakalp Awards through periodic monitoring and supportive supervision.

State Specific Findings

Andhra Pradesh

- Visited facilities are found neat and clean and had good Kayakalp score on external assessment. In FY 2018-19, 171 health facilities got more than 70% Kayakalp score (38 DHs/ SDHs, 43 CHCs, 53 PHCs & 37 UPHCs).
- Kayakalp winner facilities had not received previous year's award money, although the same is approved and released under the NHM ROP.

Bihar

- All the visited facilities are found neat and clean.External assessment under Kayakalp for Financial Year 2019-20 is under process.
- In the State, 3 DHs, 5CHCs, 13 PHCs and 8UPHCs had achieved 70 percent or more score under Kayakalp scheme in FY 2018-19

Chhattisgarh

- All the visited facilities had good IEC display, hand ishing and infection control practices.
- In financial year 2018-19, 5 DHs, 18CHCs, 79 PHCs and 6 UPHCs received Kayakalp award

Delhi

- In 2018-19, a total of 98 health facilities scored more than 70% under the Kayakalp

(27 DHs, 1 SDH and 70 UPHCs)Peer and external assessments of health facilities are in progress.

- Facilities visited are mostly clean and patient friendly, some facilities have been awarded Kayakalp Award.

Gujarat

- In FY 2018-19, a total of 1006 health facilities received Kayakalp awards.
- The state has completed external assessment of all level of facilities and about 1243 facilities have achieved more than 70% in FY 2019-20. However, Kayakalp assessment team didn't include representatives from outside the government as recommended in the guidelines.
- The State has conducted one TOT for ''Swachh Sisth Sarvatra''. A team of 3-master trainers from each district (inclusive of DQAMO, RMO, CHC Superintendent) has been formed to impart trainings

Jharkhand

- Out of 23 DHs, 200 CHCs and 330 PHCs under the Kayakalp in the state, only 5 DHs, 6 CHCs and 19 PHCs met the Kayakalp criteria and are awarded in FY 2018-19.
- The state should undertake proactive approach to target more health facilities under the Kayakalp for achieving70% score on external assessment
- The State did not extend Kayakalp initiatives to urban health facilities.

Madhya Pradesh

- A total of 26DHs, 30 CHCs, 31 PHCs and 3 UPHCs had scored more than 70% under Kayakalp scheme in the FY 2018-19
- Although, all the facilities including 1 DH, 4 CHs, 11 CHCs, 67 PHCs and 2 U-PHCs of District Chhindwara and 1DH, 1CH, 7 CHCs, 29 PHCs, 2 U-PHCs of DH Khandwa underwent assessment under Kayakalp Program in the FY 2018-19 but the awareness pertaining to the implementation of the same is found to missing especially in the PHCs and UPHCs in both the Districts.
- The internal assessment of most of the facilities had been completed for the FY 2019-20
- 243 CHCs in the ODF Blocks have received Rs. 10 Lakh under SSS scheme for improving the cleanliness and hygiene at the healthcare facilities and achieving the Kayakalp award. 26 CHCs among these had received Kayakalp awards.

Manipur

- In FY 2018-19, a total of 119 health facilities participated in Kayakalp and37 facilities (31% - 4 DH, 3 CHC, 30 PHCs (including 2 UHC)) received the awards.
- Swachh Sisth Sarvatrahadn't been implemented in the state.

Meghalaya

- For financial year 2018-19, 25 facilities (4DHs, 3 CHCs and 18 PHCs) are Kayakalp awardees.
- For the year 2019-20, the internal assessment has been completed and peer assessment is in progress.

Mizoram

- The state had made good progressunder the Kayakalp. 8 DHs, 5 CHCs, 49 PHCs and 5 UPHCs hadreceived Kayakalp awards in the financial year 2018-19
- Assessment for the current year is in progress.

Nagaland

- In the State 5 DHs, 4CHCs, 20 PHCs and 4 UPHCs had received Kayakalp awards for the year 2018-19.

Odisha

- A total of 6 DHH (18.8%), 5 SDH (15%), 43 CHC (3.1%), 86 PHC (6.9%) and 42(47%) UPHC had qualified for the Kayakalp award in the year 2018-19.

- CHC Tikabawli has been awarded as the best CHC in the district Kandhamal under the initiative. In Mayurbhanj CHC and SDH had received Kayakalp award since last 3 years and both facilities had applied for the LaQshya certification.
- PHC-HWC Guttingia has been awarded commendation prize under the Kayakalp initiative

Rajasthan

- The State has implemented Kayakalp programme in all health facilities of State (except in Hospitals associated with Medical College). Total 10 DHs, 03 SDHs, 57 CHCs, 119 PHCs and 16 UPHCs had qualified for the Kayakalp award in FY 2018-19.
- The State has also launched a Kayakalp portal in 2016 for better and real time monitoring of the programme. The software is being used by the state for implementation of programme as all the health facilities upload the filled Kayakalp checklists through the portal only. Based on input automatic ranking of the facilities is generated which is available on the portal.
- As compared to the state, District Sirohi has performed better in terms of its 80% facilities scored above 70% in peer assessment

Tamil Nadu

- 521 facilities have received the Kayakalp award and certification in the State (24 DHs, 70 SDHs, 158 CHCs, 218 PHCs, 47 UPHCs and 4 UCHCs)
- The state has included all urban health facilities in the current FY.
- In 2018-19, 6 health facilities from Virudhanagar HUD and 14 from Sivakasi HUD got more than 70% score on external assessment.

Uttar Pradesh

- A total of 69 DHs, 46 CHCs, 66 PHCs and 03 UPHCs had received Kayakalp awards for the year 2018-19.
- PHC Jauhra (Score-76.9), Chittora block in Bahraich district and District Women Hospital Meerut (Score-75.4%) won Kayakalp awards in FY 2018-19
- Rainwater harvesting system at the PHC Jauhra with a soak pit is also in place but requires maintenance.
- All facilities-CHCs, PHCs and UPHC conduct quarterly internal assessments followed by peer reviews.

Uttarakhand

- In the State, 10 DHs, 11CHCs and 25 PHCs had been declared Kayakalp winner for the year 2018-19
- District Female Hospital Haridwar (84.5%) is the winner for Kayakalp Award in Uttarakhand and SDH Roorkee (86.5%) is the winner for Kayakalp Award in CHC/SDH Category in the FY 2018-19
- The State did not implement Kayakalp initiatives in urban health facilities.

TOR 8: HUMAN RESOURCE FOR HEALTH

National Overview

The health workforce constitutes the backbone of health systems and their contribution is imperative for ensuring delivery of quality healthcare. No country can achieve its health goals in the absence of effective, accountable and efficient human resources. Improving coverage and enabling positive outcomes of health services require skilled, competent and motivated workforce. There is vast evidence to suggest a correlation between improved availability of skilled healthcare providers and decline in key mortality indicators such as the MMR, IMR and U5MR.

This TOR reviews the contribution of the National Health Mission in improving and transforming the situation of the HRH in the country. It seeks to identify the existing bottlenecks and imbalances related to human resources for health that affect the health systems. The progress is reviewed on three parameters: *Availability of Human Resources, Workforce Management and Capacity Building*.

Key Findings

Availability of Human Resource

Sanctioned Positions

- It is observed in most states that the sanctioned posts are not as per IPHS norms. For instance, there is no sanctioned post of a dental surgeon at CHC level in Uttar Pradesh. Dental OPD is being conducted by a dental hygienist alone, thereby affecting the range and quality of services.
- Unavailability of sanctioned posts as per standards has also resulted in irrational deployment of existing staff. For example, some states have posted ANMs at CHCs and District Hospitals to meet the shortage of staff nurses there. This, in turn, hinders service availability at the sub centers (SC) and PHCs.

Recruitment Process

- Non fulfilment of vacant posts due to delay in recruitments is rampant across states. Major reasons cited for this includepending court cases, administrative issues such as involvement of different stakeholders, absence of a separate specialist cadre, centralised recruitment process leading to time overrun, low salaries and remoteness of health facilities.
- Vacancies, due to this, are observed both under regular cadre and NHM in case of Specialists, Medical Officers (MBBS), ANMs, Staff Nurses as well as other paramedical and programme management staff. Inadequate staffing leads to overburdened Human resources, resulting in attrition. Also poor employment opportunities and other associated factors in home states causes migration of skilled workforce to other states in search of employment as seen in Chhattisgarh.

- Many states have devised their in-house strategies to address HR concerns such as - Uttar Pradesh, Bihar, Jharkhand, Rajasthan, Madhya Pradesh and Uttarakhand have engaged HR agencies to support and assist them in large scale recruitment of contractual HR on time. Similarly, Nagaland has adopted a simple recruitment process under NHM, where in the state is able to fill almost all vacant posts, except specialists, within three months.
- Other Strategies such as absorbing NHM employees in regular cadre in Tamil Nadu and giving preference/weightage to NHM employee during recruitment under regular cadre in Uttar Pradesh, AP, Mizoram and Rajasthanhave also been adopted to attract and retain HR.
- Several initiatives are also being taken by some states for ensuring availability of medical officers and specialists such as walk-in-interviews (in Odisha, Nagaland, Uttar Pradesh, Gujarat, Madhya Pradesh), engaging specialists through bidding process (in Uttar Pradesh, Uttarakhand, Jharkhand),using District Mineral Fund (DMF) and corpus fund for bidding process in Odisha, and empanelling part-time specialists through state initiated scheme 'CM Setu' in Gujarat.
- Despite the continuum of efforts,challenges pertaining to recruitment and retention of skilled HR remains. The data on recruitment carried out through empanelled agency in Uttar Pradesh shows that joining letter is issued only against 47% of the posts advertised; while the number of persons who joined the system is even lower. The specialists hired through bidding process primarily constituted of retired government doctors. In Gujarat, attrition rate both among empanelled specialists and contractual NHM specialists is high. There is a need to further explore the possible reasons.

Quality Concerns

- Competency-based skill tests have been initiated for recruitment of frontline workers, staff nurses and paramedical staff in Gujarat, Madhya Pradesh, Odisha and Jharkhand to ensure optimum quality recruitments.
- Uneven distribution and irrational postings, of the health workforce is a challenge especially in hilly states such as Manipur, Meghalaya, Mizoram, Nagaland. This leads to subpar quality of service delivery.
- At the community level, absenteeism of staff from the health facilities is highlighted as one of the major challenges in availing the services at public facilities in some states. These issues are leading to significant financial burden to the families and a decrease in health-seeking behaviour amongst the communities.

Workforce Management

Comprehensive HR Policy

- A comprehensive HR policy, that can help the state and districts managers perform functions at different levels in a coordinated and synergistic manner, is presently lacking in most states. Madhya Pradesh, Odisha, Tamil Nadu and Nagaland has State HR policies or guidelines. Among other states, Uttar Pradesh is in the process of finalizing the HR policy and implementingit.

Retention and Distribution of HR

- Retention of HR at all levels especially- medical officers and specialists is a challenge in most states. Major reasons cited during interactions with staff are disparity in the remuneration& working hours, delay in release of salaries and incentives, unavailability of basic amenities and staff quarter, lack of security at workplace, lack of recognition for good work and lack of career progression.
- To attract & retain HR in rural and remote areas, states have adopted several strategies. For e.g. Nagaland, has categorized its geographical area into A, B, C categories and higher compensation is paid to staff in category C districts (most difficult).Similarly,states like Tamil Nadu andOdisha are providing some weightage of rural/tribal area postingsor of a fixed duration posting in public health facilities, in the PG entrance examination to MBBS

doctors. In Uttarakhand, the Medical Officer in charge working in 24-hour shifts gets an incentive of INR 1000 per duty.

- Moreover, Tamil Nadu and Odisha have devisedcareer progression pathways for the NHM staff for long-term retention. In Odisha, the state has introduced Dynamic Assured Career Progression(DACP) Scheme for Medical Officers providing them with three assured promotions i.e., after 7 years, 14 years and 21 years of service counted from the direct entry level.

HRMIS (Human Resource Management Information System)

- States like Delhi, Gujarat, Odisha, Tamil Nadu have implemented HRIS (Human Resource Information System) which captures staff data and is linked with salary, generation of payslip, managing transfer, posting the staff, leave management module for the service delivery and program management. In Rajasthan, the state has developed (CHRIS) Computerized Human Resource Management System to capture the data of NHM contractual staff and now is in the process of developing another Human Resource Information System (HRIS) with NIC for the regular staff. Meghalaya has also initiated implementation of HRMIS.

Rationalization of Human resources

- There is a felt need of salary rationalisation of staff working under different programmes in many states. For e.g. High attrition of service delivery staff is reported in Delhi due to the difference in salaries between the staff in the same cadre working under different national programmes. Disparities between regular and NHM staff not only in terms of salary but also in work load is noticed in some states like Nagaland.
- In Uttar Pradesh, the district ROP has segregated the NHM-HR under different programmes both in service delivery and under program management.

Performance Appraisal

- Annual performance appraisal of NHM staff is carried outin Gujarat and Madhya Pradesh and appears to be more structured as compared to other states. However, minimum performance benchmark has not been implemented in any of the states visited.

Capacity Building

Orientation and Training Schedules

- Few States such as Manipur, Mizoram, Odisha and Tamil Nadu organise orientation training for newly recruited staff. However, most states still do not prioritise induction training programmes, resulting in inefficient use of available Human Resources and reduced productivity.
- Monthly training plan is developed at State and District level for both regular and contractual staff in states of Andhra Pradesh, Odisha, Tamil Nadu and Gujarat but yearly training calendar and plan are not charted out in most states.

Training infrastructure and other resources

- Lack of proper infrastructure hinders quality training. In states like Mizoram and Nagaland, there is no training site at the district level. There is also a limited pool of trainers available in the state.The dilution of training content and number of days is noticed in Nagaland resulting in substandard quality of training delivery as evidenced from participant feedback.
- Appropriate utilization of development partners for the training of service delivery staff is seen in Bihar. The quality of teaching and training conducted for the health workforce of Odisha, Tamil Nadu and Andhra Pradesh is well reflected in the knowledge, attitude and practice of the healthcare delivery staff.
- However, the training conducted for service delivery staff of Nagaland, Chhattisgarh, Delhi, Mizoram, Gujarat and Jharkhand is ad-hoc and inadequate. Training institutes such as Institute of Public Health in Jharkhand are not functioning optimally.
- Training Management Information System (TIMS) has been integrated with HRIS in Odisha; but in Rajasthanthere is lack of interoperability between TMIS and CHRIS.

Recommendations

- There is a major gap in availability of HR as per IPHS norms in most states. Since the number of posts sanctioned in many of the facilities are developed prior to IPHSthese are mostly on ad-hoc basis or programme specific. It is pertinent that the states create the sanctioned number of posts as per IPHS norms and at least meet the minimum criteria.
- Necessary measures to fast track the recruitment process needs to be taken. States must also ensure availability of required infrastructure and enabling working environment prior to recruitment or posting of HR to the health facilities.
- Training of the Medical Officers by starting/ enrolling them in DNB/CPS courses or other courses is required to fulfil the scarcity of specialists& to provide career progression opportunities. Engagement of private practitioners to strengthen secondary care services is desirable.
- A robust HR policy must be developed by all the states including the entirety of HR lifecycle. It is also essential to set-up an HR management cell. The cell should be responsible for coordinating with different programme divisions and manage HR starting from planning, recruitment, and management till exit. The personnel for this cell can be identified from the existing pool of competent Human Resource.
- All states should have separate specialist cadre so that the PG doctors get entry in the system at a higher rank and salary. NHM provides flexibility in order to ensure availability of all type of specialists in public facilities as per IPHS. The “you quote we pay” scheme can be explored to the fullest and other initiatives such as CM Setu adopted by Gujarat can be evaluated to assess its adequacy in recruitment of specialists.
- States must have an integrated HRMIS, capturing details of all regular and contractual staff. A comprehensive real time data on HRH can also help the states in dealing with issues related to irrational deployment.

- The TMIS/ Training module should be integrated with HRMIS. The system must have provision to generate salary slip, linked to transfer and posting, record performance of staff, and skill gaps so as to enable the states to plan for need based training modules.
- Apart from implementing HRMIS, it is essential that HRIS is used as a planning and monitoring tool by the planners, decision makers, HR managers and programme officers.
- Improved retention strategies should be adopted by states to sustain skilled HR, especially in remote and rural areas. Monetary and non-monetary incentives that have been successfully adopted by other states such as timely release of salary and incentives, fixed tenure posting, linking experience of remote/ difficult/ tribal areas to post graduate entrance, providing suitable working and living conditions, support for continued learning, recognition for good work should be explored.
- Rationale utilization of funds through proper planning for recruitment purpose (new staff/ filling vacant position). This is the only way to scale up National programmes, staff satisfaction by dividing work load, better work culture, and distribution of responsibilities.
- States need to devise ways for timely and appropriate recognition of its healthcare staff, especially the frontline workers to keep them motivated.

State Specific Findings

Andhra Pradesh

- The staff at all public health facilities i.e. doctors, nurses, ANMs, laboratory technicians, others are committed, hardworking and confident and facilities open as per scheduled timing (UPHC 8 AM to 12 Noon and 4 PM to 8 PM)
- The state has shortage of staff at all cadres such as Medical officers (35%), Specialists (40%), consultants (30%), Staff Nurse (22%), Mid-Level Service providers (54%), nearly 50% Paramedical staff, & lab technicians..
- State has selected young women with BSc Nursing for the role of MLHP, who are provided with 6 months training. The standard of training is also found to be high for the MLHP & ANMs.
- HRIMS is implemented but there is lack of interoperability between Training Management Information System (TMIS) and HRMIS
- No dedicated Specialist Cadre or Public Health cadre and all Medical Officers are hired at the same rank. During recruitment in regular services, the state gives additional weightage to candidates from NHM with minimum service of five years.
- No clear HR policy is in place either for permanent or contractual staff. There is no dedicated HR cell and need-based departmental orders are issued to facilitateworkforce management.
- HR task distribution is skewed leading to inefficient or improper work sharing. Also, e.g. MO is doing finance work. Non- availability of residential facility is another concern hampering provision of 24*7 care at health facilities. Dissatisfaction noticed among contractual staff on emoluments.
- Overall people are satisfied with the services provided at public health facilities, but instances of poor staff behaviour, inadequate treatment at PHCs and infrequent visits of ANMs in remote villages forcing villagers to take treatment from quacks are reported in few PHCs e.g. SC Burra and Village Chappadi.

Bihar

- The State has hired an HR agency for recruitment process. It has also initiated a review of the sanctioned posts to identify unnecessary posts, especially under program management for rational hiring & deployment of HR.
- In-principal approval for a public health management cadre has been obtained.
- HR rationalization is being done at district level to ensure operationalization of upgraded facilities.
- Development partners are being utilized for training of service delivery staff in some districts.

However, regular training for all cadres of staff and supportive supervision of ANMs and ASHA facilitators is found to be a weak area.

- Longstanding vacancies of key programme management (PM) staff like District Planning Coordinator (DPC), District Community Mobilizer (DCM) seen, affecting overall implementation of programmes e.g. implementation of communicable disease control programs is poor throughout Bhagalpur district, due to non-availability of technical staff such as District Epidemiologist, VBD Consultant and IDSP data manager.
- A meticulous system for annual performance appraisal of NHM staff using Minimum performance benchmarks/ key performance indicators (KPIs) remains missing.
- Staff interviews revealed lack of recognition/ appreciation as a major factor of dissatisfaction. Absenteeism of MOs in peripheral areas still remains an issue. Also, only 50% of the selected candidates, especially Specialists, are found joining service owing to unwillingness to join in remote districts despite being offered hardship allowances for working in such areas.
- Lack of specialists and non-availability of functional BSU/Blood banks are the key reasons behind non-operationalization of FRUs in the state (Only 36 out of 130 Functional FRUs fulfil the conditionality).

Chhattisgarh

- A motivated team with extensive community support. Training of ANM as Yoga instructors (4 days training) has further strengthened the community interaction and the bond between community and health workers.
- Good HR creation pool with over 100 institutes producing over 3000 medical & paramedical staff (ANMs, SNs, MOs) annually and the number is expected to increase in coming years with two more medical colleges but due to the unavailability of employment opportunities in the state, the candidates are migrating to other states in search of jobs.
- Delay in timely and regular recruitment of state cadre officials is one of the major sources of discontentment amongst the staff and community.
- A Public Health Cadre is yet to be formed in CG. Also,there is no specialist cadre in the state. In District Hospital Korba and CHC Kathgora, specialists are attending both general and emergency duties. A Radiologist in DH Korba had resigned due to overload of work.
- Lack of IDSP cell in the state & training of health officials in IDSP is seen. Also, quality issues in training are observed. For e.g. LSAS trained doctors exhibited reluctance towards practising due to lack of confidence in doing anaesthetic procedures.
- Disparities in salaries and working timings of regular and contractual staff noticed. Also, instances of delayed payments of CHOs seen.
- Huge HR Gaps noticed. Number of vacancies under regular cadre is way more than the vacancies under NHMAlso, approvals for recruitment of MPREGNANT WOMEN have not been issued for quite some time.
- Admin issues observed at District Hospital, Rajnandgaon which need to be addressed on priority for provision of secondary level care to reduce high Maternal Mortality, Still Birth and Neo Natal Deaths.

Delhi

- The State has a Human Resource Information System (HRIS) covering information on HR working in all facilities.
- Most of the staff members including Medical Officers, Specialists, ANMs and ASHAs are trained under various National Programs through regular meetings and interactive sessions with the programme nodal officers. NCD training is yet to be rolled out.
- Recruitment is centralized at the State level, which makes it a time-consuming exercise. The recruitment process in MCD and NDMC is

separate. There is no combined mapping of HR from all the sources. Hence, the rationalization of HR across facilities needs to bedone.

- There is HR crunch at all levels (ANMs, Staff Nurses, Pharmacists, MOs and Specialists) - UPHC, M&CW, MH, CHC and DH and also disparity in remuneration among staffs with same designation under different agencies. Infact, there has been no new recruitment of staff nurses through DSSSB in last 5 years.
- There is non-availability of QA Consultant, QA Manager, Biomedical Engineer, M&E Officer, State MIS Expert and Accounts Assistant in the SPMU. No post of district VBD control officer and Epidemiologist sanctioned.
- The state does not have an HR policy. There is no dedicated HR cell for managing and supporting the HR.Moreover, no definite and fair transfer policy for the staff exists. High attrition rate of all staff is observed, especially Medical Officers, ANMs and Staff Nurses.
- Community is satisfied with overall facilities but complained of behaviour of ANMs.

Gujarat

- Qualifications of staff recruited under different posts, both regular and contractual, are in line with their job responsibilities but the number of sanctioned positions for key service delivery staff is less than the IPHS. Shortage of service delivery staff at lower level facilities is concerning.
- Recruitment follows a decentralised process with state level positions filled at state level and district and block level posts are filled through recruitment at the district level.
- The State has taken pro-active measures such as conducting walk-in interviews on every Mondays and Tuesdays for recruiting MOs and Specialists respectively, on an ad-hoc basis.
- Renewal of contracts and calculation of increments is based on the performance appraisal score. No delay reported in contract renewal or disbursement of salaries.
- Biweekly capacity building sessions are held for all staff at CHC, Bardoli in Surat, to improve the quality of services being provided.
- In service training of Medical Officers is not found to be upto the mark.Trainings at state level are conducted by the SIHFW. State reports have a yearlong calendar for the trainings.
- HRMS has been rolled out at the state-level. All NHM contractual and regular staff has been enrolled in the HRMS.
- The upgradation of DH, Dahod to a Medical College through a PPP with Zydus has resulted in adequate HR at the DH, however, quality of services might need to be further assessed.
- In Dahod, a district with 70% tribal area, a 30% hike on basic pay is offered to MBBS graduates to work as MOs. However, the uptake is very low as no communication is received from the State regarding implementation after the hike is announced.
- State has initiated a scheme called CM Setu to attract specialists; however, the attrition rate among empanelled specialists is almost as high as contractual NHM specialists. Presently, the state has an average of 0.84 specialists per CHC.
- The available human resource had not been rationally deployed as per the need of facilities, resulting in underutilization of the available HR. for example- DH has separate counsellors for HIV and STI/RTI, whereas there is none in SDH for ICTC (in Dahod).
- The State also needs to take steps to ensure availability of equipment where skilled HR is available. SDH (Dahod) has two dental surgeons, however, water facility, fracture kit, RCT kit, Implant kit, etc. are not available. Similarly, Places where lab technicians are available, tests are not available due to lack of equipment such as cell counter, biochemistry analyser.

Jharkhand

- With over 50% posts vacant, the state has hired specialized recruitment agency for hiring/

engaging skilled manpower to the health system, which shall take some time for optimal functioning.

- The HR gap is such that there are hardly any GNMs in labour rooms and ANMs are being involved in conducting deliveries. There is also a dearth of specialists (Obstetricians, Anaesthetists, Paediatricians and Physicians, Radiologists) across the state as well as in the two districts which is one of the major reasons for non-functional FRUs.
- The state has three (03) medical colleges with annual intake capacity 350 MBBS seats and 132 Post-Graduate medical seats (MoHFW annual report). Further the state has nine nursing colleges (1 Govt and 8 Pvt) with 1295 Registered Nurses passing out every year and 2280 seats for ANMs.
- There is no HRH policy at state and district and no career ladder is in place for Nurses. HRIS and TMIS are also not in place in the state
- Skill India institute trained personnel are being utilized at HWCs as Yoga Instructor. Various kinds of trainings- orientation and modular pertaining to all National Health Schemes and Programs have been initiated but utilization of services is very poor due to logistic mismatch. e.g. LSAS trained MO at CHC Basia is conducting surgeries. Hence, there is need to develop a comprehensive training plan of action from state level to HWC level, based on local need assessment.
- DEOs are compiling and submitting reports. Inadequacy of healthcare staff and competency of the existing and new recruits is a major challenge for delivering quality services in all fields. Competency based assessment during recruitment is not followed for all skilled posts
- Diploma in Psychiatric Nursing is running in the state since 1983 but Psychiatric Nurses are not utilised effectively as counseling centres under National Mental Health programme are not functioning at the districts.
- State Nodal Centre for Midwifery Training is at RIMS and is imparting 6 weeks educator training course to strengthen Midwifery education who may be engaged in the NHM.

Madhya Pradesh

- The state has initiated HRMIS for management of existing HR “Manav Sampada” developed by National Informatics Centre.
- The state has HR Manual 2018 in-place for contractual NHM staffs. It entails salary increments as per the tenure of employees, performance appraisal, posting and transfer. The contract of NHM staffs is renewed based on the performance appraisal on yearly basis.
- High numbers of vacancies seen as no positions are advertised in last five years. Overall vacancy is 27% in Chhindwara district and 33% in Khandwa district which will rise to nearly 43% in next five years due to retirement of various staffs.
- Existing DH in both the districts have been upgraded to Medical colleges. In order to fill all sanctioned positions promptly, State has initiated walk-in-interviews for MOs at regional joint director level on weekly basis. For other vacancies, MP-Online agency has been identified for advertisement, skill-testing requirements.Skill test in recruitment has also been introduced for some of the positions.
- There is gap in pay-parity in regular and contractual staffs particularly in paramedical cadre.
- There is no specific HR cell at state level and no HR Manager beyond state level
- There are few programme specific incentives that the state has given to SNCU MOs in 2018 and team incentives under Kayakalp programme but details of incentives are not shared by the District Hospital. Also, about Rs. 84,192 are distributed as incentives for medical procedures among service providers under Ayushman Bharat
- There are regular training programs conducted by the state on various programs but there is no defined training calendar available at district level and no specific mechanism to track the

training program organized and details of personnel trained in these trainings.

Manipur

- Paucity of workforce is evident. Only 840 MBBS doctors are in position against the sanctioned 1385 regular posts. Only 4 Psychiatrist are in position against 18 sanctioned posts. Similarly, only 4 Ophthalmologists are in position against sanctioned 23 posts.
- Training is conducted on "Mental Health Care at Primary Care set up" for MO, CHO/Paramedical staff/nurses. Suicide Prevention Workshop for Professionals and representatives also gets organised.
- Since inception in January 2016, the NCD app and VIA training for CHO, ANM , ASHA and MO has been imparted to 1050 ASHA, 650 ANM, 85 Staff Nurse and 150 MOs.
- There is irrational deployment of specialists at district level. Too many Specialists are posted in the DH but there is a dearth in other health facilities.
- Wide disparities in the salaries paid for the regular and contractual staff under NHM exists which discourages the morale of NHM staff.
- The NHM health staff has also been provided the following trainings:5 days induction training of District malaria officers, 3 days re-orientation training of District consultants, 3 days reorientation of malaria technical supervisors&2 days re-orientation training on PFMS.

Meghalaya

- Staff in general is motivated and providing good services to the community even though they are yet to receive salaries for many months.
- The state has signed MOU with CDAC Silchar in February 2019 for the implementation of HRMIS and the system is likely to be functional soon.
- The State does not have an HR policy in place for regular / contractual staff. In absence of a clear HR policy governing rotational postings of staff serving in difficult areas remain difficult.
- The State has only one fully equipped training site. Training institute (i.e. RHFWTC) needs strengthening in terms of infrastructure and HR. There is no training plan and no training calendar in the State. TMIS is not used.
- Skill labs (DAKSH) created as per GoI Guidelines in both districts. The trainings are on and mentoring visits have just been initiated.
- Mainstreaming of AYUSH has been done well. The AYUSH services are good and appropriate medicines are available for the various branches of AYUSH.
- The state does not have a Public Health or Specialist cadre. The state has not yet introduced any relaxation in norms for absorption of NHM staff into regular services.
- 53 percent positions of Specialists, 22 percent positions of MOs, 18 percent positions of Dentists and 12 percent positions of Staff Nurses are vacant in the State.
- Judicious deployment of HR as per the requirement is missing in Ri-Bhoi DH, MCH Hospital, Tura and Jeldopara PHC. In Tura district hospital, five dentists shared a single dental chair and despite an available CT scan, no technician is available. Similarly, The Specialists in Nongpoh district hospitals are being utilized as GDMOs and only few speciality OPDs are conducted.
- Performance appraisal of staff is conducted on generic templates and does not take into account job specific indicators. A flat increment is given to all staff irrespective of the result of performance appraisals. There are no additional incentives like hardship allowances, team-based incentives, etc. for existing staff. The performance appraisal system is used only for contractual staff.
- Specialists attribute inadequate remuneration as an important disincentive from joining public services. Significant attrition of MOs is also reported.

Mizoram

- The existing staff is motivated and cheerful. The state has the policy to give preference in the

selection of doctors and paramedical staff who are working in NHM. Contract renewal of NHM staff is done regularly; however, their salaries are often delayed by 2-3 months.

- Residential facilities are available for the staff in the vicinity of health facilities. Health workers in SC are accessible even after operational hours of 9:30 am to 3:30 pm. Rest of the facilities PHCs/DHs/CHCs work 24*7.
- The construction of Multi-Disciplinary Training Centre for the Health Staffs is in process. The state has conducted training programs for mental health, orientation training for ophthalmic assistant, NPCDCS, palliative care, RKSK and Mini Lap in RCH since April 2019 till date. Immunization training for newly recruited Medical Officers is also going on during the CRM visit at the Conference Hall, DHS.
- Induction Training for the newly recruited medical officers (4 days) and foundation Training for one month is conducted at ATIs. There is no separate training wing or Nodal Officer for trainings at Districts/State level. Also, no TMIS is in place.
- There are no sanctioned posts at health facilities, and vacancies are filled as per the availability of staff. Irrational deployment of HR and irrational filling of the vacant posts seen.
- No PHMC in both the districts. TOR/JD not given to any staff at the time of joining. Most of them are not even aware of their key responsibilities.
- There is no HR policy for recruitment, performance appraisals, carrier progression, posting and transfer and retention of the staff. The districts face shortages of human resources in regular cadre as well as NHM and the issue of irrational deployment of the staff prevails in the districts.
- Human Resources Information System (HRIS) is accessible to the state staff but not to district staff. Staff in the districts is also not aware of any standard operating procedures and guidelines for HR. Attendance registersare not properly maintained and has no bearing on salary processing.
- System for field-monitoring of services provision and facility management is non-existent. No vehicle/funds are provided to program managers for monitoring quality of services delivered by the PHC/CHC/SC staffs.

Nagaland

- The workforce is cheerful, positive and motivated. However, these individuals need to be supported by a robust system of supportive supervision and capacity building which is in need of some long due changes.
- In District hospital, Phek the district hospital team meets at least once a month for a learning session which could be presented by a doctor or a nurse.
- While the total number of MPREGNANT WOMEN (male and female) are more than adequate as per IPHS (1171 posts against a requirement of 1075), many of the regular posts of MPREGNANT WOMEN(F)/ANMs are at DH and CHC levels, leaving very few of them available for SCs.
- The recruitment process under NHM is simple and almost all vacancies except specialists are filled within 3 months' time. There are walk-in interviews for doctors and specialists. However, there is no arrangement for conducting skill tests of frontline health workers.
- Performance linked payments (PLP) for HWC team is yet to be institutionalized at the HWC-SCs/PHCs.
- The State doesn't have a separate specialist cadre, though the doctors with post-graduate diploma/degree are given 1-2 increments. Lack of adequate number of posts and lucrative salary acts as a hindrance in attracting specialists
- Frequent transfer of trained staff is a challenge. E.g. 6 out of 15 CHOs, trained in Dakshata and RMNCH+A interventions, in Kiphire are transferred recently to other places. The specialists at district hospitals are also transferred without a replacement. Most of the health care providers and doctors hailed from other districts and faced communication

gap and language issues with local people for providing health services and counseling.

- The HRH policies and rules, especially for NHM staff are not known to all. There is a disparity between regular and NHM staff both in terms of salary as well as workload.
- Rationalization of HR is needed to ensure availability of adequate HR at all levels of care. Staff must be posted in the home districts with good provision of non-financial incentives like better accommodation facilities.Many SCs CHOs reported dissatisfaction over these issues
- There are some HR policies which have been implemented. State provides for paid study leave and at a few facilities, the doctors are on study leave for higher qualifications. The State has also categorized the districts into A, B, C categories and higher compensation is paid to staff in category C districts.
- The health staff is not given any orientation training. The capacity building seemed ad-hoc and knowledge on new programs are inadequate. Even among program managers training is a neglected area. Many instances of dilution of training content, number of days and even selection of trainer and trainee is noticed.
- Absenteeism, especially in the regular cadre, is very high.

Odisha

- There are huge vacancies under various regular cadre posts for specialists, MOs, Staff Nurse, Pharmacist, Lab technician, Dentist, MPREGNANT WOMEN-M , MPREGNANT WOMEN-F and programme managers in the state.Walk in interviews are done from 1st to 15th of every month at the district and on 27th of every month at the state level to fill various vacancies.
- The reasons identified for vacancy are hard to reach areas, non-availability of basic amenities including good education for children, non-availability of residential quarters. Interaction with staff also indicates poor motivation due to unnecessary and avoidable scolding/shouting in public to subordinates.
- The State has recently established 4 medical colleges to minimize crunch of doctors and specialists. The no. of MBBS seats increased from 450 to 1150 and PG seats up to 468. To create more specialist doctors in the state, MoU has been signed with College of Physicians and Surgeons (CPS) of Mumbai for starting Post Graduate Diploma courses which has been rolled out in 11 districts of the state. The state has also proposed three centres for midwife training.
- The state has created public health cadre with sanctioned post of Public health officer at state, district and block level and has included performance appraisal, career progression, posting and transfer in the HR policy. For the retention of the staff, the state has introduced Dynamic Assured Career Progression (DACP) Scheme for Medical Officers providing them three assured promotions i.e., after 07 years, 14 years and 21 years of service counted from the direct entry level which has been implemented.
- Specialist cadre is yet to be implemented, in absence of which many specialists are found working as MOs.
- State has classified its geographical area into five different categories as V0 to V4. This incentive is applicable to contractual, ad-hoc and regular doctors. The General (MBBS) doctors working in V4 area CHCs and PHCs gets an incentive of INR 40,000, whereas a specialist working in V4 CHC gets INR 80000 as incentive. Doctors working in V1 to V4 institutions are entitled for additional marks in PG entrance examination.
- State HRIS has been implemented from September 2019 onwards which captures data of regular as well as contractual staff. Training Information Management System (TIMS) has also been made part of the HRIS. Monthly training plan is developed at State and District level for the regular and contractual staff.
- The State has implemented “You Quote, and We Pay” scheme under NHM for attracting

specialist in rural areas. Incentives for Specialists have also been provisioned (August'18) for motivating Specialist doctors of Odisha Medical & Health Services (OMHS) cadre.

- There is in general lack of dentists in the facilities. The facility which had dental chair did not have Dental Surgeon in place and vice versa.
- Lack of security of the doctors at workplace is a major barrier for retention of the doctors.

Rajasthan

- State has HR plan to fill the vacant 6000 vacancies including 2310 CHOs through various empanelled agencies. During recruitment in regular services, the state gives additional weightage to candidates from NHM with minimum service of five years.
- State has developed (CHRIS) Computerized Human Resource Management System to capture the data of NHM contractual staff. State is in process of developing another Human Resource Information System (HRIS) with NIC for the regular staff.
- The state provides 7-day induction training to all the newly joined Program management staff under NHM. State has one SIHFW, one Collaborating Training Institute and two Regional Institute of health & family welfare but training calendar is not available on website. Skill labs are also operational at SIHFW, NS, Udaipur and at all ANMTC.
- The primary reason identified for the vacant positions is procedural delay in recruitment process. Existing Staff is also demotivated due to pending of loyalty bonus, absence of opportunities for career progression, absence of salary hikes & any other monetary incentive for difficult areas etc.
- State does not have a dedicated HR policy for contractual staff. As and when required, department orders are issued to facilitate the workforce management practices. State does not have any transparent policy for transfers and postings of regular and contractual staff
- There is lack of inter-operability between Training Management Information System (TMIS) and CHRIS. There are two separate software systems for contractual and regular staff in the state, which are not synchronized with each other.
- A dedicated Public Health Management Cadre is not there in the State. Also, specialists and all Medical Officers are hired at the same rank. There is no mechanism of performance monitoring at the facility level.

Tamil Nadu

- Medical Recruitment Board recruits MOs, Specialists, SNs, VHNs, ANMs, LTs and Pharmacists centrally through open competitive examination.
- State has a unique career progression plan for ANMs and AWWs. ANMs join as Village Health Nurse (VHN) and are promoted to Sector Health Nurse and subsequently Community Health Nurse and District Maternal and Child Health Officer (DMCHO) based on vacancy and seniority. The State has a policy to select ANMs from the cadre of AWWs with qualification of 12th standard, 5 years of service and above 35 years of age.
- The posts of Staff Nurses are created in the ratio of 1: 2 (Regular: Contract) so that all contract Staff Nurses can move into the regular posts after a period of 2 years
- There is 21% vacancy of second VHNs and 11% vacancy of regular ANMs at HWC HSC in the State, with 205 of 985 UHC HSCs functioning without a second VHN and 106 functioning without a regular VHN.
- Tamil Nadu has a separate Public Health Cadre supported by Public Health Directorate having its own budget and legal support. Recruitment is through TNPSC or by transfer of service from PHC MOs with five years of service and public health qualification. Specialists in the cadre of Public Health are available in the district as per directions from the concerned Directorate.
- State has a HR Policy and a HR cell in place; however, a clear transfer policy and performance appraisal mechanism is not fully developed. System in place for career

progression of medical doctors when after two years of work all becomes eligible to compete for PG specialization as government candidates in all Govt Medical colleges. Doctors working in identified tribal areas are incentivized by giving a monetary component (hill allowance) and additional 'points' in the post graduate program.

- HRMIS is well in place for NHM staff. Salaries, attendance joining, and transfer entries are captured in HRIS. Loyalty bonus and 5% increment is given to staff to encourage retention of posts
- There is a provision of induction training for all the newly recruited medical officers; the same does not exist for other cadres including Staff nurses. Training schools with adequate infrastructure, mobility support and trained staff exist, where an annual training plan is in place.
- Tele monitoring has recently been started for the MLHP programme for mentoring of VHNs

Uttar Pradesh

- Uttar Pradesh has empanelled recruitment agencies and is conducting recruitment drives under NHM on regular basis. During recruitment, under regular cadre, additional weightage is being given to staff with experience of NHM. For every three years of experience under NHM, 5 additional points are given to the candidate.
- The state is in the process of creating Specialist cadre. This will ensure availability and rational distribution of specialists in the public health facilities. Presently, Shortage of Specialists, both on regular and contractual basis is seen, due to which specialists services are not available at district and CHC levels.
- The state is also implementing the "Buddy Model" in phases wherein specialists/ EmOC and LSAS trained doctors are posted together.
- Recruitment is centralized at state level. Recruitment at districts level is conducted only for Specialists and MOs in case they could not be hired at state level.
- State is taking initiatives for fast tracking the hiring of Specialists and MBSS doctors through bidding process and walk in interviews. However, the bidding process is limited to recruitment of specialists under RCH, i.e. Gynaecologists, Paediatricians and Anaesthetists.The specialists hired through bidding process majorly constitutes of retired government doctors.
- State has formulated HR Policy and is in the process of implementing the same. Renewal of contracts of NHM contractual staff are being done timely. The State has also rolled out HRMIS portal (Manavsampada) and is in the process of linking salary with HRMIS portal. Minimum Performance Benchmark has not yet been implemented in the districts visited.
- No separate Public health cadre.
- The health facilities below DH level do not have sanctioned posts of HR as per IPHS norms. For instance, there is no sanctioned post of dentist/ dental surgeon at the CHC level, but it has a sanctioned post of dental hygienist.
- There occurs irrational deployment of staff at various levels. For instance, designated FRU with non-functional BSUs have Gynaecologist in place but no Anaesthetists/ LSAS doctor. Similarly, the medical college in Meerut district has nearly 40 OBG specialists posted and are conducting only 250-300 deliveries per month. On the other hand, the DWH has only 7 Doctors including 5 OBG Specialists and 2 MOs are conducting 500-600 deliveries in a month. No night Caesarean Sections being conducted due to shortage of staff.
- Under-utilization of HR in peripheral facilities is leading to overburden at DH level. Also, sufficient number of ANMs are in place in both the districts (considering 2 MPREGNANT WOMEN per sub centre as per IPHS), yet majority of the sub centers have just one ANM in place. This happens because ANMs are posted at higher level facilities as there are lesser number of sanctioned posts of staff nurses under regular cadre.
- Absenteeism of staff from the health facilitiesis a major reason for dissatisfaction among the community. This not only leads to OOPE, but

in areas where there are no private providers, people end up visiting local healers or buying medicines prescribed by the local pharmacy.

- The major reasons for vacant positions of specialists and MBBS doctors are low salaries, no career progression initiatives (for MBBS), non-availability of security staff at peripheral facilities, lack of infrastructure and facilities are major reasons for dissatisfaction and attrition of HRH. Delay in release of salary is also a reason for staff dissatisfaction.
- Trainings for in-service staff are conducted through SIHFW and 11 RIHFWs and Medical Colleges in the state but most of the Staff Nurses and MOs in the facilities visited are not trained in SBA, NSSK, F-IMNCI and Dakshata etc.
- The State level HR cell has 9 people in place for management of approx. 65000 contractual engaged through SHS & DHS. Though the HR cell is responsible for management of all HR under NHM, lack of coordination between HR cell and programme division is observed. Also, district level staff seems to be unaware about HR cell.

Uttarakhand

- The state has initiated the process of recruitment for filling-up vacant regular as well as contractual positions. It has started undertaking recruitment through walk in interviews and has also roped in an HR agency to recruit the necessary Human Resource in different areas.
- The State has implemented “You Quote, and We Pay” scheme under NHM for attracting specialist in rural areas.Medical Officer In Charge, who is performing 24 hrs in- house medical duty is also provided an incentive of INR 1000 INR/ Day by DM fund.
- Key cadres absent (epidemiologist, statisticians, entomologist, VBD consultant). Shortage of key para medical staff especially nursing staff (GNM/ BSc Nursing), Lab technician, OT technician seen.
- Because of limited resources and hard to reach areas, HR is not adequately distributed in whole of the state, e.g. there are six personnel catering to all health care service needs in SC-HWC Kiccha but only 1 ANM in SC- Khatima.
- AIIMS Rishikesh and Sushila Tiwari Medical college provide quality medical education and the institutes have the potential to be created as Knowledge hubs for providing refresher training and research activities for the medical professionals.
- There is lack of dentists in the facilities along with disparity and mismatch in HR and physical resources available as the facility which had dental chair did not have Dental Surgeon in place and vice versa.
- The attrition rate is high attributing to hard to reach areas, non-availability of basic amenities including good education for children, non-availability of residential quarters.Lack of security of the doctors at workplace is also a major barrier in retention of the doctors. Also, Specialist cadre is absent.
- The motivation among staff is poor due to less salaries and practice of delayed release of salaries. Many also complaint that major part of the salary gets exhausted in travel expense.
- There is overall lack of training component of the available HR which leads to service delivery by untrained staff. Deliveries are being performed by SBA untrained staff and newer contraceptives like Antara etc. are not being used in the field because of unavailability of training of these methods.

TOR 9: GOVERNANCE, ACCOUNTABILITY AND FINANCE

This TOR comprises of three sub themes, namely Governance, Accountability and Finance.

Part 1. GOVERNANCE & ACCOUNTABILITY

There are various Acts which makes important public health contribution if implemented well. In most of the CRM states visited it was generally observed that there is no focused review and actions in implementation of the legal Acts pertaining to health. For eg only 5 out of 16 states have adopted Clinical Establishment Act (CEA). Proper enforcement of PCPNDT Act was observed in 3 out of 16 states. There was lack of clarity amongst service providers on various legal Acts like Medical Termination of Pregnancy (MTP) Act, Prevention of Sexual Harassment at the Workplace (POSH) Act, COTPA Act - The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution Act) etc.

The inadequate or poor awareness on various health related legal Acts is largely because there is no organized training program for service providers to orient them on the various health related Acts. There is not even a consolidated guidance note for health facilities on medico legal protocols. In absence of these guidelines or orientation various important implementation parameter gets compromised. However certain provisions like sex selection, view of two doctors for conducting MTPs beyond 12 weeks, examination and counselling of victims of sexual violence while maintain privacy are some of the important provisions which are widely known by the service providers in the facilities visited by the CRM team.

State and district health missions are not found to be playing a supervisory / lead role in providing direction for action at State level for the state / district health societies. The society actions are largely governed by the source of funding and conditionalities associated with them. The functionality of RKS in terms of identifying the priorities of the hospital, planning of resources, appropriate expenditure for ensuring quality patient care services etc. needs improvement. Among the core components of the Grievance Redressal System (GRS), help desks and call centres are by and large established in the States. The call volume for the grievance component, however, is less. Poor IEC on these services, among others, is the key reason for low uptake of GRS services. None of the State except AP, Bihar, and Rajasthan has implemented time bound grievance redressal system for effective and assured resolution. Supportive supervision in the States is weak and needs strengthening in terms of scheduling, action planning, feedback and effecting changes as per the visit report. District planning is also on the low priority listing of the State, and plans below district (block or village) is almost non-existent. The vibrance of VHSNC is largely in MCH and in organizing VHNDs.

KEY FINDINGS

- Some overall and abiding findings on implementation of health related laws that - *barring very few exceptions* - are applicable to most states:
- States do not give priority to implement laws relating to public health.
- There is hardly any training provided by the states on various health related laws, on rights and entitlements of patients; processes and protocols to be followed and documentation to be maintained; offences and penalties etc.
- This leads to minimum awareness on the provisions of the laws/acts, among the healthcare providers as well as the community
- Due to the lack of focus and push given to enforcement, the implementation of these laws is inadequate, to the detriment of the end users and community (as they remain deprived of their rights); as well as the health care providers (as they remain unaware of their legal obligations).
- **CEA** - The adoption of CEA by the states is still lagging, mostly due to strong opposition by interested groups. Where adopted, the registration of all facilities is still not completed and implementation is very slow. Out of the states visited this year, only Bihar, Himachal Pradesh, Jharkhand, Uttarakhand and Uttar Pradesh have adopted the CEA. The following states have not adopted the CEA yet but have a pre-existing law to register private health facilities – Andhra Pradesh, Madhya Pradesh, Tamil Nadu, Manipur, Meghalaya, Nagaland and the NCT of Delhi. States of Chhattisgarh and Gujarat, however, have neither adopted the CEA nor do they have a state law on the subject.
- **PCPNDT Act** – the institutional mechanism under the Act is in place in almost all states. However, the implementation is highly uneven. Robust awareness and social mobilization around gender equality and the punitive provisions of the Act lacks. States visited this year that have taken steps to enforce the act properly are– Tamil Nadu, Rajasthan and Uttarakhand.

Key identified problems in the implementation of the PCPNDT Act include –lack of funds/underutilization of funds, non-renewal of registration leading to automatic renewal of registration, non-maintenance of patients' details and diagnostic records, lack of mapping and regulation of USG equipment, lack of tracking system in USG machines, no training of medical practitioners conducting USG, inadequate number of decoy operations, non-imposition of penalties, lack of regular meetings by authorities and insufficient inspections.

- **MTP Act** – Inconsistent practice related to documentation and Form C in many facilities. There is lack of clarity about the provisions of the Act among programme officers, especially around issues of consent requirements. There is also stigma associated with abortions, which needs to be tackled.
- **POSH Act** – Very low awareness about the POSH Act. In most facilities, internal complaints committee is not constituted and trainings on sexual harassment at workplace not conducted. No written policy on the sexual harassment at workplace available in any facility.
- **MLP for Rape/Sexual violence** – Lack of training of health care providers on the protocol aspects of examination, consent, treatment, counselling and police intimation. In some facilities, if there are no female gynaecologists, the survivors are referred to another facility for examination and treatment. A clarification should be issued on this matter and proper training ought to be provided.
- **COTPA** – The Act is being implemented but needs to be enforced more vigorously. Monitoring and supervision of the act is deficient in most states. While most facilities in many states have signages, they are not as per the specifications of the Act. Further, in some health facilities of states such as- Nagaland, even the health workers were found consuming tobacco.
- **RBD Act** – The implementation of this Act is uneven across states. Systems and mechanisms under the act are not streamlined at the facilities level.

- **Disabilities Act** – Most states/facilities are not aware of the provisions of the Act and in many states the certificate is being issued at the district hospitals level only.
- **HIV/AIDS Act** – It is yet to be implemented by the states. There is no awareness about this law in most states. State rules need to be passed and institutional set up needs to be put in place such as having an Ombudsman and Complaints Officer at facilities level. The post exposure protocols on display need to be revised, as it does not mention administration of ARVs as part of the post exposure prophylaxis protocol.
- **MHC Act** – More than two years after the enactment of this Act, around 10 states are yet to set up authorities for the proper implementation of the rules under the new legislation. The Act mandates the states to have a functional authority within nine months of the law coming into force, but most of the States have missed the deadline. The States are also yet to draft the rules of the Act.
- **Institutional Structure of Program Management** includes State and district health missions (DHM) and health societies. These platforms of governance are functional in almost all the states. SHS under the chairpersonship of Mission Director regularly takes the review and also suggests the way forward. However, the review meetings of State Health Missions (SHM) and District Health Societies (DHS) are not taking place regularly in some of the states. DHS do not give adequate focus to monitor the progress achieved on various program indicators.
- The institution structure at block level still remains a weak link and the capacity of program managers to implement and follow up of various programs is suboptimal. They have never been oriented on public health issues and its monitoring parameter as a result reporting, analysis and addressing these issues remains a weak link.
- During the visit, it was observed that none of the state gives adequate focus and weightage on decentralised planning. Involvement of districts and block in the planning process is limited to preparing budget sheets that too in states like Bihar, Chhattisgarh, Gujarat and MP. In some states like Jharkhand, district officials were not aware of the same. Even if some districts prepare their health action plan, they are not getting adequate cognizance in the State PIPs.
- Rogi Kalyan Samitis (which is named differently in different states like HDS in Andhra Pradesh, JDS in Chhattisgarh etc.) are formed in all states. However, the regularity of meetings leads to compromise in functionality. However, one of the important positive point noted was funds allotted to RKS are being utilised on various development activities in the health facilities.
- Grievance redressal system functioning sub optimally across the country. However, as a part of good governance, one of the states (AP) launched a new initiative- **"Spandana Programme"** in which Grievances are registered through online portal, and issues are resolved within 3 days.
- Supportive supervision in almost all states is weak and lack structured templates for planning and supervision. There is no structured reports of the monitoring visits are being submitted

in many states where ever the reports are submitted its follow up for corrective actions remains a weak area.

- Availability of computers and internet connectivity was not an issue in most of the states visited except a few like Meghalaya, Orissa & Uttarakhand. In Uttarakhand, staff was found using their personal phone data package for official purposes, the bills of which had to be borne by the staff themselves.
- Proper recording and reporting of key data was found to be a weak area across many states. Similarly, referral and follow-up mechanism needs strengthening to ensure desired health outcomes.
- Though Tablets have been given to ASHAs and ANMs in most of the states, issues related its quality and training were seen everywhere.
- Tele-consultation is yet to catch pace in most of the states. Though, AP is ahead of the rest, in terms of giving tele-consultation and e-drug delivery at the HSC level.

RECOMMENDATIONS

- **CEA** – All states should prioritize adopting/ adapting the CEA or its core principles, including those that have a pre-existing legislation. States that have adopted the CEA need to notify state rules constitute and notify counsel of Clinical Establishments, notify registration authorities in districts and initiate process of registration
- **PCPNDT** -The guidelines for implementation of PCPNDT Act issued by MoHFW should be disseminated to all the states. States must ensure strict monitoring and compliance with the provisions of the Act. It has been seen that if a state enforces the act strictly, then people seeking sex selective foeticide, move to neighbouring states for the services. This underscores the point that all states need to implement the act equally strictly across the country, in order to realise the objectives of the law. States can confer and share best practices with one another.
- MTP Act - The MTP Act has recently been amended and the States must organise training workshops to orient relevant health care providers on provisions of the latest MTP Act and Rules, especially on provisions related to consent of the woman, extended periods of time limits and forms to be maintained.
- Training on protocols for medical termination of pregnancy is required.
- Every health facility that is deemed recognized under MTP Act should indent and maintain a stock of medical abortion pills
- ASHA, ANM, doctors must receive gender sensitive knowledge and skill based training. The training should address managing unwanted pregnancies and providing services without any stigma or discrimination.
- **Medico-Legal Care Protocols for Survivors of Rape/sexual violence** -
  - Every district hospital should have dedicated rooms with examining and counselling facilities supported by adequately trained staff for victims of sexual violence, domestic violence etc.
  - Train the MOs and gynaecologists in medico-legal protocols with particular emphasis on current medical and legal protocol for examination, treatment, psychosocial intervention, consent requirements etc.
  - Make the printed formats available and ensure ‘chain of custody’ of samples.
  - States should do periodic audits of the forms, formats and ‘chain of custody’ of samples. This is essential for ensuring compliance with the protocols.
  - POSH Act - The States must ensure that -
  - Every district has a Local Committee (LC) with composition as per the Act.
  - An Internal Committee (IC) is set up within every establishment that has 10 or more workers to examine and investigate matters of sexual harassment within the workplace.

- Written policy on sexual harassment at the workplace and trainings and workshops are done as per the requirements of the act.

- **COTPA**
  - Standardize anti-tobacco signage with the specifications as per the Act.
  - Ensure that the health facilities are smoke free.
  - At behest of MoHFW, the Ministry of Home Affairs vide letter dated 07.05.2014 sent an advisory to the Director Generals of Police in States /Union Territories to incorporate provisions of COTPA as one of the agenda items in the Monthly Crime Review Meetings at the District Level. States must follow up and ensure that this is happening.
  - State must enforce the Act, especially provisions 4, 5 and 6 (smoking in public place, prohibition of advertisement of tobacco products and prohibition of sale to minors).
  - Along with strict enforcement of the act, the State must provide addiction treatment support at all facilities.
  - State & District Health Missions needs to be more proactive by taking regular program review and also provide necessary policy support.
  - DHS be more accountable for planning, implementation and outcomes for various programs. Every state needs to prioritise decentralized planning. State plan should take into account the District Health Action Plans.
  - Before planning exercise State needs to inform districts of the available envelope so that districts could plan 20-25% in-addition to their envelope.
  - Convergence betweens with various departments like MC, WASH, WCD, etc. at block, district and ward level needs to be strengthened for universal coverage and effective implementation of programs.
  - State/NHM needs to facilitate by empowering DHS so that they are more accountable for technical interventions and outcomes.
  - The fragmentations in various programs need to be consolidated for which more responsive and accountable system needs to be in place. The states should actively consider implementation of PHMC as per the recommendations of NHP 2017. This will help in establishing a vibrant and accountable workforce which has better understanding of public health challenges and various programs.
  - Supportive supervision needs to be strengthened with use of structured templates for planning, supervision and monitoring.

STATE SPECIFIC FINDINGS

Andhra Pradesh (District: Kadappa & Vishakhapatnam)

- **CEA** - State implements a pre-existing legislation, namely - Andhra Pradesh Allopathic Private Medical Care Establishments (Registration and Regulation) Act, 2002. It had initiated the process of adopting the CEA. However, in the face of protest from interested groups, the decision to adopt CEA was dropped.
- **PCPNDT Act**- Act is being implemented. Meetings are held regularly and minuted for record. Incomplete forms, particularly Incomplete Form F seen at Area and District Hospitals. Supervision is required to improve documentation.
- **POSH Act** - A special room and manpower given at Teaching Hospital with interdepartmental coordination and registers well maintained.
- **MTP Act** - (Form – C) not followed in any Health Facilities at District, not even DH. MTP services were not seen provided in any of the facility visited including FRUs. Non availability of Mifepristone in the facilities. Although MVA tray is maintained but without MVA kit.

- **RBD Act** - is in force at all the health facilities
- **COTPA Act** - Orders given by the state in 2016. Act is being implemented in the district hospital, but not in other facilities.
- **HIV/AIDS Act**- Implemented in the facilities
- SHS, DHS, CHC, PHC are registered as Health Development Society (HDS) (equal to RKS) under Certificate of Registration of Societies Act 35 of 2001.
- Advisory committee meeting has been conducted but not on regular basis
- Tele consultation and e-drug delivery at sub center level is a good practice.
- GRS- Grievance redressal is done by a new initiative known as "Spandana Programme" on every Monday through online portal, the program aims to resolve the issues within 3 days. However, State has not shared number of grievances registered and resolved under this initiative.
- The ANMs were using ANMOL Tablets earlier, recently new Samsung tablets were given for updating the data.
- HMIS Data with registers are tallied and maintained well. IHIP not rolled at District and to be implemented.
- Referrals from tribal areas are made from PHC – CHCs, CHCs – Area and ultimately to medical college hospital, the overall travel time in reaching to teaching hospital being 8-12 hours. Despite availability of infrastructure, health service delivery is poor in tribal regions due to lack of HR.Tribal community not aware of grievance redressal and not using complaint box in all Health Facilities. No registers are maintained. Even internet, road & transport poor in tribal terrains.
- Activities at the level of facilities are well coordinated and departments of Social and Tribal welfare, SC/ST welfare and WCD departments are setting a good convergence example. However, there is no coordination with the district Medical and Health administration while planning for annual budget plan of the state.
- In all the Health facilities, prescription audits need to be done regularly. Priority to be given to emergency patients and high risk pregnancies, elderly, disability people etc.

Bihar (District: Bhagalpur & Begusarai)

- **CEA** - Clinical Establishment Act had been implemented since 2016. However, enforcement needs to be strengthened.
- **PCPNDT Act** - The tenure (i.e. 3 years) of State Supervisory Board and advisory committee has completed and both committees are under reconstitution since last one year. In addition to the monthly & quarterly reporting on a regular basis, state has developed a dedicated website for PCPNDT as well as a portal for complaint management.
- **COTPA** – The Act was being enforced but its periodic monitoring and implementation was deficient. A system of challan and reporting was in place. Staff was not aware about penalization process in case of non-compliance with the COTPA rules. De-addiction Centres are functional in all the DHs but one in District Hospital Bhagalpur was converted into Dengue ward. Counselling for tobacco de-addiction needs to be initiated. Nicotine patch and Nicotine gums are not part of State EDL.
- **RBD Act** - Death & Birth registration certificates are being provided by DH.
- **Disabilities Act** - Disability certificate is issued by the DH.
- **MHC Act** - State has already started process for implementing the MHC Act. However, the National Mental Health Programme (NMHP) was found to be non-functional in the district.
- POSH committee is available, but no complaints received so far. No formal training of committee members has conducted till date. No IEC regarding workplace sexual harassment displayed anywhere in any facility
- CPHC NCD IT application is being used only at 25 HWCs-HSC. Various other IT Portals like PMMVY-CAS, SAG-RRS are being used however training regarding data entering and

reporting needs to be imparted. Similarly, ANM have been provided with tablets for usage of NCD-IT application, however, their training was pending.

- Institutional arrangements (State & District Health Society, Programme Management Units and City Level Committees) were in place and have been following decentralized planning across the State.
- Intra-sectoral convergence with Education department for RBSK & WIFS programme, Water & Sanitation, Environment & Urban development etc. was observed in the State.
- State has dedicated toll-free number (104) for Grievance re-addressal but its awareness among community & health care staff was insufficient.
- Tele-consultation started in DH has been discontinued subsequently.
- Frequency of RKS meetings is less, most often once a year, where the entire expenditure is booked.
- Statutory Audit Reports of State Health Society of earlier years haves not been placed to Governing Body meeting for acceptance.

Chhattisgarh (District: Rajnandgaon & Korba)

- **CEA** - State has own legislation in place for registration and regulation of clinical establishments.
- COTPA- Premises of DH Korba are tobacco free. Presence of smokers seen in DH Rajnandgaon. IEC materials are displayed in the most of the facilities. Offenders are penalized as per the law. Counselling and treatment to the patients is being provided through the psychiatric OPD of the medical college in the Rajnandgaon DH. School Awareness program is minimal in Korba.
- MHC Act-State Mental Health Authority has been constituted. Five District Level Boards (for each zone) are being constituted. Nomination of retired judges has been sought. Framing of Rules under the MHC Act are under process.
- PCPNDT – forms were available and monitoring visits were happening.
- RBD Act – registration of birth was happening and birth certificates distributed from hospitals.
- AERB guidelines - Risk of radiation exposure to pregnant women and others at DH Korba was also noticed as the X-ray facility did not adhere to AERB guidelines. USG & X-Ray rooms were found to be adjacent (without proper radiation shielding).
- Tele consultation is limited to phone consultation with PHC M.Os/AMOs
- 102 & 108 transport services poor, IDSP cell was non-existent at Medical collage Rajnandgaon, ICDS-CAS not implemented in almost 20 districts.
- Poor quality of tabs is seen used by ANMs

Delhi (District: East Delhi & New Delhi)

- **CEA** – Delhi has not adopted the CEA and is implementing its own pre-existing legislation, namely, The Delhi Nursing Homes Registration Act, 1949.
- **COTPA** - Tobacco control initiatives such as counselling, health talks and IEC are underway in both the districts visited. Most of the facilities have tobacco free premise and displayed signages. Tobacco control activities are undertaken by dental department that is functioning very well at Delhi Cantonment Hospital. State had taken initiative in banning of e-cigarettes.
- **RBD**- Upon interaction, the community was found to be aware of the process of getting birth and death certificates.
- **PCPNDT** Actis implemented and a dedicated officer is looking after its implementation, especially BCC activities.
- POSH Act is in place with internal committee formation. Workshops for female staff are done to generate awareness.
- Multiple types of MCP card due to various governing bodies. State to ensure availability

and use of single MCP card to avoid confusion and duplication of work.

- State uses several platforms such as HMIS, FP-LMIS, IDSP, MCTS for regular reporting. But NCD app not functional in state.
- No tele-consultation services are being provided. Tablets not provided to ANMs.
- No area was attached to M&CW Centres in East Delhi, owing to which no ASHAs were assigned to them, leading to immunization of children in the OPD on an "as and when" basis, with no provision to ensure complete immunization or follow-up of missed cases.
- 104 (GRS) and 108 (Ambulance services) are functional and time bound escalation system is in place. But community awareness about existence of GRS is poor.

Gujarat (District: Dahod & Surat)

- **CEA** – The State has not adopted / adapted CE Act.
- **PCPNDT Act** -Only one person at the District PCPNDT Cell to monitor USG practice. At facilities in Surat, where USG services were available, PCPNDT Act mandates were followed.
- **MTP Act**: In the few facilities where MTPS are conducted, guidelines for recording and waste management are followed.
- **POSH Act**: In Surat, Committees have been formed as per guidelines. In Dahod, POSH Committee in SDH is defunct (only 3 out of 6 members). Need to appoint members. In both districts, no complaints received.
- **Medico-legal protocol for Rape/Sexual violence:** No training of providers on medico-legal protocols in SDH and Zydus (in Dahod). There is a One-Stop Centre in Dahod SDH. No designated room available in Surat. In Surat CHC Bardoli and Dahod SDH, SOPs are available and MOs conduct medical examination for evidence collection. In Dahod, however, women are referred to Godhra for vaginal swabs.
- **COTPA:** COPTA provisions are enforced and during last one year, 1405 persons have been penalized monetarily in Dahod district, and 3314 persons in Surat district. Despite this, use of tobacco and spitting at public places is quite common including govt. offices, hospital campuses, etc. and warrants more comprehensive efforts.
- Executive Committee of District Health Society (DHS) are being held regularly. In both districts, programme officers make visits to facilities. Weekly Taluka Health Officers and monthly MO meetings are held in the district. While meetings are held at the district, the meetings are sporadic. No templates are used to prepare written reports making follow-up difficult.
- **Community** - There is generally poor awareness among community regarding health hazards of tobacco use and other laws
- SATCOM sessions are being held. No telemedicine is being used at all facilities at all levels.
- Meetings of GB and Executive Committee of District Health Society (DHS) are being held regularly. Weekly Taluka Health Officers and monthly MO meetings are also held in the district but sporadically. No templates are used to prepare written reports making follow-up difficult.
- Online reporting is done for various programs under HMIS, IDSP, NCD, NPCDCS, MNY (for diagnostics). Use of HMIS planning however needs strengthening. Data collected is not being analysed and used for programme planning and monitoring.
- Toll-free numbers for 104 and 108 are functional 24*7. In Dahod, 181 Abhyan helpline was in use for those reporting VAW.
- The NCD app is being used, with some technical glitches. However, this is not being used at MO level as yet.
- No GRS committee at DH and SDH level, no Help desk at facilities.
- Lack of data driven planning was observed, a random 10% increase is added to every year target instead of Population based indicators.

- VHSNCs are constituted at village levels with limited training of members. Lack of involvement of VHSNC in social audit and comprehensive primary health care activities is observed.

Jharkhand (District: Gumla & West Singhbhum)

- **CEA**–State has adopted the CEA but the implementation is lax. The certificates was not found displayed anywhere in the facilities visited, that were registered under CEA.
- **PCPNDT Act**- A supervisory committee is formed and last meeting was held in July 2019. At Gumla district, DH did not have facility for USG and provided service in PPP mode.
- **POSH Act** - State level committee was formed in this year (FY 2019-20) but not at any level below. Service providers were not aware about the provisions of this Act or even about the Vishakha Guidelines.
- **Medico-Legal Care Protocol for Rape/ Sexual violence cases -** No protocols, formats/forms were available in the facilities visited. One stop crisis centre is not functional in both the districts. Service providers at Gumla were reported to be trained in the protocols, but upon interaction, they were found unaware of these.
- **COTPA** - In the facilities, 'No Smoking' signages were displayed. However, contact number of nodal person was not displayed.
- **RBD Act**–Gumla DH and CHCs had facilities for birth and death registration. At DH, Sahiyas at Sahiya help desk were guiding patients to appropriate person for getting the birth registration and Sahiyas were also checking the forms for completeness. At CHC, Block Extension Educator was responsible for these functions.
- **MHC Act** - State Mental Health Authority has been formed and formation of Mental Health Review Boards is under process. Suicide helpline was functioning in 12 districts as reported by the state. The helpline was not functioning in the district WS.
- Most of the X-ray facilities were not AERB certified.
- IT applications like HMIS, RCH Portal and NCP app are in place; however, in absence of adequate training the quality of data entered was poor and uninterpretable.
- A system of preparing district health action planning does not exist.

Madhya Pradesh (District: Chhindwara & Khandwa)

- **CEA**- State has not adopted the CEA and has been implementing its state law, the M.P. Nursing Home Act 1973, instead.
- **PCPNDT Act** - 19 centers including 1 DH and 18 private centers are registered under the Act for providing ultrasound services during ANC. Regular monthly meetings, chaired by DC are held to discuss progress report, monitoring visits and minutes are documented. Monitoring visits to facilities are done on a quarterly basis.
- **MTP Act** - 4 public facilities (DH, CHC Mundi, Chhega on Makhan, CHC Harsud) and 10 private registered facilities are providing MTP services within the district. All 10 private facilities are located in the town Khandwa (Khandwa Urban). Poor documentation was noticed at CHC Mundi, especially related to consent forms. Some consent forms were filled in but were not signed by the clients. Maintenance of records was not as per the protocols.
- **POSH Act** - Each facility has their own committee under POSH Act with at least 2 females in the committee and a minimum of 4 members. Details of the members of the committee were available, but no details were available for any meeting held, training organized or any documented materials. No records of any complaints filed were available.
- **MLC/ GBV** Excellent One Stop Centre at Khandwa District Hospital run by WCD and supported by the DH for addressing GBV and MLC cases involving woman. 212 cases have been registered here since its inception in September 2018. It has a medical doctor, and supporting staff including a counselor. An indoor ward with 3 beds is also available for any survivor requiring stay at the facility.

- **COTPA** - Anti-tobacco signage was visible at all facilities visited. Penalization for smoking inside premises is done at the DH and a register for fines collected is maintained.
- 31 DHs have been developed as per AERB Norms.
- GRS is non-functional, including for ASHAs. However the ASHAs can lodge their complaint with the Block Community Mobilizer and if not settled, can complain to DCM. Complaints by ASHAs at the DCM level are recorded and documents are available.
- At state, district and block level, Mentoring group on Community Action (MGCA) were constituted. Support provided by MGCA is mainly through the implementation of capacity building training for ASHAs, VHSNCs, RKSs and monitoring of services through ASHAs and VHSNCs.
- MAS were vocal on the effects of change they had made in the society which also includes advocacy for the posting of a regular doctor in the PHC and helping woman in domestic violence issues.
- ANMS were using Anmol App and were comfortable with it.

Manipur (District: Bishnupur and Chandel)

- **CEA** – State has not yet adopted the CEA and is implementing a pre-existing legislation, namely: The Manipur Homes and Clinics Registration Act, 1992
- **PCPNDT** - In view of the fact that unlike many northern states, Manipur lacks entrenched patriarchy, there is little attention paid to gender sensitization in the state. Ultra sound machine at DH Bishnupur is registered under PC-PNDT Act.
- **RBD**- Registration of births and death are entered at facility level under RBD Act.
- **COTPA** - Enforcement squad had been constituted in the district. Training of the Law enforcers, health professional and stakeholders were done. Awareness camps were held in 15 schools by the NGOs in collaboration with the District NCD Cell. No Tobacco Cessation Centres had been established in the DHs and no nicotine replacement therapy carried out. So far, no drive on compliance to anti-tobacco laws had been undertaken.
- None of the facilities visited by the CRM team were AERB compliant. Infact, a warning letter has been issued to DH, Bishnupur by AERB for not having X-ray facility as per AERB norms.
- No IEC regarding radiation safety and warning for patients was present.
- It was observed that no staff wears radiation monitoring badges or tags in the visited facilities.
- **Community awareness** - Awareness on HIV-AIDS, TB, Drug dependence was high among the community. NGOs working for IDUs were actively involved.
- HMIS is functional in the state and is being used at all levels of care (DH, CHC, PHC, HWCs). The data entered in the HMIS portal is verified and signed by the Medical Superintendent / Medical Officer and then entered into the portal. However, during the visit, some errors in the data were found reflecting training issues among the staff presumably due to data entry problems.
- PPP are implemented in areas of diagnostic services at all levels, Biomedical Equipment Maintenance and Management Program (BMMP) and also under process in tele-radiology services.

Meghalaya (District: West Garo Hills & Ri Bhoi)

- **CEA** - The State has a pre-existing law - Meghalaya Nursing Home (Registration and Licensing) Act, 1993 in place for registration and regulation of private clinical establishments. However, implementation of the act is weak in terms of utilizing / bringing them towards executing activities relating to the broader objectives of public health.

- **PCPNDT Act**– Form F available. At the community level, there was hardly any male child preference. At the facility, IEC against sex selection foeticide was seen. Mandatory formats are maintained and USG units are registered. However, in this year there hasn't been any prosecution under the Act.
- **MTP Act** – no centres in Ri Bhoi district providing Comprehensive Abortion Care (CAC) services. In West Garo Hills the DH provides CAC services and also maintains mandatory formats.
- **POSH Act** - internal complaints committee is yet to be formed in many institutions.
- **Medico-Legal protocols for Rape/Sexual violence cases** - Printed formats and orientation of staff, especially Medical officers were found to be missing. One – stop centre is seen established at district hospitals.

In WGH detailed injury/medical report supported by laboratory investigations is submitted to police, with one copy kept as record. No gender-related training of health service providers and no specific protocols for gender- based violence were available at healthcare facilities in both districts. In Ri Bhoi, in Women's Economic Development Society (WEDS) which is a registered Non-Governmental Organization (NGO) Nongpoh, One-stop centre, for women affected by violence under Ministry of Women and Child Development is present.

- **COTPA**-IEC available but mandatory signage not displayed in any facility visited. IEC on tobacco use were found to be displayed in all the facilities visited. However, statutory warnings as per COTPA are not displayed. The ASHAs & AWC workers are aware of the NTCP requirements. Tobacco chewing is rampant in the state.
- **RBD Act** – the State is implementing this very well. The mechanism is in place for registration of institutional deliveries as well as home deliveries.
- **MHC Act** - State has notified State Mental Health Authority and Mental Health Review Boards. The state Mental health screening and treatment programme was launched during the visit of the CRM team in the state.
- **HIV/AIDS Act** - Community is knowledgeable regarding HIV/AIDS & its transmission. Universal precautions are not fully practiced at facilities. State has not yet appointed Ombudsman under the Act.
- **Disabilities Act** – one of the few States that implements the act very well. The medical officers are oriented, printed formats are available, IEC is displayed so that public is aware of the facility and disability certificate is issued.
- **Atomic Energy Act** – the units (X-ray) do not have registration from Atomic Energy Regulatory Board. TLD badges are also not used. PPE is in place.
- The X-ray units do not have registration from the AERB. TLD badges are also not used.
- State and District Health Mission is in place. However, the functionality as per guidelines to be ensured.
- District planning process is limited to preparation of budget sheets. The districts have this document available which is used mainly as a financing tool.
- Convergence with other departments beyond WCD, especially in the aspirational district (Ri Bhoi) needs improvement.
- Public Private Partnerships – the PPPs in place have faced some difficulties in the state in terms of (a) enabling appropriate provisions in the contract (b) the details of the deliverables of the private provider not clear because of which desired output/service is not achieved.
- The panchayat in the State does not have a funds of its own but draws from various schemes of the government, VHSNC funds being one of them. The village headman (Nokma) many times exerts pressure in expenditure beyond the purpose specified in the guidelines.
- Poor IT connectivity impacting all IT platforms. DVDMS used only by NHM & not directorates. Good System of Medical Records Management with retrieval facility is available.
- GRS System poor in the state.

- Good progress in making the blocks ODF free across the State.

Mizoram (District: Mamit & Aizawl East)

- **CEA** – The State has adopted the CEA but is yet take steps to implement it.
- **PCPNDT Act** - The certificate of registration are not displayed at proper place. Form F not available even at DH level.
- **POSH Act** - The staff of the facility is not aware about POSH Act.
- **MTP Act** – documentation poor and Form C not available even in DH.
- **Medico-Legal Protocol for survivors of Rape/ Sexual violence** - The staff is not aware about Protocols. No MLCs were reported since July 2019. One Stop Centre is not available even at DH. No records related to medicolegal cases, including rape and sexual violence cases are maintained as well.
- **COTPA** –Signage such as "No Smoking Area – Smoking here is an offence" were there at most of the health facilities but the contact details of the person to complain about it were present only at DH Mamit's signange.
- **RBD Act** - The MS is the Registrar at DH Mamit and responsible for Registrations of Births and Deaths. At PHCs, MO is the registrar & responsible for providing these documents.
- **Disabilities Act** - The facility is not issuing any Disability Certificate to the patient.
- Tele-medicine is not yet rolled out in any of the facilities visited (Both East Aizawl and Mamit).
- No systematic Grievance redressal system including for ASHAs.
- State PIP is not being prepared in consultation with Districts and Blocks Units
- Due to the low community awareness and absent of referral mechanism, the referral linkages with higher centre is suffering.
- The IT based reporting system include HMIS, IDSP, NCD Portal and NCD App is functional.
- Monitoring and Supervision mechanism is not in place and completely invisible in DPMU Unit.

Nagaland (District: Phek & Kiphire)

- **CEA** – The State has a pre-existing legislation, namely – The Nagaland Healthcare Establishments Act, 1997.
- **POSH Act** - There was lack of awareness about the Act and VISHAKHA guidelines in both the districts.
- **Medico-Legal Care protocol for Rape/Sexual violence** - At the district level, a One stop crisis centre "Sakhi" was set up by the Social Welfare department. OSC is also integrated with the Women Helpline-181 and the Family Counselling Centres (FCCs).
- **COTPA** - IEC materials on tobacco as a risk factor were displayed at HCFs, with facilities being labelled as tobacco free areas; however, at few facilities service providers including Medical officers and staff nurses themselves were observed consuming smokeless tobacco. Tobacco Cessation Centres were not available at all the districts. Nicotine replacement therapy was not available at any of the facilities visited. Counselling was only done for those who visit the counsellor separately in the NCD clinic.
- **HIV/AIDS Act** – Despite, Nagaland's state prevalence rate amongst the highest in the country at 1.15%, HIV/AIDS Act hasn't been implemented here.
- **MHC Act** - Mental health related issues were more common in adolescents and school going children in the community with young population sub groups getting drawn into substance use and dependence. MHC counselling services were being delivered in both the districts.
- MTP Act- MTP services, upto 12 weeks, were only available at CHC and DH. Majority (~70%) abortions were done in private facilities. FP-LMIS not yet rolled out.
- The health facilities of Phek and Kiphire with X-ray equipment do not adhere to AERB norms.
- In the State Health Societies/ District Health Societies are in place. However, the planning is

very weak and over last few years it has become weaker even the district RoPs are not prepared.

- DVDMS not functional in state. CPHC-NCD IT app rolled out and tablets are used to feed in the data but poor internet connectivity hampers the same. ICDC-CAS not used by AWWs as it is in English language and the modules are difficult to understand as well.
- Other governance related gaps identified are - poor GRS, lack of supportive supervision & monitoring and inadequate recording, and reporting process.

Odisha (District: Mayurbhanj & Kandhamal)

- **CEA** – State has not adopted the CEA and implements its pre-existing legislation, namely – The Orissa Clinical Establishments (Control and Regulation) Act, 1990. SDH Udala was reported to have CEA certifications
- **PCPNDT Act** -At SDH Rerangpur, the USG is done on routine basis (though license expired since March 2019) and also uses Form F for all cases and records are well maintained. It has a clear display of advisory against prenatal test for sex determination. USG not done at CHC Jashipur.
- **MTP Act** - CHC Jashipur and SDH Rerangpur are MTP sites and have ObGyn doctors who provide MTP services on routine basis. Medical Abortion (MA) Drug was available at both SDH and CHC.
- **Medico-Legal care Protocol for Rape and Sexual Violence Cases:** The ML cases for sexual assault are attended at CHC Jashipur as well as SDH Rerangpur (though the latter is not attending sexual assault cases anymore due to unavailability of an OBGY doctor). But, there is no dedicated room or 'one stop crisis centre' available at either of the facilities CHC/SDH. OSC at Mayurbhanj is functioning well and a total 45 cases of GBV have been registered since June 2019. No OSC seen in Kandhamal district. Overall, state has 22 OSCs. Victims at OSCs complained that their statements aren't correctly recorded.
- **RBD Act** - Good system of maintaining hard copy (form2&3) and online entry of all births and deaths (both from the field and the hospital) seen at CHC Jashipur and SDH Rerangpur. Both the facilities have a designated unit and a point person (a male supervisor in Rerangpur and Clerk at CHC Jashipur) designated under RBD Act.
- However, low community awareness (including ASHAs) on the need and process to be followed to obtain birth and death certificate seen. Incomplete registration of birth continues to be an issue in CHC Jashipur. There was fair gap between the total births reported and actual number of Form 2 filled/ uploaded.
- **HIV/AIDS Act:** The VCTC centre and the Integrated Lab had detailed SOPs for HIV PEP and safety norms at the SDHs visited but the same was missing at the PHC and CHC level. Awareness of community and health staff was very high regarding transmission of HIV.
- **Disabilities Act:** The SDH Rerangpur and SDH Udala are both disable friendly facilities. However SDH is not issuing any disability certificates.
- **POSH Act:** SDH Udala has a committee to address Sexual harassment of Women at workplace and the members are oriented. No such committee formed at any other facility in the state.
- **COTPA** - Lack of awareness (tobacco harms and legislation) among the community and the staff working in the hospital. In Kandhamal, it was observed that the DH was not tobacco-free zone. District tobacco consultant under NTCP programme was not recruited and hence, all the tobacco control activities apart from the IEC were affected. Same was noticed in Mayurbhanj as well.
- The SHS had conducted two EC meeting in 2018-19 and till Sep 2019 only one meeting has been conducted. At facility level, RKS are constituted and meeting regularly.
- The State follows the system of bottom up approach for planning and budgeting.

- Internet connectivity issues limited the use of RCH portal, MCTS etc.
- State has successfully signed into several contracts under PPP- outsourcing PHC New management, Dialysis, Pathology, X-ray, CT Scan, MRI, Laundry & CSSD.
- Separate position (OSD) in the Department for addressing the public grievances seen.
- Enhanced incentive to LSAS & EmOC doctors at FRUs from Rs.5000/- to Rs.30,000
- Monitoring & Supervision through monthly VC by SPMU with the DPMUs. Similarly, the MD reviews the progress of NHM activities through quarterly review meetings.
- Separate position (OSD) in the Department for addressing the public grievances.

Rajasthan (District: Churu & Sirohi)

- **CEA** – State has adopted the CEA but its implementation needs to be stepped up. The process of registration of clinical establishments is yet to be initiated.
- **PCPNDT Act** –Impact Software has been developed for monitoring and online registration or reporting of Form F. Block wise monitoring of child sex ratio according to PCTS software and survey was completed, based on a report of IMPACT software. Total 3318 ultrasound facilities were registered under PCPNDT Act till September 2019. About 152 convictions have been made till date.
- **MTP Act** - MTP services are being provided at CHC level. IPAS (NGO) is providing technical and training support to MOs/Gynecologists.
- **POSH Act** - No written policy available at the facilities and no records of complaints found anywhere. A committee is constituted at CMHO office level.
- **COTPA–** COTPA has been included in the monthly crime review meeting of SHOs as per order issued by Home Department. A well-defined monitoring challan and reporting mechanism has been set up and notified by the competent authorities for effective implementation of Section 4, 5, 6 & 7 of COTPA. From the year 2011 to September 2019 total 289978 Challan have been issued under section 4 & 6 (a) and (b). All educational institution including health care institutions and ICDS centres are notified in the category of educational institutions and sale of tobacco products within 100 yards of these institutions is prohibited in the State. Various signages for "NO smoking" displayed at schools and AWC level and in event of violations, challans are issued. No tobacco vendors noticed within 100 metres of HCFs.
- **RBD Act** - Birth and death certificates are issued at PHC and CHC level institutes. For below PHC level, the certificates are issued by the Gram Level Officials.
- **Disabilities Act-** PHC and CHC level institutes are verifying the cases and certificates are issued by CMHO at District level.
- **MHC Act -** Implementation of Mental Health Act was not observed in the Districts.
- The visited facilities were not certified for AERB site approval except the DH & CHC Sahawa, Churu. TLD badge was also available with the staff in CHC Sahawa. At other facilities, staff wasn't found to be using the TLD at chest level while the X-ray unit was being operated.
- Machine operators were not using lead aprons. No unit was being operated from the control room or from behind the Mobile Protective Barrier (1.5 mm lead equivalent).
- Well defined Institutional Structure with SHS and DHS in all districts. Convergence between Health and WCD was observed in the field through ASHA Sahiyoginis. Involvement of PRIs through VSNCs and RKS with a purpose to increase accountability through communitization was observed in the districts.
- The planning meeting is organized with Block & Sector level officials for block PIP preparation in the light of GOI guidelines and financial envelop.
- All health facilities were having computer and internet facility and were reporting in

HMIS, PCTS and NCD Portals. Monitoring and mentoring of program activities, various checklist and RAJDHARA/ DAKSHTA inspection app developed which is followed by block/ District level officials in supervision.

- MoU is signed between district CMHO and Concessionaire which is valid for period of 3 years subjected to review and confirmation of the arrangement after every year. NUHM is doing annual performance review every year for continuation of the agreement. NUHM is providing the financial assistance of Rs. 21.59 lakh to the concessionaire to maintain and operate the facilities.
- A centralized grievance redressal system at state level is functional.

Tamil Nadu (District: Villupuram & Virudhunagar)

- **CEA** - Tamil Nadu Clinical Establishments (Regulation) Act extends to the whole State of Tamil Nadu with the exception of those areas controlled or managed by the Armed Forces. There are 2785 CEs registered in the State, 145 in Virudhunagar and 119 in Villupuram including CEs in Allopathy and AYUSH systems of medicine. The certificate of registration under CEA is displayed at a prominent place.
- **PCPNDT Act**- Around 7198 Institutions with USG services are registered under the PCPNDT Act (173 at Virudhunagar and 176 at Villupuram), including private facilities. In the wake of recent dip in SRB in TN, from 915/1000 to 907/1000 (SRS- 2015-17) there has been increase in monitoring, inspections and strict action against violations of the PCPNDT Act. The State has also brought within the purview of the implementation of the PCPNDT Act, genetic counselling clinics and ART clinics. There were 147 cases registered under this Act, out of which 118 resulted in convictions and 29 are under trial.

Protocols related to appropriate signage and displays were being adhered to, across all levels. The District Advisory Committees have been constituted; however reconstitution of the committee and organization of meetings as per guidelines need to be commenced. Furthermore the districts need to ensure that due procedure is followed for issuing renewals especially to clinics and centres that have previously been sealed due to non-compliance with the PCPNDT Act.

An emerging area of concern is that with an increase in action against violations of the PCPNDT Act in Tamil Nadu, families wanting to sex select, are tending to seek illegal sex determination and sex selection in the bordering districts of Andhra Pradesh and Karnataka, which needs urgent attention of the state & necessary action.

- **MLP for rape/ sexual violence:** 46% women in Tamil Nadu, aged 15-49 have experienced physical or sexual violence (NFHS-4). At present there are two One Stop Crisis Centres (OSCCs) operational in the State. In the district of Virudhunagar, the OSCC sanctioned is under construction at the DH. The DH is currently attending to about 3-4 cases of sexual assault and rape per month.

There has not been any training at the State or district level for screening and clinical management of cases of violence against women and children (VAWC). Written SOPs were available for taking informed consent for medical examination, evidence collection, reporting to the police, etc. Psychological and medical treatment is being provided to the survivors. There exists a chain of custody of medical evidence collected involving the medical superintendent and the police. Forensic testing is undertaken at Ramanathapuram Forensic Centre. TAEI Casualty Centre also intimates any rape or sexual violence cases and the survivors are processed accordingly.

- **POSH Act** - An Internal Complaints Committee was formed in 2018 with the prescribed members, at the District and State level. There were no complaints registered at Virudhunagar as on date.
- **COTPA** - COTPA has been included in the monthly crime review meetings. There is a well-defined challan mechanism being set up and notified by the Competent Authority.

The Signage of "No Smoking Area- Smoking Here Is An Offence" is present at most of the government building premises but not found in many of the health facilities visited. Wherever the signage were available, the name and details of the nodal persons were not mentioned.

A video regarding ill effects of tobacco is running in the facility during OPD hours and was observed at UPHC in Virudhunagar. Fines are being charged for smoking in public places (Rs 100/200). Rallies by school children, IEC as hand bills distributed in shops and among public are often carried out. In Virudhunagar, 418 individuals were fined during 2018. At state level, a cell has been set up, staff appointment is under process and district level committee is in place in Villupuram.

In Virudhunagar community was not aware of Tobacco cessation. School authorities were aware about tobacco ban & sessions on awareness about tobacco were held in schools under the RBSK. Tobacco cessation and pharmacological treatment facilities are yet to be introduced in the health programme.

- **RBD** - The State has launched various IEC measures like hoardings, posters, hand bills, video clippings on issue of birth/death certificate on national holidays like Independence Day and Republic Day. Regular training/sensitization programmes are conducted for Birth and Death Registrars. Issue of birth certificates from hospitals itself to mothers delivering in government institutions at the time of discharge is a good initiative. Birth and Death registers are maintained at all levels of facilities.
- **HIV/AIDS Act** - SOP on safe working environment (gloves, aprons, masks) and occupational exposure to HIV available only at DH level. ART is being provided for PEP. MO is appointed as the complaints officer. At community level, police harassment of the vulnerable high risk groups is common especially brutality towards the FSW. The transgender (trans-women) community seemed more cohesive; more empowered and well informed about the health and social sector services targeting them as well as their incentives and promotion activities from the government. They were also aware of the Gender Clinic at Chennai where counselling, testing and sex-reassignment surgeries take place under one roof, all provided free of cost by the State government.
- **Disabilities Act**- Disability Certificates are only issued at the DH level following a regular meeting of the Disability Board on selected and well-advertised days.
- **NMHC Act** - The State had constituted a State Mental Health Authority under the previous Mental Health Act, 1987, which was performing its functions well. It is not clear if the State has reconstituted the Authority as per the new Act passed in 2017.
- AERB certified X-ray unit in Tindivanam, Govt. Hospital is working without a lead door.
- During the visit to the health facilities, District Health Society (DHS) and State Health Society (SHS), it was observed that the Books of Accounts are maintained properly at all levels.
- There no evidence of decentralised planning reported during the visit. State needs to implement the block to the district to the State.
- Computer and Internet facility is available at all facilities. Tablets for ANMs have been provided. Information regarding number of deliveries, surgeries conducted (major/minor), specialists available, vehicle status, dog/snake bites, complicated maternity admissions etc. are being submitted on HMIS, IDSP, MCTS, etc.
- 102 and 104 HHS active in the state. The 104 HHS is run by GVK EMRI in partnership with State Government of Tamil Nadu.
- Regular visits by the District/State officials are undertaken for monitoring/supportive supervision.

Uttar Pradesh (District-Meerut & Bahraich)

- **CEA** – State has adopted the CEA Act.
- **PCPNDT Act** - Large number of decoy operations conducted in district Meerut. Greater participation from District Administration can further enhance performance.

- **RBD Act**-The notification mechanisms to appropriate authorities for births, deaths and still births are quite weak. MOs and frontline workers had limited understanding of the standard reporting formats for such events and also the standard formats were found unavailable at the facilities.
- **MHC Act**- While NMHP is being implemented incrementally, implementation of district mental health Programme at facilities in block and below in terms of screening and identification was found to be weak. The MHC Act not fully implemented yet.
- **COTPA** - Facilities visited displayed adequate IEC materials. Despite this, people visiting facilities were consuming tobacco in various forms. Imposing strict fines were not observed in any facility. In Meerut, fines have been collected at Bus stop and RTO only and no fines have been reported by the health facilities (PHC/CHC/DH). Combined awareness camps were conducted through mental health and NCD cell.
- **POSH Act** - There was lack of awareness among staff regarding POSH Act or Vishakha guidelines. No committee has been constituted in any facility.
- MTP Act- CAC services were available only at DH not at the CHC level. Majority of CAC services reported to be provided till 10 weeks of pregnancy.
- The team reported that State Health Society, District Health, RKS and VHSNC are in place.
- VHSNCs and MAS members are not familiar with roles and responsibilities. VHSNCs do not have 50% female members. There is no involvement of VHSNCs in Community Action for Health

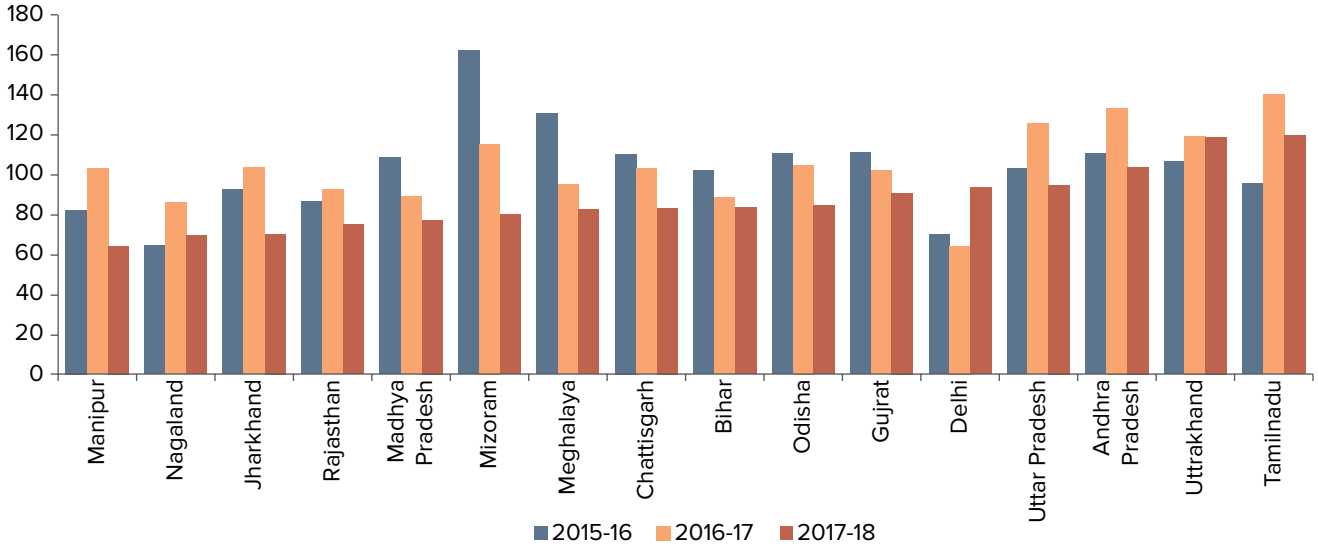
Uttarakhand (District: Haridwar & Udham Singh Nagar)

- **CEA-** Reportedly, every public facility is registered under Clinical Establishment Act and each facility has received Certificates. But certificates are not displayed in the hospital.
- **Pre-Conception & Pre-Natal Diagnostic Technique Act:** District Udhamsingh Nagar has been felicitated at national level for good enforcing of the PCPNDT act. There are currently 5 public facilities and 88 private centres, registered for providing USG services in the district. In 88 Private USG centres, 127 USG machines are installed, and tracker is installed in 93 USG machines. Through strict enforcement of act and regular monitoring visit by district committee, 9 USG Centres have been sealed in the district.

Electronic scroll board is installed in all government health facilities where there is facility for displaying Sex Ratio of deliveries in their hospital. Gudda-Guddi Chart is displayed in all Private and Government hospital, which shows the sex ratio of that facility. This is being displayed in CMO's office, DHS and important district and block offices.

- **COTPA** - The CHC is tobacco free premise. Standardized anti-tobacco signages are displayed at CHC but not at SC. Records of individuals penalized in last year are not available. Awareness about tobacco cessation are provided to patients visiting the SC or CHC. Tobacco cessation clinic, nicotine replacement therapy and counsellor is available at DH only. The community had no knowledge about COTPA or quit line number.
- **POSH Act -** Internal complaints committee was not constituted by written order. If any complaint comes, departmental enquiry was being done.
- **Medico Legal care Protocol** for rape and sexual violence cases – printed protocols are available and the copies are sent in triplicate to CMO office, DC office and to the Police.
- **Registration of Births and Deaths Act–** hospitals are providing certificate of birth registration. In addition, the panchayats are also involved in issue of birth and death certificate.
- **MHC Act-** DH Rudrapur has a dedicated mental health team. District Counselling Centre (DCC) is available at DH. Line listing of patients with diagnosis was maintained by the Psychiatrist at DH. General lack of awareness on mental health issues, attached stigma, and availability of services was observed in the community. No IEC/ BCC materials on the programme were seen in the community.

Fig.1 NHM Tamilnadu Uttrakhand Andhra Pradesh Uttar Pradesh Delhi Gujrat Odisha Bihar Chattisgarh Meghalaya Mizoram Madhya Pradesh Rajasthan Jharkhand Nagaland Manipur 2017-18 2016-17 2015-16 Utilisation* (In %) across the States



Source: *FMG, National Health Mission, Ministry of Health and Family Welfare, Government of India; accessed from http://nhm.gov.in/images/pdf/FMG/FMG_RTI/Central_Release_State_Share_Credited_and_Expenditure_undr_NHM.pdf*

- **MTP Act-** The abortion care facility under CAC program was available at SDH and DH level. Trained MO, MVA kits and MTP register was available at the facility but very few abortions done.
- State has institutional structures (SHM/DHM, SHS/DHS) in place. At facility level, Rogi Kalyan Samiti (RKS) are there but in visited CHC meetings held once in the past year against a quarterly meeting.
- There is no bottom up planning approach evident in the state. Presently, funds from district level to block level is based on demand and not on plan based.
- **Internet** connectivity was not available at any SC HWC or PHC HWC in the district visited. Staff uses personal phone connections for using app. Payment and reimbursement of mobile payment is not being done.
- All required diagnosis tests are done free of cost in the facility to the patients. Expenses incurred for these tests are reimbursed to Rogi Kalyan Samiti by Red Cross Society. Rogi Kalyan Samitis from CHCs/SDH&DH are receiving Rs. 75000/- to Rs. 1 lakh per month from PM-JAY yojana where it is implemented.
- Anganwadi Workers from ICDS are not members of the VHSNC.
- It is observed that state has inadequate monitoring and supportive supervision mechanisms.

Part II: HEALTHCARE FINANCE

NHM is one of the most important initiative of the GOI that envisage achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs. This initiative is directed towards financing and supporting the states to strengthen public health systems and healthcare delivery in India. Allocation of State NHM budget is based on Project Implementation Plans (PIPs) submitted by State governments which are approved by the Union government. Both Central and State Governments contribute in implementation of programs under NHM in a ratio of 60:40 for all States and UTs with legislature. For hilly and North Eastern States, it is 90:10 and for Union Territories without legislature, centre contributes 100%. Since its inception in 2005- 06, National Health Mission has released about Rs.2.1Lakh Crores[1] till March 2019.

1 National Health Mission, MohFW.

Table: Out of Pocket expenditure across the States*

Out of Pocket Expenditure (OOPE)				
	In Rs. Crore	Per capita in Rs.	% GSDP	% THE
Share of OOPE IN Total Health Expenditure 40%-50%				
GUJRAT	11399	1781	1	48.1
Share of OOPE IN Total Health Expenditure 50%-60%				
CHATISGARH	5711	2040	2.2	55.9
RAJASTHAN	14504	1934	1.9	56.7
Share of OOPE IN Total Health Expenditure 60%-70%				
JHARKHAND	5496	1527	2.3	66
MADHYA PRADESH	15166	1944	2.3	68.9
ODISHA	12582	2796	3.2	68.9
UTTRAKHAND	2748	2498	1.4	62.1
TAMIL NADU	22626	2938	1.7	62.1
Share of OOPE IN Total Health Expenditure 70%-80%				
ANDHRA PRADESH	20928	3322	3	72.2
BIHAR	20857	1830	4.9	77.6
UTTAR PRADESH	56609	2597	4.5	74.8
India Average	3,40,915	2,570	2.2	58.7

Source: *National Health Systems Resource Centre (2019). National Health Accounts Estimates for India (2016-17), New Delhi, Ministry of Health and Family Welfare, Government of India*

**Estimates for four North eastern States namely Manipur, Meghalaya, Mizoram and Nagaland along with Delhi is not reported due to small sample size of household at the State level.*

Optimal utilisation of these funds is very important to meet the health needs of the country and ensure zero OOPE on health. In most of the States visited this time, OOPE exceeds 50 % of total health expenditure. Gujarat is the only State with OOPE under 50 percent. In Andhra Pradesh, Bihar, and Uttar Pradesh, share of OOPE exceeds 70 percent of total health expenditure.

Among all the CRM states visited, the utilisation of NHM funds has reduced between 2015-16 and 2017-18, only exceptions being Delhi, Nagaland, Tamil Nadu and Uttarakhand. As per 2017-18 estimates, states with very high utilisation include Uttarakhand, Tamil Nadu and Andhra Pradesh where the utilisation exceeds 90%. On the other hand, Manipur and Nagaland have relatively lower utilisation with utilisation rate less than 80%.

NHA data, NHSRC.

1* Utilisation of NHM = Expenditure ÷ Centre Release + State Share

2. Expenditure (as per FMR reported by the State/ UTs) includes expenditure against Central Release, State release & unspent balances at the beginning of the year.

KEY FINDINGS

- Most of the States have reported a robust financial system. With the use of PFMS the beneficiaries under various programmes like JSY, JSSK, ASHA, NTEP (erstwhile; RNTCP) etc are getting their money through DBT. However, issues with opening of bank accounts noticed

in many states has led to lesser number of beneficiaries getting the entitlements.

- Few IT initiatives such as e-vitta pravaha in Madhya Pradesh, or use of ASHA Soft and OJAS (Online JSY, Rajshree and Subhalaxmi) Payment System in Rajasthan and application of e-Janani in Bihar have simplified the fund flow process in these states. Such good practices can also be replicated in other states for efficient payment and monitoring of funds.
- The availability of finance personnel is not seen as a problem barring in few states that had vacant positions of finance staff. Rather capacity building of finance personnel was seen as one of the important requirements as observed in the states of Andhra Pradesh, Gujarat, Meghalaya, Nagaland, Mizoram and Uttar Pradesh.
- Most of the states reported less than optimum utilisation of NHM funds. Multiple reasons were identified- some of them were procedural and some were due to inefficiencies of the system. Procedural delay can be due to the late release of funds from Treasury to State (Uttar Pradesh) or non-submission of utilisation certificate for the outsourced work given by NHM (Bihar and Delhi) or parking of funds at the District/State level (Nagaland and Meghalaya). On the other hand, the inefficiencies of the system affect fund absorption when there is- dearth of health personnel (Chhattisgarh), lack of information about routine activities at the district level due to lack of planning (Jharkhand, Uttarakhand, Nagaland and Mizoram) or distribution of funds to peripheral units uniformly without analysing the utilization pattern (Bihar).
- Delay in fund disbursal from the State treasury to State Health Societies (SHS) continues to be a major problem in many states such as- Andhra Pradesh, Chhattisgarh, Jharkhand, Manipur, Nagaland, Mizoram, Tamil Nadu and Uttar Pradesh, directly impacting the utilisation of these funds for various health programs.
- Overall, there has been an improvement over previous years, on delay in payment to ASHA or JSY beneficiaries except in states of Manipur, Nagaland and Meghalaya where irregularities in payment of ASHA incentives and in Meghalaya and Uttar Pradesh where delay in payment to JSY beneficiaries was found. In few states, payments were made by cheques to the JSY beneficiaries.
- Differential financing system within the State was not followed in AP & TN as allocation of an additional 30 % of the fund in HPDs was not done.
- Steps to ensure accountability of fund was present in all the States. Although the uptake varied. Statutory Audit was already submitted in the States of AP, Gujarat and MP. On the other hand, in Chhattisgarh, Jharkhand, Manipur and Nagaland the audit process was not complete. Account keeping practices, especially at the facility levels, vary across the States. In AP, Gujarat and Madhya Pradesh books of Accounts have been maintained at all levels but in Chhattisgarh, Meghalaya, Nagaland and Mizoram the accounting system was not proper at the facility level.
- Regular meeting of Rogi Kalyan Samiti (RKS) to decide expenditure at the facility level was not held in most of the States. There were instances of non-utilisation of untied fund allocated for RKS. The accounting system for most of the RKS was not satisfactory. Apart from untied fund, user charge was another important source of revenue for RKS as seen in Uttrakahand. Utilisation of user fees at facility level has led to under-utilisation of the seed money from GOI, reducing allocations in the subsequent year. Thus user fees, which reflect OOPE borne by patients visiting the facility, appear to be substituting the grants being given by the government.

RECOMMENDATIONS

- All entitlements under JSY, JSSK, PMSMA, PMMVY should be assured at all levels. Display of IEC for entitlements under various schemes (JSSK etc.) along with awareness generation among service providers and the beneficiaries to be ensured. States also need to address delays in timely payments to staff and ASHA incentives.

- There is an urgent need to reduce delays in fund transfer from State Treasury to State Health Society and also for the fund transfer to facilities. States should also ensure the timely release of RoP approvals and funds to the Districts.
- There is a need to explore an alternate route for the transfer of the fund to reduce delay in fund transactions in states like Nagaland where banking facilities are not well developed. States may think of utilizing the postal services for banking facilities in areas where there is no / poor banking system.
- The financial performance of Districts and Blocks needs to be monitored on a regular interval.
- The age-wise advance register should be prepared at all levels for monitoring and settlement of advance outstanding.
- Regularize RKS meetings and there should not be any delay in disbursal of the untied fund to RKS. RKS funds to be utilised properly. Accountability of RKS for ensuring timely resolution of issues in the health facility must be delineated.
- Differential financing should be followed strictly within the State and high priority districts (HPD) should get 30% additional funds.
- Capacity building of finance staff at State and Regional levels should be done at regular interval and accounting system at the facilities to be improved.
- Finance & Accounts wings at district level must be integrated. All the accountants may be placed under the DAM with rational distribution of work.

STATE SPECIFIC FINDINGS

Andhra Pradesh (District: Kadappa & Vishakhapatnam)

- Payment and Fund transfer takes place regularly through E-Transfer and CFMS. Some payments of JSY in Vizag were done through non a/c payee cheques
- Delay in the transfer of funds has been observed (132 Days as on 30.09.2019).
- Low utilization reported- 39% as on 30.09.19 against PIP at State.
- Districts RoPs have not been circulated by the State at the district level.
- State has not followed the criterion of allocating 30% more budget per capita to High Priority Districts (HPDs). The CRM Districts Visakhapatnam and Kadappa are HPDs
- Books of Accounts have been maintained at all levels but more capacity building is required at downward periphery like at CHC, PHC, Area Hospital and DH.
- Meetings of RKS are conducted but not regularly at most of the visited facilities.
- Fund diversion taking place due to delay in the release of the state's share for JSY.
- Statutory Audit has already been conducted for the Financial Year 2018-19 and Report is submitted in Ministry in time. Concurrent Auditors for the FY 2019-20 has not been appointed by the State.
- The State is running its own scheme called Dr. YSR Aarogyasri Scheme which provides end to end cashless services to BPL beneficiaries for 1059 procedures.
- Janani Suraksha Yojna payment approved under RoP of 2019-20 is Rs 700 for rural areas but AP is giving Rs. 1000/- after incorporating Rs. 300/- from the State scheme named "Sukhi Bhawa". But for last 1.5 years, no funds received from state fund, indicating use of NHM fund for payment of Rs 300.
- **ASHA Payments:** ASHAs are getting their payments on regular basis through E-Transfer as a fixed honorarium of Rs. 10,000/- (Rs. 7200/ - from State Fund and Rs. 2800/- from NHM Fund). It is pertinent to mention here that NHM Incentives to ASHA are performance based as per the PIP approvals of Current Financial Year 2019-20 but State is not abiding by this guideline.
- **Banking Guidelines** not been followed at State and District level. All transactions are carried out

from one bank account though all programme accounts are opened at SHS and DHS. Because of this reason, exact bank balances cannot be tracked for each programme.

Bihar (District: Bhagalpur & Begusarai)

- Decentralised planning attempted across the state. DHAPs and Block Health Action Plans have been seen in the districts visited.
- All payments are made electronically through PFMS
- **e-Janani application for online viewing** of JSY payments has been initiated by the State. Yet, delay ranging up to 6 months in JSY payments was noticed at DH Begusarai and Block-Khodawanpur and many other facilities. Also, JSY payments are made on receipt of claims from beneficiaries; **it should rather be spontaneous.**
- There was no display of JSSK entitlements, and the service providers lack adequate knowledge about JSSK Scheme
- The Concurrent Audit Mechanism has been strengthened but Statutory Audit Reports of State Health Society of earlier years have not been placed to Governing Body meeting.
- The accounting software is being restructured for use as a management tool for fund management and decision-making MIS.
- No reconciliation is seen between the Delivery Register and Payment Register while making payment to JSY beneficiaries. Delay in DBT Payments for Nikshay Poshan Yojana under NTEP (erstwhile; RNTCP) was seen at visited District Hospitals.
- In the District Begusarai it has been observed that vendors have been selected without competitive bidding and some high value payments were made accordingly
- No Financial expenditure incurred during the last 1 year under National Programme for Health Care for Elderly, though enough fund is available at DHS Begusarai
- The State is having substantial advances under various pools of NHM as a result of which there is difficulty in receiving Central grants on time. Under the scheme of Mission Flexible Pool, the State is having unspent balance of Rs.8940 million which is more than the Central allocation of Rs.8179.6 million.
- **Slow Financial Utilization:** No age wise analysis of advances was available at SHS-Bihar, leading to high unspent balances. **E.g. Advances of Rs. 840.7 million were lying with BMSCIL from last year** related to MCH Wings, procurement of Tablets and Equipment etc. Non-collection of utilisation certificates from implementing agencies was quoted, by the state authorities, as the reason behind such high Unspent balance in the account though the work has been ongoing.
- A substantial amount is being expended every month without any verification at Block levels. At District level only fuel vouchers were available but there was no visit report, purpose of the visits, monitoring calendar and outcome of the visit etc. All such payments need to be outcome based. Payments were made to vendors for vehicles hired for RBSK mobility supports and BPMU Mobility supports without any bill, photocopy of logbook and verification of KMs through logbook.

Chhattisgarh (District: Rajnandgaon & Korba)

- There has been negative growth rate in Health Budget for the period 2018-19 to 2019-20.
- The utilisation of NHM funds till September was 32%. At the district level utilisation of funds was less than 75 % in 2018-19 whereas in the present year till September utilisation was around 35%.
- Underutilisation of funds due to the dearth of manpower at the facility level, delay in the transfer of funds and delay in getting UCs from various implementing agencies.
- Transportation cost is one area of concern for people adding significantly to OOPEs.
- Revenue received by RKS under PMJAY in empanelled hospital is around 90 lakhs at the district hospital and at the PHC level, it is around

3 to 4 lakhs. Money is used as per the guideline given by PMJAY.

- In some cases, money transfer under JSY is taking place through bank cheques.
- The State has not submitted statutory audit report to GOI for the financial year 2018-19 till now while the last date of submission was 31st July 2019.
- Books of account at the HWCs/Sub-center are not kept in a proper manner.
- The team-based performance incentive has not been very effective for the HWC field-based worker.

Delhi (District: East Delhi & New Delhi)

- Public Financial Management System is used at Delhi Government Dispensary level in both the districts.
- Patients (pregnant women, NTEP (erstwhile; RNTCP) etc.) received money through DBT. A few cases seen where DBT payment was not done due to non-linkage of bank account linkage with Aadhar. DBT payments (i.e. Payments for Family Planning & Quality Insurance Scheme) are made through NEFT at Lal Bahadur Shastri Hospital.
- Delay due to non fulfilment of DOE conditionalities by the State i.e. State share pendency is of Rs.12.46 crores.
- Audited UC along with Audit Report is pending for GOI submission.
- Statuary Audit Report of SHS and IDHSs for the FY 2018-19 is pending for compilation at the State level. Appointment of Concurrent Auditor for current FY 2019-20 is under process.
- Funds under RKS are not utilized (especially at PHC level) due to the non-formalization under RKS for 4 units under East Delhi district
- In East District, low pace of financial progress under Non-Communicable Disease and NTEP (erstwhile; RNTCP) has been observed in FY 2018-19 as well as current financial year.
- In New Delhi District, low pace of financial progress under Reproductive and Child Health, National Leprosy Eradication Programme (NLEP) and National Tobacco Control Programme (NTCP) have been observed in FY 2019-20.
- District Health Payments through PFMS mode were not made at Maternity Home Munirka. It has been reported by concurrent auditor in last audit report from December 2018 to March 2019.
- Interest received on funds under NHM is not reported properly in the Statement of fund position at District and State Level.
- In East district, additional charge to any competent person was not paid due to absence of DDO, who is verifier and approver of Print Payment Advice generated by PFMS.
- About 86 lacs have been given to LHMC till Feb 2019 for construction purpose. But, utilization certificate of the above amount is still pending till date.

Gujarat (District: Dahod & Surat)

- All payments (except statutory dues) are being done using PFMS at all levels. Direct benefit transfers have been done to the beneficiaries under various programmes like JSY, JSSK, ASHA, etc.
- Statutory audit for FY 2018-19 has been completed and the Audit Report has been submitted to GOI in time. Concurrent audits are done regularly and the auditor's observations, if any, are duly complied.
- Books of accounts are maintained both electronically and manually upto the PHC level. Bank Accounts are reconciled monthly upto the PHC level.
- TDS is deducted and deposited timely at all levels. Joint signatories are there for all banking operations with one employee of the regular cadre.
- Strong internal control mechanism with respect to compliance of procurement procedures.
- No diversion of NHM funds for state specific programmes. Funds are being utilized as per the NHM operational guidelines.

- The State has reported share pendency of 22% as on 30.09.2019.
- The State has reported low financial progress under various programmes as on 30.09.2019. Utilisation for RCH was 27%, NUHM was 34% and non-communicable disease was 25%.
- Negative unspent balances are reflected in Statement of Fund Position as on 31.08.2019 under many programmes like RCH, PPI, IDSP, etc.
- The concerned staff needs to be trained in operating the accounting software i.e. Tally ERP 9.
- Cases of overwriting in cash book at some facilities were noticed.

Jharkhand (District: Gumla & West Singhbhum)

- There is a delay in the release of funds from SHS to DHS. Even in case of release of state share, it is delayed by 10 to 15 days.
- Most of the payment is done through PFMS. DBT for all TB patients are done at the district level. JSY and FP payments are done at the block level.
- There is no monitoring of expenses against approval at the district level. The district only monitors its expenditure against the amount released.
- There has been a diversion of funds from NHM to other programs.
- Both the districts received money apart from NHM funds. West Singhbhum district received money from District Mineral Fund and Health facilities in Gumla district received money under PMJAY.
- State sends the district RoP to districts in fragments, with no rationale.
- Districts have not received approval for untied funds for the last 2 years.
- Funds allocated under state budget are being used for recurring grants only. Additional capital and recurring grant for new activities are being borne through NHM & DMF.
- Audit conducted is not inclusive of all the parameters. Audit for facility-level funds for PHCs & SCs was not done since 2014.
- More than 6 month delay in release of Payment related to incentive provided under vertical programmes noticed.
- Financial progress against approval is not monitored at district level.
- Records for areas of expenditure for HMS/ untied funds not being maintained at CH/SHC level in Gumla
- At DH Gumla, user fee was charged (exempted-BPL, JSSK). Hospital manager was even not aware about exemption of charges for patients availing treatment under National Programs- TB, HIV-AIDS. In house diagnostics were charged to APL patients and a pay-ward was available with rate of Rs. 300 per day.

Madhya Pradesh (District: Chhindwara & Khandwa)

- The decentralised process is followed while making the DHAP. Regular meetings are held by the DAM with all the available BAM for review of expenditure, payment processes and any issues related to accounting.
- Funds are released periodically. At the block level Funds are disbursed within 5-7 days after the demand has been made.
- Around 78% of the State PIP budget was spent during the last FY. In the present financial year utilisation was around 40.57%.
- State uses software portal ‘e-vittapravah’ that enables fund flow from state to block-level with lesser checkpoints and less weightage at the district level in fund allocation. State also has a Lok Sevak App for staff management to help smoothen their attendance, salary, monitoring, field movements etc.
- Audits for NHM were done last year. Annually 1 AG, 1 Statutory and 4 Concurrent (quarterly) audits are done. This year the 1st concurrent audit was done in July 2019. But the reports are awaited.

- Two schemes are running in the district, PMJAY a government-financed health insurance for poor; and Sambal scheme, a cash benefit scheme for mothers belonging to the unorganised sector.
- Meeting held against proposed by RKS members regularly to decide expenditure of Untied Funds, funds under PMJAY and others.
- No trainings are held at the district level for the finance staff. An annual training is conducted at the State level.

Manipur (District: Bishnupur and Chandel)

- Public Financial Management System (PFMS) is in place at the District level only. Most of the payments to beneficiaries are DBT Aadhar Linked in the District.
- District ROP in the form of District Health Action Plan (DHAP) has been received from the State but there is no Block ROP.
- There has been delay in the disbursement of funds by the State Treasury to SHS.
- There is no delay in the fund transfer in the account of JSY beneficiary while for the incentive for ASHAs there is a delay in the entire district of up to 4 months.
- No re-orientation / orientation training has been provided to finance staff at State as well as District-level during 2018-19.
- Rs. 22.25 crore is lying unspent at State level. Utilization Certificate & Audit Report for the financial year 2018-19 not yet submitted.
- The utilization of NHM fund till the ending of the 1st Quarter 2019-20 was 11%. Separate bank accounts are opened at the Municipal Corporation and facilities level for NUHM funds. Utilization of NUHM fund till the ending of the 1st Quarter 2019-20 was 8%.
- Untied fund not yet released from State to District and below level health facilities for the current Financial Year.

Meghalaya (District: West Garo Hills & Ri Bhoi)

- Megha Health Insurance Scheme (MHIS) is operational in the state that provides health insurance to all residents of the State (excluding state and central government employees). 100% ASHAs and AFs have been enrolled under the scheme. The scheme is now in convergence with AB-PMJAY.
- An average delay of 80 days has been observed for funds release under NRHM RCH Flexible Pool in FY 2018-19.
- There has been a delay in the issue of ROPs to the District during 2019-20.
- The utilisation of NHM funds has been low in the State. Only 13% till June 2019.
- The allocation of higher funds to High Priority District is not followed in the state.
- The payment of JSY beneficiaries is pending in both the Districts. Even payment of ASHA incentives is delayed in one of the Districts (Ri Bhoi).
- Funds have not been released for the VHSNC from the past three years in West Garo Hills District whereas in Ri Bhoi district funds have been released in FY 2017-18. Also, ASHA shared some incidents related to VHSNCs where they were coerced into signing the cheque & utilization of funds, not for the purpose intended for.
- RKS untied funds have also been not released to both the Districts: For 2018-19 only 50% of the fund were released and for 2019-20 no funds are released.
- TDS is not being deducted as per guidelines on MMU Payments.
- Cash Book is not maintained properly at the facility level.
- FMR compiled on a quarterly basis at the state level is not shared with the respective programme divisions to monitor the financial progress of the activities undertaken by them. No information is available at both the districts regarding the actual amount of liabilities.

Mizoram (District: Mamit & Aizawl East)

- Weak Health Financing System for beneficiary incentives (JSY, NTEP (erstwhile; RNTCP), ASHA

Incentives) in terms of planning, utilization and accountability. Only a few beneficiaries are getting funds through DBT.

- Delay in disbursement of funds from State to various facilities observed. Drafting of PIP is not in consultation with Districts and Blocks Units
- Most of the funds collected through user fees are used for procurement of Drugs and Reagents.
- Accounting Practices followed at facilities is violative of the financial guidelines and General Procurement Rules.

Nagaland (District: Phek & Kiphire)

- Very strong community ties contributing towards payment of loans to HCFs for JSSK/ JSY /ASHA benefits and other essential commodities (land, in certain instances) for construction of wellness rooms in HWCs.
- Paucity of funds along with delay in state share and delayed preparation of Utilisation certificated is responsible for poor program implementation and HR issues in the state. The fund to the facilities are given only for salary, JSSK, JSY and partial untied funds. Due to paucity of funds only the regular incentive of ASHA i.e. 1000/month is being paid, that too not regularly.
- There has been delay in fund transfer from State Treasury to State Health Society.
- District RoPs are not prepared. The fund is transferred along with a letter that gives directions on how to spend.
- Though Concurrent and Statutory auditors have been appointed in the FY 2018-19 the report has not been submitted.
- Bank passbook reconciliation is not seen in any of the facilities. The banking facility in District Kiphire is poor with only 2 SBI bank branches operational in District.
- The untied funds are spent based on the decisions taken in the meeting of the hospital committee (RKS).
- Lack of coordination between district and state account/ finance staff seen. The staff handling the accounts were not trained.

Odisha (District: Mayurbhanj & Kandhamal)

- Under the initiative of Hon'ble CM, the State has initiated monitoring of various schemes and programmes under the caption 5-Ts that is Team Work, Technology, Transparency, Time and Transformation
- The hike in the State health budget in 2019-20 over and above 2018-19 is only 3.38% against the norm of at least 10%. Percentage utilisation of NHM Funds has also decreased significantly- from 79% in Yr 17-18 to 53% in Yr 19-20.
- The State follows the system of bottom up approach for planning and budgeting. Also prompt release of funds from State to districts and districts to blocks in Flexi-pool mechanism provides greater flexibility of fund utilization.
- All the agencies have been registered in PFMS and the Expenditure, Advance and Transfer (EAT) module has already been rolled out. Further, along with NHM schemes, the transactions of State budget schemes are also operated through PFMS.
- Payment of dues to the ASHAs and all beneficiaries under JSY, FP, NTEP (erstwhile; RNTCP) is made through Direct Benefit Transfer (DBT).
- Supply chain cost of transportation of drugs from CHC to PHC and Electricity bill, water bill and wages to sweeper are being incurred by PHC/SC from Untied Funds.
- In spite of fulfilment of DoE conditionalities, grants under NVBDCP, IDSP, NLEP and NCDs could not be released to the State in 2019-20 due to high unspent balances.
- There is a substantial delay in the transfer of funds from Treasury in 2019-20 for key schemes like RCH Flexi-pool and HSS, which is more than 100 days as on date of visit. Also, delay in payment of incentive to ASHAs has been noticed particularly under NVBDCP and

NTEP (erstwhile; RNTCP) schemes mostly due to delayed provision of funds to CHCs.

- A separate RKS audit has been implemented at all the facilities under NHM (only rural).
- Grants under Infrastructure Maintenance (IM) for the year 2019-20 could not be released to the State due to the non-fulfilment of conditionalities.
- Computers have not been provided to non-H&WC PHCs to maintain books of accounts and other record keeping.

Rajasthan (District: Churu & Sirohi)

- Beneficiaries under various FW or Maternal activities are paid through web based OJAS (Online JSY, Rajshree and Subhalaxmi) Payment System. NHM Rajasthan is the first state to start and adopt DBT method for JSY online payment. Currently OJAS is being used up to the PHC level with around 3000 institutions (users) along with online payment of Rajshree Yojna which is the state specific scheme started from 1st June 2016 (along with Shubhlaxmi Yojna). This system has been integrated with PCTS software (Pregnancy and Child Tracking System of the State).
- "ASHA SOFT" is another web based application to measure the performance of ASHAs and to ensure timely and transparent payment of incentives to ASHAs across Rajasthan. With the help of ASHA SOFT, the online payments in ASHAs bank account are transferred by 7th of next month.
- PFMS was operational for payment to NHM contractual employees. All contract staff Database is managed in CHRIS software which is NHM conditionality.
- Untied fund was provided to various hospitals for improvement or strengthening of infrastructure.
- Overall, fund utilized under NUHM was around 60 % however it was noted that one of the Districts (Churu) had shown negative balance.
- NHM Fund utilization was 60% in the year 2018-2019 with low expenditure in Training, Quality and IEC.

Tamil Nadu (District: Villupuram & Virudhunagar)

- The State has successfully implemented PFMS leading to a better financial management system that facilitates real time monitoring and reporting of expenditure under the various flexible pools under National Health Mission.
- Payment of Beneficiaries under different schemes is done through Direct Benefit Transfer (DBT) into their accounts in nationalized banks.
- All necessary registers, account books, cash books, ledgers, etc. are kept in order along with the prescribed authorized signatories.
- Statutory Audit has been cleared by the District. There has not been any concurrent audit since March 2019 as auditors were appointed in October 2019 only.
- There is a delay in range of 26-84 days (Under RCH Pool and Health System Strengthening) in the transfer of funds from State Treasury to State Health Society (SHS). Processing time for transfer from SHS to District Health Society (DHS) stands at 4-35 days.
- Dissemination of District ROPs is not done. Although ROP after approval is uploaded in the NHM website.
- The utilization of NUHM funds for 2018-19 against approved budget at the State level was 88%. There is no finance consultant at city levels (except Chennai) under NUHM.
- As per the DOE conditionalities, 2nd tranche of funds is not released as the latest Financial and Management Report (FMR) and Statement of Fund Position (SFP) reporting the expenditure is still pending from the State.
- There has been an instance of JSY payment made in cheque despite 100% registration of PFMS agencies and in some cases, there was delay of payment too.
- The bottom-up approach is not followed in the preparation of the District PIP or District Health Action Plan (DHAP). There is no evidence of 30% additional fund being allocated for Aspirational Districts.

- No user charges were found in health facilities; and no Out Of Pocket Expenditure (OOPE) shared by any patient.

Uttar Pradesh (District-Meerut & Bahraich)

- Rs. 49 crores of 2018-19 and Rs.1851 crore of 2019-20 are still parked with the government treasury which is to be transferred to State Health Society.
- Utilisation of NHM funds till September 2019 was 23% and for 2018-19 it was 47%.
- Delay in payment JSY beneficiaries were observed in the facilities visited. Age-wise advance registers were not prepared at DHS, CHC and PHC level.
- The unspent balance was available in the bank account of all VHSNC and SCs.
- Refresher training on PFMS implementation is required at State level. Bahraich is facing problem of bank validation of Garmin Bank for implementing the PFMS system at CHC and PHC level. Print Payment Advices are pending at Meerut and Bahraich.
- Many key positions under finance department are vacant in the state. There is an urgent need for training finance personnel in the state.
- There is no proper financial management system followed for proper maintenance of Books of Accounts in DHS of CRM districts (Meerut and Bahraich).
- RKS book of Accounts is maintained at District Hospital, but proper accounting practices not followed.
- District Accounts Manager (DAM) plays a limited role in planning and their activity is restricted to preparing accounts or necessary reports.
- The liability of TDS on payment of salary to Doctors on a contract basis is not executed on a regular basis and timely EPF is not deposited in one of the Districts (Bahraich).

Uttarakhand (District: Haridwar & Udham Singh Nagar)

- In 2019-20, till September 2019, 52% of the fund could be utilised against total fund availability. In the year 2018-19, utilisation was 74%.
- Block level ROP is not provided to any of the blocks and fund flow from District level to block level is based on demand.
- In absence of an accountant is DH, cash book is not maintained on a regular basis and cash book was last updated till 30th August 2019
- RKS in CHCs, SDHs and DH level has multiple sources of revenue which includes NHM funds, funds coming from Red Cross Society, CSR fund, User charges and fund coming under PMJAY. Meetings of RKS CHC are held infrequently. User fee on OPD slips, admissions, diagnostics, investigations (CXR), referral transport is considerable leading to high OOPEs. Anecdotal evidence of informal payments for services was found as well.
- Statutory audit and concurrent Audits are done every quarter. CAG audit is also done every year. Tally software is used for accounting at the District and Block levels.
- VHSNCs are formed in every village. Funds are being utilised for cleaning the village, referral of sick people to the hospital, etc.
- JSSK implementation is in place. There is delay in JSY Payments (Up to 30 - 45 days) and also community doesn't prefer to open bank accounts because of extra expense associated with travel and other formalities to open and operate the bank account. Instances of payments via cheques for JSY, JSSK, ASHA/ AWW were also noted.
- No financial authority at PHC level – all centralised to the Block level. The distribution of Golden cards in different vulnerable populations is not uniform.

TOR 10: ACCESS AND EQUITY

National Overview

- Achieving Universal Health Coverage (UHC) is integral to achieving SDG-3, ending poverty and reducing inequalities. As per WHO, atleast half of the world's population still does not have full coverage of essential health services. UHC doesn't only mean healthcare financing but it involves building sustainable models via health systems strengthening to ensure assured availability and accessibility of affordable and quality healthcare services to all individuals and communities without imposing any financial hardship.
- Under NHM, GOI has launched various initiatives namely- Free Drugs and Diagnostics Service Initiative, National Ambulance Services, Pradhan Mantri National Dialysis Program (PMNDP), DH Strengthening etc. to ensure delivery of comprehensive health care at all HCFs, thereby improved access and equity for all, especially for the rural and remote subsection of the country.
- During the 13th CRM visit, a review of various NHM programmes aimed at Health Systems Strengthening and thus ensuring better ACCESS & EQUITY in healthcare services is done to understand their functional status in the states visited. This TOR covers review of Infrastructure, Medicines, Diagnostics and Equipment Management, Blood Banks/ Blood Storage services, Ambulances/Referral Transport, MMUs and DH Strengthening as Knowledge hubs, at the health facilities visited in 16 CRM states.
- Overall the infrastructure of the public health facilities at all levels, from SCs to DHs, is found satisfactory in most of the states visited; especially post launch of Kayakalp programme and upgradation of many SCs/PHCs into HWCs as per Ayushmaan Bharat. Use of solar energy for electricity purposes and back up is a good practice seen in a few states like Jharkhand, Mizoram & MP and needs to be promoted across all the states. However, infrastructure with regard to provision of adequate residential facilities to the medical staff, well- functional Aanganwadis, enough space for wellness activity at HWCs and pending constructions still needs a much needed impetus across the country.
- With formulation of state's own Essential drugs and diagnostics list for each level of health facility, availability and accessibility of drugs and diagnostics is found much improved in the states visited. Community in states like Odisha, AP, TN reported negligible OOPE on drugs, diagnostics and transport which is a major milestone in the path to providing universal health coverage. Ensuring availability of all the drugs/diagnostics as per the essential list, strengthening lower level HCFs like PHCs/ CHCs for provision of desired diagnostics and rational deployment of lab HR are few of the recommended areas for improvement to achieve desired benefits from the program across the nation.

- Biomedical Equipment Maintenance and Management program (BMMP), also needs to gain desired momentum in the states where it is implemented. Measures such as proper equipment tagging and inventory mapping with proper condemnation policy are recommended for providing quality diagnostic services in public health facilities.
- Timely availability of blood to all is one of the key reflections of a strengthened healthcare system. During the CRM visit, a need to strengthen blood services with regards to timely renewal of license, blood equipment availability & maintenance, operationalization of BSUs and availability of blood component separator unit is realized in most of the states visited. Also, IEC campaigns to encourage voluntary donation are suggested to improve availability of blood.

- Ambulance and Referral transport services are found well functional in many states such as AP, UP, Uttrakhand, TN, Delhi, MP, Gujarat and Odisha. Novel initiatives like Bike Ambulance (in Odisha), Khilkhilahat express for pregnant women (in Gujarat) and Feeder Ambulance for pregnant women in hard to reach areas (in AP) are applaudable and can be replicated elsewhere for better outcomes. However, issues such as delay/inavailability of service in difficult geographies like NE states and in otherwise hard-to-reach areas in other states and ambulances that are ill-equipped to manage emergencies are found that need priority attention. Mobile Medical Units are found in place as well in many states delivering health services ranging from ANC to Cataract screening at community's doorstep.However, the performance and reach of MMUs varied widely in the States visited.
- DH Strengthening initiative to build state DHs as nodal training centers for capacity building of HR and as knowledge hubs for carrying out DNB/CPD courses is not found in place in the states visited except Odisha and Uttrakhand which had a prospective plan in place for the same. PMJAY is however found functional with deployment of AarogyaMitra in the DHs in the states visited.
- Newer initiatives such as Pradhan Mantri National Dialysis Program (PMNDP) for provision of free dialysis services has already been launched in 34 states and UTs, via in-house as well as PPP mode and out of 16 CRM states visited, 14 are found providing free of cost dialysis services to BPL patients.
- Atomic Energy Regulatory Board Certification (AERB) program, to address concerns related to radiation safety, however is yet to gain momentum in all the states visited and needs concerted efforts by the states to reduce hazards due to radiation exposure.
- In a nutshell, the available services and infrastructure including drugs and diagnostics have varied distribution and accessibility in States. The healthcare services in the remote areas, tribal areas and other vulnerable areas

of the selected states are compromised due to absence of adequate road connectivity, round the clock electricity services, internet services, safe drinking water supply etc. The health system support like HR, infrastructure, critical care services, equipment maintenance, dialysis services etc. are also not equally available in tribal, aspirational, remote and hilly districts as compared to other districts. This skewed distribution not only affects the access but also the equity in services being delivered to the population. Also, the monitoring and supervision visits in such areas remain irregular further deteriorating the quality of services delivered.

- RHS data reports that infrastructure shortfall exists in almost all states except for Gujarat, Mizoram, Nagaland and Tamil Nadu in tribal areas. In terms of human resource, unavailability of specialists in tribal areas is observed in all the states, even the ANMs at SCs are not as per the required norms in Gujarat, Tamil Nadu and Uttarakhand. States like Manipur, Meghalaya, Odisha, Rajasthan and Tamil Nadu have ensured availability of GDMOs as per the IPHS norms at CHCs. The CRM findings also reflect that geographical locations of the ambulances are not suitable for far flung communities for time to care approach.

National Overview: Infrastructure

Since the launch of NHM, there has been a steady improvement in availability and functionality of public health infrastructure. As per RHS 2018-19, 99% CHCs, 94% PHCs, 75% SC-HWCs and 70% urban facilities are functioning in government facilities and footfall has also increased in these facilities.In urban areas of Jharkhand, M.P. and U.P more than 50% facilities are still functioning in rented buildings. RHS further reveals thatoverall percentage of Sub Centers, PHCs and CHCs functioning in the government buildings have increased by 31.5%, 25.5%, 7.7% respectively from 2015 to 2019. This is also evident by 75th round of NSSO data which indicates decrease in Out Of Pocket Expenditure (OOPE) due to increased accessibility to health care services. A rapid assessment is undertaken during 13th CRM in 16 states to evaluate the infrastructure of health facilities as per IPHS particularly availability, accessibility and utilization of services. The same is also reviewed for Health and Wellness Centres (HWCs), delivering comprehensive primary healthcare services.

The team observed that almost 50% of states have achieved accessibility as per the population norms in IPHS. However, a shortfall of 44% is reported in urban areas as per population norms. Improvement in infrastructure is seen in all states however, the completion rate of construction varies from state to State. Similar improvements are observed for urban areas where almost all the states have shown increase in the number of functioning Urban PHCs in government buildings. Despite such evidences reported during the CRM visit, accessibility to services and adherence to time to care approach still remains a challenge especially in hilly and tribal areas. Currently, all visited facilities have OTs, Labour rooms and Laboratories as per the level of services but mostly functioning with insufficient infrastructure, restricting flow of services in those areas. CRM also reported that assured emergency services, at the level of District Hospitals (DHs), are not adequate to deliver critical services resulting in increased OOPE. This inadequacy is due to lack of proper hospital design for emergency care services. Some of the facilities visited have received Kayakalp/Quality certifications but there are challenges in maintaining the same.

Table.1: Population based utilization of existing infrastructure for surgical services			
Large States with higher utilization *(major surgeries in Public Health facilities per 1000 per year)*	**Large States with low utilization (***major surgeries in Public Health facilities per 1000 per year)*	**Small States with higher utilization** *(major surgeries in Public Health facilities per 1000 per year)*	**Small States with low utilization (***major surgeries in Public Health facilities per 1000 per year)*
1. T.N. (8.8) 2. Rajasthan (3.19) 3. Andhra Pradesh (3.08)	4. Odisha (2.64) 5. Bihar (2.33) 6. Gujarat (2.11) 7. M.P. (1.6) 8. U.P. (1.09)	9. Delhi (20.46) 10. Mizoram (10.87) 11. Nagaland (4.92) 12. Manipur (4.53) 13. Meghalaya(4.34)	14. Uttarakhand(1.88) 15. Jharkhand (1.66) 16. Chhattisgarh(1.3)

**The states with population ≤ 4 crores are referred to as 'Small states' & states with population ≥4crores are referred to as Large States. (Source: HMIS 2018-19)*

Table.2: Population based utilization of existing infrastructure for institutional delivery services			
Large States with higher utilization *(% of institutional deliveries ≥75%per year)*	**Large States with low utilization** *(% of institutional deliveries ≤75% per year)*	**Small States with higher utilization** *(% of institutional deliveries ≥75% per year)*	**Small Sates with low utilization** *(% of institutional deliveries ≤75%)*
1. M.P (95) 2. Bihar(89.7) 3. Odisha(84) 4. Rajasthan (76.7)	5. U.P. (74.1) 6. Gujarat(54.6) 7. Andhra Pradesh (43.4) 8. Tamil Nadu (37.3)	9. Delhi (81.2) 10. Manipur (81) 11. Mizoram (80) 12. Meghalaya(77) 13. Nagaland (76.5) 14. Chhattisgarh (75.8)	15. Jharkhand (72.8) 16. Uttarakhand (68.1)

**The states with population ≤4 crore are referred as 'Small states' & states with population ≥4crores are referred as Large States. (Source: HMIS 2018-19)*

One of the objectives of this CRM is to assess the utilization of existing infrastructure in terms of service delivery. On analyzing key performance indicators of HMIS, it is found that the number of OPDs and IPDs has increased over the previous years. However, as per 75th NSSO survey, the utilization of the government healthcare facilities in these 16 states remains less than 50% except in states of Manipur, Mizoram, Meghalaya, Odisha and Tamil Nadu.

As per HMIS 2018-19, the number of major surgery in Public Health facilities per 1000 population varies across states. Even the better performing larger states like Tamil Nadu (8.8) & Andhra Pradesh (3.08) are not able to utilize the available infrastructure to provide surgical services as compared to smaller states like Delhi and Mizoram where usage is much higher which is 20.46 & 10.87 respectively. *(Refer to Table.1)* CRM visit indicated that less utilization of public health facilities is due to Irrational distribution of human resource, Lack of assured critical care services (Emergency, HDU/ICU, Blood banks/ Blood storage units), Support services (Manifolds, CSSD & Mechanized laundry) & Full AMC coverage for equipment maintenance and Non-availability of drugs and diagnostics.

Among the 16 states visited, the range for utilization of public health facilities for institutional delivery is 37.3% to 95%. The results reveal that in better performing states (e.g. Tamil Nadu, Andhra Pradesh, Gujarat), the use of public facilities is less than 75% for institutional deliveries and in EAG states like MP

, Bihar, Odisha, Chhattisgarh, more than 75% of the deliveries are being conducted at public facilities. *(RefertoTable.2 for details).* The visit reported that patients availed delivery related services at public facilities even in absence of cleanliness. An important finding unveils that 48 hour stay after delivery is not ensured. The identified reason is non availability of basic amenities such as toilets, lockers, safe drinking water and overnight staying arrangement for attendants & ASHAs at the public health facilities, despite key focus on program specific services under RMNCH+A.

Another critical observation of the teams is that maintenance of hospital infrastructure is still a major challenge even after the launch of Kayakalp program. Through the institutional mechanism, RogiKalyanSamitis (RKS) is established under NHM, with a vision to maintain and upkeep hospital infrastructure, yet issues like lack of funds, absence of clear guidance & training to undertake such activities by RKS are not completely addressed. However, after the introduction of insurance scheme (PMJAY) under Ayushman Bharat, the functional public health facilities are able to mobilize more untied funds, still there is need to develop a robust mechanism for maintenance of health facilities, along with this some percentage of total infrastructural cost should be allocated to the states.

Key Findings

- Among 16 states visited, 8 states have achieved infrastructure requirements as per IPHS population norms for DH, 13 states for CHCs, 8 states for PHCs and 9 states for HSCs. However, shortfall of facilities is reported in almost all states except in Gujarat, Mizoram, Nagaland, Rajasthan, Tamil Nadu and Uttarakhand where the facilities are in surplus.
- Physical access to health care, has improved with a concomitant improvement in health infrastructure. This is mainly due to addition of government buildings in the states of Uttar Pradesh, Madhya Pradesh and Gujarat.
- It is reported that almost all states have increased the number of Urban PHCs functioning in govt. buildings and states like A.P., Gujarat, Manipur, Mizoram, Nagaland and Odisha have all Urban PHCs functional in govt. buildings. Andhra Pradesh, Delhi and Rajasthan have achieved the target of UPHCs as per the population norms.
- The status of construction of health infrastructure varied across states. Manipur (100%) and Uttar Pradesh (98%) reported good completion rate as on March 2019. Relatively poor completion rate is reported in Madhya Pradesh (21% completion) and Tamil Nadu (115 buildings incomplete) due to absence of monitoring mechanism to regulate construction work leading to escalation of overall cost. However, delays in handing over the constructed buildings are another issue observed in states like Odisha (31 completed constructions not handed over) and in Tamil Nadu (20 completed constructions not handed over).
- Also, the statutory provisions like National Building Codes, AERB, Fire safety normsand provisions for disaster management are not being observed by states, which are inherent part of hospital development.
- Across states, it is a common finding that most of the facilities do not have disabled friendly structures. They also lack zoning/ adequate space in critical areas like OT, Lab, Labor room and Emergency. Besides, all the administrative wings, offices and non-critical areas are found on the ground floor while patients are availing services available at first/second floors. So the presence of infrastructure in certain instances, are by itself, not a criteria, that it will be utilized for the benefit of the public.
- At the facilities visited, there is hardly any infrastructure for critical care services like HDU/ ICU, isolation ward, accident and emergency. Availability of electricity and safe drinking water is still a challenge in some HSCs located in remote areas of Madhya Pradesh, Manipur and Meghalaya.
- The inadequacy of infrastructure in terms of service delivery islargely due tolack of availability of hospital designs at local levels.

Therefore, it becomes difficult to establish processes, flow of services and protocols.

- Even the facilities which received Kayakalp awards and Quality certifications find it challenging to sustain the upkeep of available infrastructure. Despite, the provision of funds available for repair and renovation through insurance scheme of Ayushmaan Bharat (PMJAY) facilities have not been able to utilize the funds to keep infrastructure of facilties in good shape.
- Under Ayushman Bharat, a gap in planning of infrastructure for HWCs is reported across all the states visited. Satisfactory progress is not observed to achieve target of creating 1.5 lakh Health and Wellness Centers by 2022. However, the progress on branding of HWCs in the states is expeditious.
- There is a significant shortfall in the number of HWC-SC in Bihar (53%), Jharkhand (43%) and Meghalaya (42%) where as these facilities arein surplus in Rajasthan, Gujarat and Nagaland.
- The utilization of available infrastructure is limited to services under RMNCH+A and a few services related to other programs. Even the designated FRUs are not able to provide assured surgical services as they either lack blood storage units or dedicated emergency units.

Recommendations

- States need to assess the facilities as per IPHS andaccordingly a time bound action plan to improve infrastructure with required quality and range of services needs to be undertaken. In the urban area, states should develop a locally relevant/contextual strategy for creation of infrastructure in coordination with local urban bodies/ULBs.
- To avoid inordinate/inadvertent delays to complete the construction, the states are suggested to conduct monthly monitoring of the activities and penalty clauses to be reinforced for timely completion of work.
- While planning hospitals, the key stakeholders at the facility and district level should be involved and layout designs should be aligned with the standard GOI designs for various facilities and service areas. Thus, state should organize capacity building workshop for engineers and doctors on hospital planning.
- States should also adhere to the statutory provisions such as National Building Code, fire safety norms etc.
- As strengthening services at the facilities needs continued attention, states need to prepare a prospective plan for all infrastructures, particularly district hospitals incorporating requirements for IPHS and various technical protocols.
- States should empanel/ appoint in-house team of hospital planners, architects and public health professionals for prospective planning of public health facilities.
- It is recommended that states organize orientation program for Rogi Kalyan Samitis on planning and upkeep of infrastructure.
- States should develop a road map for creation of infrastructure in order to timely achieve the target of 2022 for HWCs.

State Specific Findings

Andhra Pradesh

- The state has a shortfall of 38 PHCs and 155 CHCs to ensure accessibility as per population norms.
- Team observed that DH Proddatur has zoning of OT as per the guideline with well-demarcated Protective, Clean, Sterile and Disposal zones. Patient amenities like clean drinking water, toilets, linen, diet services etc. are available.
- In terms of services available- RMNCH+A, facility level services for various communicable and non-communicable programs, Lab services including digital X-Ray, Free CT Scan and MRI for all and Tele-radiology are available at District Hospitals.

- Among the facilities visited, the infrastructure is maintained except for CHC Raichoti, AH Pulivendula and PHC Hukumpetta where dilapidated buildings with seepage, broken plasters and broken tiles are observed.
- Inordinate delays in completion of constructions e.g. Additional Block and Boundary wall at CHC Badvel is pending since August 2012. Two tenders have expired and now no organization is willing to complete the work at rates of the year 2012.
- Inadequate space for conducting wellness activity observed in HWCs which are upgraded from SC/PHC.

Bihar

- In Begusarai, DH is functioning well and OT and labour room are better organised whereas Bhagalpur district hospital is running in old building and the service delivery is compromised and also due to availability of Medical College in Bhagalpur district, referral rate is very high almost nearing 72%. Besides, block PHCs are functioning in Bhagalpur but not in Begusarai despite available infrastructure as per the population norms.
- Many HSCs and additional PHCs (APHCs) have been converted to H&WC in both the districts. Branding of HWCs has been done as per GOI guidelines with display of services and citizen charter.
- In the urban areas, state has well-established and operationalized Urban Healthcare Facilities (98) in terms of infrastructure and hasmade marked progress in completion of GIS and vulnerability mapping. UPHCs visited are patient friendly and basic amenities for patients are available. Branding with proper display of IEC materials is found at all the UPHCs visited.
- Overall, facilities visited are neat and clean with basic amenities for patients like separate toilets for men and women, running water, sitting arrangement, ramps/side grills for disabled population and dedicated spaces in each facility for maintaining the privacy of patient during examination.
- Non-compliance to statutory requirements viz. Authorization for BMW, NOC for fire, AERB for X rays etc. is observed in most of facilitiesvisited. Also, implementation of condemnation policy for timely condemnation of non-functional equipment is not done.
- In district Begusarai, blood bank is functioning without any license due to lack of proper infrastructure. The number of blood banks & blood storage units are found to be insufficient in the state.

Chhattisgarh

- Labour rooms are found to be as per MNH tool kit and is clean with toilet facilities and standard protocols are being followed. SNCU at District Medical hospital is well maintained with all the essential components.
- Thereis shortage of 118 SCs, 51 PHCs and 40 CHCs as per RHS 2018-19. Also, construction of new infrastructure is delayed in the state.
- In DH Korba, pregnant women are observed sitting in common waiting area next to USG & X-ray room without lead coated door.
- Infrastructure of drug storage facility in the visited districts is not properly managed as per the protocol.
- The available infrastructure of PHCs is not utilised due to huge HR gaps created because of irrational postings of HR. Similarly, FRUs are not providing assured services because of systemic issues leading to poor utilisation of existing public health infrastructure.

Delhi

- Overall, the upkeep of the facilities is found to be satisfactory. The general perception of the patients about the public health facilities is good. Patients acknowledged that the facilities are improving in terms of cleanliness and basic amenities.
- Presently in the state two constructions out of 8 and 5 upgradations out of 102 are pending under NHM. It is also reported that in East Delhi, construction of ANM School is pending

for more than 2 years due to exhaustion of funds sanctioned.

- In LBS hospital, inadequate space has been observed in emergency department & critical care area. It is reported that the facilities are under various stakeholders (Municipal Corporation/Cantonment Board, etc.). They have different layout plans altogether which are not as per the IPHS.
- Most of the Delhi government dispensaries are functioning in rented buildings in both the districts. The rent is in the range of 30,000 to 60,000 INR. The timings are 8am to 2pm for 6 days every week. None of the dispensaries are functional 24*7. However, MCD facilities have adequate infrastructure. The Maternity Homes and M&CW centers function in MCD owned buildings with timings 8:00 am to 4:00 pm for 6 days per week.
- Utilisation of public health facilities in the state is not adequate; the state has 60 Delivery Points at present, of which 36 are Public Hospitals and 24 Maternity Homes. On an average, 700-800 deliveries are conducted every month in the DH/Tertiary care centres. However, deliveries are taking place at tertiary levels, instead of secondary care centres due to lack of 24*7 CHC/Maternity Homes in districts. High risk pregnancies, C-section cases are directly referred to higher centres like LHMC and LBS hospital.
- It is suggested that M&CW centres of MCD should be utilized well, since they have very good infrastructure. Maternity Homes should provide delivery services 24*7, ensuring the availability of Medical Officers, Gynaecologists and Paediatricians. This would reduce the load (especially Maternity related) on the currently overburdened District/Tertiary Hospitals. Skill labs and HDU/Obstetric ICU should be established at higher level facilities.

Gujarat

- The district population of Dahod is 2127086 (census 2011); currently being served by 97 Primary Health Centers (average of 01 per 21928 population) and 634 sub health centers (about 01 SHC per 3350 population) distributed among 691 villages. There are also 14 CHCs, 01 Sub district hospital at DevgadhBaria and a District Hospital affiliated Zydus Medical College at Dahod (PPP mode). Thus, the numbers of public health facilities are adequate with respect to population norms as prescribed in Gujarat state and also in both Dahod and Surat districts.
- The average OPD registrations per day varies among facilities; about 30-100 in PHCs, average 200-300 at CHC level, and about 1500 at DH level as noted in Dahod district (including average 40-60 patients in emergency). IPD services are not available at PHC level and CHCs have lower utilization of IPD services and 300 bedded DH while Dahod had almost 90% bed occupancy at time of CRM visit. Rate of home deliveries is reported to be significantly low (0.17%) in Dahod. Most sub health centers are not delivery points and intra partum services for normal delivery are functional at all PHCs, ranging from 01 to 10 deliveries per month.
- Most facilities visited by the team including PHCs/SHCs/CHCs/DH, both HWC and non HWC are having functional toilets, except for PHC Salara (Dahod). All facilities had drinking water supply, space available for examination in privacy, patient waiting area, cold chain for vaccines and BMW buckets for waste segregation at point of generation. Branding is done well in all HWC-PHCs and HWC-SHCs. Citizen charter is seen at most facilities. Internet connectivity, computers, smartphones etc. are available in most PHCs.
- In-patient services in all CHCs, SDHs showed very low utilization; including remote blocks, as noted in both the districts. The range of inpatient services provided at block levels is notably narrow in both districts, and also in DH Dahod.
- Critical care services including emergency surgical services are either limited or unavailable in public health facilities, as noted in both the districts. In Dahod district, there are no private surgical facilities, thus making DH the only center in the district with emergency surgical facilities. In Dahod district, 24 hours C-section

facility is available only at SDH and DH and none in any private hospital. Here the farthest PHCs are at a distance of about 60-70kms; that takes about 1-2 hours of travel to a referral facility.

Jharkhand

- The health facilities in the Gumla district include one District Hospital, 11 CHCs, one UPHC, one PHC, and 242 SHCs. The district West Singhbhum has 1 District Hospital, 1 Sub-divisional hospital, 15 CHC and 15 PHCs. Around 12 % of the SHCs have been converted into HWCs.
- The state has reported 62 functional FRUs which are adequate as per population norms of one per five lakhs. However majority of the designated FRUs are either non-functional or partially functional. The Blood storage units at both the FRUs in Gumla & CKP are non-functional.
- Infrastructure and equipment are available for management of trauma cases. However, triage area in the emergency and zoning in all critical area is not available.
- In Gumla district, 13 PHCs are sanctioned. Even though the population of district is 12 lakh and most areas are tribal and difficult areas, the sanctioned PHCs are short by around 40-45 PHCs (as per IPHS). Moreover, out of total 13 sanctioned facilities, only 1 PHC is functional due to non-availability of infrastructure and human resources. 9 PHCs are operational in SHC building as reported by the district. However, none of these 9 PHCs had the required HR. The number of SHCs is less compared to IPHS for tribal and difficult areas.
- The state has made good progress in strengthening facility-based new-born care over the years with 19 functional SNCUs of which 18 report online. However, all 24 districts still do not have a SCNU. Labour rooms across both districts are well maintained. No separate infrastructure for NCD clinics - established at CHC level. At present NCD clinics at DH Gumla are co-located in the male OPD and NCD clinic at Sadar hospital is functioning in the main OPD manned by a dentist with no separate HR.
- Existing HWCs have good infrastructure along with internal and external branding. Block saturation approach is not adopted, primarily due to limited infrastructure availability. In Gumla district, proposed SHC-HWCs are present across all 11 blocks, ranging from 1 to 8 SHC-HWCs per block.
- In west Singhbhum district unfinished infrastructure has been observed because of some legal issues. State to take steps to resolve the pending issues as soon as possible.

Madhya Pradesh

- As per the population norms the state has shortfall of 250 CHCs, 839 PHCs & 1281 HSCs. Currently, there are 51 DH, 73 SDH, 334 CHCs, 334 PHCs and 10211 HSCs.
- The status of construction 2013 onwards reflects that in total 22% of the construction is completed and 15% is still pending. The delay in construction is at the level of DH, CHC & SC where only 67%, 70% & 21% of the work is done till now. The renovation/upgradation work is happening at a faster pace where 85% of work is complete.
- For the population of 7.26 crores, the state needs 145 FRUs. According to HMIS, the state has a total of 71 functional FRUs. There is a shortage of 81 FRUs in the state. The shortage exists because the FRUs do not meet criteria for C-section. According to state reports, the state has 123 FRUs and a shortage of 22 FRUs.
- The state has begun with the approach of upgrading existing PHCs to HWCs. In the districts of Khandwa and Chindwara, no Sub-Centres are yet upgraded to a Health & wellness centre. In addition to the IPHS prescribed infrastructure requirements, HWCs must have undergone the specified branding and must have a designated space for health promotion. Most of the facilities have undergone branding. Space is a constraint at few facilities – for wellness activities. In general, the rural PHCs had better space as compared to the UPHCs.
- Creation of separation units for blood is required at District Hospitals of both the districts. The

facilities should get AERB certification for the X-ray room specially CHC Mohkhed. At CHC Mundi & CHC Chaurai available X-ray machines should be operationalised.

Manipur

- In the state, the status of construction indicated that till March 2019 no new constructions and renovations/upgradation are pending however, shortfall in number of SCs & HWC-SCs is observed. A new construction has been approved for CHC Chakpikarong and is expected to start by next year.
- All the visited HWCs have been established, branded and well maintained. None of the building had cracks, seepage and water logging issues. Medicinal plants have been planted and the sewerage system is well maintained. Surrounding environment is clean, attractive and under good maintenance. The availability of space is found to be insufficient to provide required quality services e.g.: provision for delivery services is absent at HWC TaraoLaimanai, LR at HWC KhudeiKhenou is under construction and absence of dedicated wellness room is seen in almost all HWCs.
- The existing infrastructure at DH Chandel is old and not well maintained with cracks and seepage, water logging outside the drainage. The hospital has in-house drinking water but had to purchase weekly for 20 litres at 40-50 rupees through the untied funds and sometime from their own pocket. The toilets are non-functional due to leakage and problem with the flusher. The electricity back up is limited to Emergency, OT and Labour room. Privacy during examination is ensured through separate OPD room for each programme and separate male, female, palliative care and paediatric wards are available. SNCU and NRC are not functional and no separate room for ARSH clinic is available. Poor ventilation is observed in one OT room and in the Pharmacy. The new 100 bedded hospital building is under construction to establish a hospital which is 50 bedded at present.
- In all the visited health facilities functional toilets are available with adequate supply of water except in CHC Moira and DH Chandel. Genset as power back-up are available at PHC, CHC, DH Bishnupur. Solar energy is used as a backup at CHC Chapikarong whereas no electricity back up is available at the visited HWCs.
- Infrastructure of CHC Moirang and CHC Chapikarong is quite old with congested service areas e.g.: General OPD is running with OPD for elderly, NCD clinics and adolescents. Also, AYUSH OPD and Dental clinic are in the same room. Infrastructure in PHC Komlathabi is maintained well despite unavailability of adequate space and has been winning the KAYAKALP award for consecutively 3 years.
- It is suggested that designated LR with facilities can be offered at HWC Tarao with provision of staff quarter as it is in a difficult to reach area due to poor road condition and accessibility to other health facilities is problematic. Additional room for post-natal care is required at HWC Unopat and PHC Komlathabi. Provision of separate male and female ward at PHC Komlathabi is required. Ensuring provision of electricity with back-ups at all 24*7 facilities with IPD services to be looked into. In DH Chandel, repairing of plumbing and proper wiring is immediately required and provision of ventilation in OT washroom and Pharmacy to be ensured.

Meghalaya

- As per RHS, state is facing shortage of 20% SCs, 5% PHCs and 10% CHCs out of the required number as per population norms mentioned under IPHS. However, no pending constructions for more than two years are observed in the state.
- Certain facilities are observed to have dilapidated civil structure and others with space constraints. The facilities (Urban and Rural) visited in both the districts have completed the branding as per HWC norms.
- In sub-centers, privacy for examination is maintained with temporary screens. There are no issues related to drinking water, HWC branding, waterlogging, identified during the visits, but reliable electricity and functional

toilets with running water are observed to be in poor shape.

- PHC located in urban (state-managed) areas are functioning in rented buildings and none of them are running 24*7 (between 9 am -5 pm) and offering HWC services. There is sufficient space for conducting the examination with privacy and had functional toilets and a portable generator for power back up. Drinking water tested by UPHC in last two times in public lab stated unsuitable for drinking. CHC had sufficient space for conducting the examination with privacy and had functional toilets. Diesel generators used in a few places could meet / support only emergency services.
- District Hospital had sufficient space for conducting the examination with privacy and had functional toilets. The corridors and waiting areas for OPD are found to be narrow. Most often inpatients are allocated space on floor and corridor due to unavailability of beds. Acute shortages of the surgical and medical ward are observed. Only 4 quarters are available for staff and open space around DH is occupied by dysfunctional ambulances.

Mizoram

- The State has adequate infrastructure as per IPHS population norms as also reported by RHS 2018-19. All the facilities in the state are functional in government owned building.
- The overall infrastructure of the facility is as per protocols with clean and functional toilets, drinking water, branding, and space available for conducting examination in privacy without any cracks, seepage and water logging within the facility and outer premises.
- It is observed that fire safety norms are not followed. Only the availability of Fire Extinguisher is reported in the facilities.
- DH Mamit and PHC Raupuichhip have enough space for conducting examination in privacy, functional toilets, and drinking water and devoid of any cracks, seepage and water logging. It is important to note that no electricity backup is available but both the facilities are providing 24*7 services.
- Among the visited facilities for HWC, all facilities are well built with OPD, waiting areas with proper branding as per norms of HWC. However, the wellness rooms or space for yoga are not identified in the visited facilities.

Nagaland

- The State has a surplus of 19 SCs, 64 PHCs and 6 CHCs still access to effective healthcare is a major problem in Nagaland. Insufficient resources, inappropriate allocation, and inadequate quality are major impediments to the delivery of effective health care that reaches the poor. The lack of mobility due to poor roads hampers the availability and accessibility of health services for the people in Nagaland.
- Most of the health facilities of Phek and Kiphire district did not have basic amenities like portable water, alternate power backups and residential facilities for the staff.
- The progress of infrastructure up gradation and development is very slow for Sub-centers. The GNM school of Phek is under construction since the last 3-4 years. The DH in Kiphire is an upgradation of CHC with availability of limited services in reference to a DH.

Odisha

- As per RHS, state has shortfall of 1694 SCs and 57 PHCs. There are a few constructions pending since last two years. Also, there are instances of completed buildings not handed over.
- HWC branding in terms of painting and logos are seen adequate. However, the other infrastructural requirements of HWCs are being met (to a certain extent) only at PHCs.
- The access to various services in the infrastructure developed is equitable and without any discrimination. However, the infrastructure visited is not sensitive to Divyangs or elderly.
- The facilities visited in the district lack properly planned infrastructure with zoning for ensuring

infection prevention in critical care area. The layout design and arrangements inside the room in various OPDs, waiting areas, emergency, laboratories, kitchen, laundry, CSSD and OT are not appropriate except in those which have been created recently as per GoI guidelines like obstetric HDU, maternity OT etc.

- It is generally observed that though the infrastructure is basically created for the community, it is largely occupied by the service providers, stores, administrative offices etc. (non-clinical work). Even the service areas have unnecessary and non-functional equipment and drug stock leaving very little space for service delivery.
- In Mayurbhanj, the medical wards, SNCUs, NICU, post-natal and antenatal wards are overcrowded with patients occupying all available floor space, and up to three newborns in one neonatal bed. On the other hand, surgical beds are largely unoccupied. Similarly, in Kandhamal, while the post-natal and antenatal wards are overcrowded, the eye ward is empty.
- At both districts, access to services at PHC and CHC level have been compromised due to lack of medical officers, and deputation of existing medical officers to other health facilities. There is community unrest at both PHC and CHC level. There are also misplaced expectations of community for these new facilities, showing that adequate advocacy to access the facilities for specified services have not been done.
- Medicine and supply storage facility at DH level is not good. Overcrowded, medicines stored in very tall racks in large containers, and a manual ladder used to lift the supplies isobserved. Wall conditions are also not good. Inflammable spirits stored with other stocks without fire safety arrangements, gas cylinders both filled and empty stocked together without weighing machines being available nearby.
- State needs to prepare a prospective plan for all infrastructures, particularly district hospitals incorporating requirements for IPHS and various technical protocols.

Rajasthan

- Overall in the state, there is a surplus of 114 CHCs, 218 PHCs and 2947 SCs considering the population norms as per RHS 2017. The district-wise data also indicates that available infrastructure is surplus as per IPHS population norms. In Churu, there is 1 DH, 2 SDHs, 16 CHCs (required 12), 86 PHCs (required 49), 13 UPHCs (required 12) and 437 SCs (required 293) and in Sirohi, 1 DH, 9 CHCs (required 9), 3 FRUs (required 2), 29 PHCs (required 21), 2 UPHCs (required 4) and 223 SCs (required 207) are available.
- There are no pending constructions in the facilities visited. Almost all facilities visited had some abandoned building in the vicinity of the hospitals. In fact, in case of PHC Bain, the waiting area is just an extension of the abandoned building which is separated by a curtain.
- In Churu, it is observed that construction of the facilities is done through fund mobilised by RKS. The layout designs are approved by the State however, issues like location of the service area (e.g.: emergency department is on the first floor), congested spaces (emergency department at CHC Sahawa) are reported. There are no clean, protective, buffer zones observed in OT and the services are running haphazardly in the facilities. The layout designs are not as per GOI guidelines in almost any of the facilities.
- Some buildings (DH- MCH wing, HWCs) had leakage issues and require repairing and timely maintenance. An alarming observation is same colour coding for air and vacuum pipe in MCH wing.
- Access to clean toilets and drinking water ismissing in the facilities. For instance, at HWC, Jaitsar there is no toilet attached with the Labour Room. The facilities do not have provisions for the disabled people from entrance to the toilets.
- Infrastructure for emergency at CHC level is good. However oxygen cylinders are found to be empty. First Referral Units arelargely non-functional even though good infrastructure,

drugs and diagnostics are available. A trauma centre which is designed at Sujangarh is non-functional due to the location of the facility in an area which is not linked to the main route.

- It is recommended that a comprehensive district plan should be prepared based on the time to care approach and disease burden of the district. The requirement of the infrastructure should be population based to avoid surplus facilities with non- functional services.
- A comprehensive futuristic plan of the facility should be prepared in consultation with the architect before initiating any construction at the facilities and doctors to be involved during construction. Also, the facilities should be planned in a way that is disability friendly.

Tamil Nadu

- In Tamil Nadu, there are 31 DHQ, 204 Taluk Hospitals, 74 non-taluk Hospitals, 423 upgraded PHCs, 1853 additional PHCs, 460 Urban PHCs and 7 Women and Child Hospitals.
- In the blocks identified for implementing Universal Health Coverage, 985 HSCs, 172 PHCs are targeted to be upgraded as HWCs. In other blocks 1212 PHCs targeted as HWCs while 460 UPHCs for up gradation as HWCs. Signage designed by the State, light and dark green paintings and the six Comprehensive primary health service (CPHC) logos painted on the boards are well visible. Space for yoga training is available at places while tele-consultancy space is yet to be added to the existing infrastructure.
- Living space for one VHN is available at the HWC-HSC and one VHN stays there for providing 24 hrs services. At HWC-PHC visited, 24 x 7 services are available. Interactions with the community indicate that people are happy with the changes and improvements in access to services.
- Apart from the fixed infrastructure, 770 RBSK teams in the rural areas and 12 teams in the urban areas have been deployed for early detection and treatment of 4 Ds in children from 0 to 18 years of age. All the 385 blocks will be provided with CBNAAT facilities to support TB control while 130 blocks till now have been provided with one Hospital on Wheel (HoW-Mobile Medical Unit) to cover the unreached hamlets and villages.
- Delay in completion of construction of buildings and handing over of the completed buildings in time are obstacles in improving access. Construction of 115 buildings has been pending beyond 2 years. Twenty buildings have been completed and not handed over so far. In Virudhunagar district only one building (Erisanatham PHC) has not been completed (tender for this work is yet to be called for). The construction of operation theatre in CEmNOC centre at Rajapalayam has been completed but building has not yet been handed over.
- State is developing 100 PHCs to promote healthy lifestyle by adding walking paths, yoga facilities, pebble paths and gardens to promote outdoors.

Uttar Pradesh

- As per population norms, there is a shortfall of 37% CHCs, 30% PHCs and 34% HSCs. It has been observed that in Meerut, there is a shortfall of around 50% CHCs where as in Bahraich the shortfall is around 54%. In comparison to CHC, in both the district the PHCs are available as per population norms. There is a shortfall of around 60 % SCs in both the district.
- With regards to the pace of construction of health infrastructure, it has been observed that pace of construction is good and around 88% of new construction and 98% renovation work has been completed.
- Though the availability of infrastructure is low as compare to requirement, the overall utilization of available health facility is very low. It has been observed that the utilization of resources has been skewed. Secondary health facilities in the districts are over-loaded with heavy footfalls.
- However, despite existing infrastructure, services at these facilities are under-utilized due to lack of HR and essential drugs and diagnostics which also resulted in seeking

health care from private sector. State is also not able tomake the FRUs functional as per requirement. Overall, there is a shortage of over 319 FRUs in the State.

Uttarakhand

- In the state, the number of SCs is 1847, PHCs is 257 and CHCs is 67. The number of facilities is slightly in excess as compared to the required number for existing population.
- ASHA Helpdesk is seen at CHC and DH level of the health facilities to guide elderly, disabled person in the hospital premises. IEC materials are kept at the desk to provide information about various government initiatives.
- HWC branding in terms of painting and logos are seen adequately however, the other infrastructural requirements of HWCs are meeting up to certain extent only at SCs.
- The access to various services in the infrastructure developed is equitable and without any discrimination.
- The State has prepared comprehensive plans for strengthening of district hospitals and developing them as knowledge hubs.
- Seepage is commonly seen in many areas of health facilities including NRC of DH, Rudrapur that leads to under-utilization of health facilities.
- The layout and designs of the visited facilities are not as per IPHS guideline. For instance, PNC ward in DH Rudrapur is far from labour room and the critical areas lack zoning to ensure infection prevention.
- It is recommended that state should prepare a prospective plan for all infrastructures, particularly district hospitals incorporating requirements for IPHS and various technical protocols.

National Overview: Free Drug Service Initiative (FDSI)

- Accessibility to affordable and quality drugs is essential for the meaningful roll-out of UHC (Universal Health Coverage). Several studies have shown that expenditure on medicines in India accounts for about 50 to 80 percent of the total cost of treatment. Infact, 65% of the Indian population lacks regular access to essential medicines and the expenditure on health is the second most common cause for rural indebtedness and is responsible for 2% shift from APL to BPL every year.
- 'Free Drug Service Initiative' (FDSI) is launched under NHM in 2015 to improve accessibility to quality essential drugs at the public health facilities. NHM scope under FDSI is not only limited to procurement of drugs but also to setup/strengthen systems of procurement, quality assurance, IT backed supply chain management like Drugs and Vaccines Distribution Management Systems (DVDMS), warehousing, prescription audit, training and dissemination of Standard Treatment Guidelines.
- All the states visited for CRM are found to have undertaken significant efforts to ensure

availability of free drugs at public health facilities and have a dedicated system for procurement and supply of drugs and consumables. Penetration of DVDMS and availability of drugs as per EDL at all level of health facilities is, however, an area of concern in the states that needs attention.

Key Findings

- Free Drug Service Initiative (FDSI) has been implemented in all the 16 CRM states, but availability of free drugs to the beneficiaries on the ground still remains a major concern.
- Centralized Procurement Agency is present in most of the states except Chhattisgarh.
- Essential Drug List (EDL), though formulated by all states, has not been disseminated to all public health facilities and service providers.
- Availability of all essential drugs at different level of health facilities, mainly of NCDs- HTN and DM-2 at HWCs has been observed in most of the states.
- Drugs and Vaccine Distribution Management System (DVDMS) is initiated in most of the states except Mizoram and Nagaland. Most states are using eVIN for cold chain logistics.
- District Drug warehouse (DDW) for storage of drugs has been operationalised in most of the states visited.
- High OOPE on drugs is observed in Bihar, Uttarakhand, Nagaland, Mizoram and Jharkhand.
- Frequent stock outs/ non-availability of drugs are reported in the states of Bihar, Chhattisgarh, Delhi, Gujarat, Uttar Pradesh, Mizoram, Jharkhand, Manipur and Meghalaya.
- No established mechanism for Quality control and Quality Assurance is in place in most states. Empanelment with NABL Accredited testing Laboratories for Quality control of drugs has not been universally undertaken. Delay in receipt of quality testing reports of drugs is observed in many states.
- Prescription audits are done in very few states- Andhra Pradesh, Uttar Pradesh, Odisha, Tamil Nadu and Meghalaya.
- Standard Treatment Guidelines (STGs) are available in most of the states but adherence to the same remains a major concern everywhere.

Recommendations

Procurement of Drugs

- The Central and independent Procurement Agency/body for all kinds of purchases and rate contracting of drugs and consumables needs to be formed.
- Evidence based demand generation should be followed with use of technology would go a long way in strengthening the cost-effective procurement system.
- Local purchase of medicines should be undertaken only for emergency requirements.

Inventory management of Drugs

- Proper infrastructure should be developed for better storage facility and stacking of drugs at appropriate temperature within the health facilities and also at drug warehouses.
- EDL should be reviewed annually through an institutional mechanism.
- Service providers should be educated for EDL and the status of availability of drugs at their respective facility.
- Availability of drugs at the warehouses and the health facilities should be ensured by the state to improve access and reduce OOPEs on drugs. Also, buffer stocks of essential drugs and supplies at the health facilities and drug warehouses to be maintained.
- Warehouses should supply drugs as per demand of the health facilities (Pull system), not pushing down the ones that have been received.
- Ensure establishment of a mechanism for managing near expiry drugs at the health facilities and drug warehouses (First Expiry First Out – FEFO).

- List of availability of commonly used critical drugs should be displayed at the facilities.

Quality Testing of Drugs

- For quality testing, sufficient numbers of NABL accredited labs need to be empanelled.
- Internal and external Quality Assurance mechanism needs to be ensured.
- Samples from each batch should be tested in the drug warehouse before releasing to HCFs.
- Facilities should be encouraged to report Adverse Drug Events on web-portal of Pharmacovigilance Programme of India.

Drugs and Vaccine Distribution Management System (DVDMS)

- IT enabled supply chain management system should be implemented health facility wise, extending upto Health & Wellness Centres (HWCs).
- Real time supply management system should be developed to get actual information of drug stock at the facility level.
- All parallel software can be integrated with the DVDMS.

Logistics of drugs

- Further planning of District Drug warehouses should be based on geographical mapping, factoring into the number of health facilities, distances etc. to minimize the logistics cost, lead time of stock replenishment and fast mobilisation of the stock in emergency situations.

Prescription Audit

- Prescription audit practice needs strengthening and internalisation at all levels of health facilities. IEC and BCC measures for changing prescription-writing behaviour of the doctors and educating patients for explaining benefits of generic drugs is needed.

Standard Treatment Guidelines (STGs)

- Though majority of the states have developed Standard Treatment Guideline (STGs), their usage in investigation, treatment, follow-up and over-all management of patients is missing. The states may create an institutional mechanism for periodical revision of developed STGs and promoting its usage at the health facilities, including engagement of non-government sector.

State Specific Findings

Andhra Pradesh

- Drug demand is generated arbitrarily. No scientific method for forecasting demand of drugs exists.
- Expired drugs are observed at few visited health facilities, for example 167 Drugs at DH Proddatur, 111 drugs at UPHC Nakash and Vit A drops at a Sub-centre are expired.
- Drugs are prescribed by brand name instead of generic names.
- ATM drug vending machine is found non-functional due to internet connectivity issue at e- Sub-centre.
- Poor utilization of telemedicine services at the state, district and other health facilities.
- Open vial policy is not being followed in Kadappa district.
- Standard Treatment Guidelines (STGs) are not available.

Bihar

- Several EDL drugs like Capsule Amoxicillin, Anti-Snake Venom, ORS, Zinc, Co-trimoxazole, Chloroquine, etc. are not available at the facilities.
- Two parallel software (DVDMS & Sanjeevani) are running simultaneously and not yet integrated. IT enabled Inventory management system has not reached lower facilities.
- There is no established mechanism to prevent expiry of drugs. Several near expiry medicines are found in the store-houses.
- High OOPE on purchase of drugs is observed in the visited facilities.

Chhattisgarh

- Poor storage conditions at CMHO drug store.
- Near expiry drugs have been pushed to peripheral health facilities.
- At sub centres, irrational use of antibiotics is observed.

Delhi

- Manual indenting is noted at many facilities.
- State has implemented “Nirantar Software”.
- ARV and Typhoid Vaccine are not available for several months at the facilities visited.
- Staffs are unaware of the process of expired drug disposal.
- First-In First-Out (FIFO) principle is followed by staff.

Gujarat

- Amlodipine and Anti-malarial medicines are not available in some PHCs and HWC-SHCs.
- No GRS committee, as recommended under the FDSI isseen at DH and SDH level facilities.
- Standard Treatment Guidelines (STG) is not used by the doctors and specialists.
- Prescription audit is not regularly conducted at the visited facilities.

Jharkhand

- Basic drugs such as oral Hypoglycaemics, Antihypertensives, Aspirin are not available.
- At the visited HWCs in both districts, antibiotics are not available. Albendazole is not available at SHC-HWCs in West Singhbhum district.
- Vaccines are available but vaccine inventory management is poor at the facilities visited.
- In West Singhbhum district, irrational administration of Injection Gentamycin to every febrile patient is observed.
- OOPE on account of purchase of drugs is observed in both the districts.

Madhya Pradesh

- Availability and regular replenishment of drugs is an issue (284 drugs are available out of 454 drugs under the essential drug list) in DH Chhindwara.
- At many health facilities, EDL list is not displayed.
- Inadequate maintenance of cold chain system.

Manipur

- DVDMS is only implemented at the state drug warehouse level, but is yet to drill down to the lower level health care facilities.
- Some of the drugs as well as consumables are not available in the visited facilities as per the EDL (such as Calcium, Vitamin A syrup, Mifepristone tablets and Sanitary napkins). Some facilities had to undertake local purchase of essential items (such as Dextrose 20% at CHC, Moirang).

Meghalaya

- No EDL is found in the visited health care facilities.
- Few lifesaving drugs like Anti-Snake Venom, anti-rabies medicine are not available. At PHC/CHC/DH, irregular supply of drugsis observed (anti-epileptic drug at CHC Selsella).
- Drugs are pushed to peripheral health facilities on random basis rather than as per demand/need.
- DVDMS system is not used for vaccine management.

Mizoram

- Facility wise EDL is not available at the visited facilities. Also, several EDL Drugs are not available at the facilities.
- Manual indenting of drugs and vaccines and frequent stock-outs of medicines is observed at facilities visited such as Anti-Diabetic, Epileptic drugs and Anti-malarial drugs are not available at some visited HWCs of District Mamit.

- Online Drugs and Vaccine management system (DVDMS) is yet to be implemented.
- Buffer Stock is not maintained at health facilities and drug warehouses.
- High local purchasing as well as High Out of pocket expenditure isobserved.

Nagaland

- There is abundant supply of few medicines, which are not required for that facility/region. E.g. availability of Metformin, but not enough cases of diabetic patient are found in the records.
- IT enabled drug inventory management system is not implemented.
- Due to inadequate supply of drugs to the facilities, maximum share of the available untied fund is being utilized for local purchase of drugs and supplies.
- There is poor infrastructure for drug storage at health facility. Drugs such as Oxytocin, Tetanus vials, etc. are not stored as per guidelines.
- There is no awareness regarding the quality testing of the supplied medicine in both the districts.
- High OOPE on purchase of medicines by institutional delivery cases to the extent of Rs 3000 to Rs 4000 is reported by few interviewed mothers.

Odisha

- Essential drugs are available at every visited health facility. However, drugs had to be purchased by the discharged patients coming for follow-up.
- The state is running its own software, not DVDMS.
- Infrastructure for storage of drugs & supplies needed improvement. Manual ladders are used for stacking of medicines. Inflammable items such as spirit stored with other stocks without fire safety arrangements are seen. Filled and empty gas cylinders are placed together.
- No penalty procedure for late/ no supply of medicines.

Rajasthan

- Facility wise EDLs have been formulated but are not found at the facilities. Some of EDL drugs are not available at the visited facilities.
- Although anti-hypertensive and anti-diabetics drugsare available at the HWCs, their utilization is minimal.
- Lack of proper guidance on managing drug inventory at all level of HCFs is observed.

Tamil Nadu

- The state has implemented free drug policy and state's Essential Drugs List (EDL) had 385 drugs for the facilities at various levels.
- The drugs are purchased centrally by the Tamil Nadu Medical Services Corporation (TNMSC) floating national level tenders.
- Each health facility had a passbook and drugs are distributed as per their entitlement. A computer portal named Drug Distribution Management System – DDMS is used by the districts and other facilities.
- Drugs are distributed only after each batch had cleared the quality test.
- For short-term or emergency requirement, the facilities are permitted to purchase drugs locally.
- Online drug distribution and management system up to PHC level is under test in five districts.

Uttarakhand

- Essential drug list (EDL) is neither available nor displayed at the visited facilities. Few essential drugs such as zinc tablet are not available at the health facilities.
- Storage facilities need to be created at peripheral health facilities such as Sub Centres, HWCs etc.
- DVDMS is not functional.

- Expired and near-expiry drugs are found at health facilities. The state and districts need to monitor utilisation of such drugs and evolve a system of managing near-expiry to avoid istage and to ensure all-time availability of drugs.
- High-OOPE on drugs is observed at the visited facilities.

Uttar Pradesh

- The state has implemented free drug policy and is using DVDMS though in limited capacity.
- Doctors at facility are not aware about the availability of the drugs. Therefore, they are not prescribing the medicines that are available.
- Despite improvement in coverage of DVDMS, its use is still very low. Out of total facilities, only 4.37% facilities are integrated with DVDMS, and out of integrated facilities, only 7 % facilities used it.
- Quality certification of each batch of drugs is not universally practiced.
- Prescription audit is practiced in those facilities, which are taken for the quality certification.

National Overview: Free Diagnostics Initiative (FDI), Biomedical Equipment Management and Maintenance Program, Pradhan Mantri National Dialysis Program

To ensure the accessibility of comprehensive healthcare in public health facilities by providing quality diagnostic and imaging services to all patients MoHFW has implemented National Free Diagnostic Initiative guidelines. The test catalogue has a list of 14 tests at Sub Health Centers/Health and Wellness Centers, 64 tests at Primary Health Centers/HWC (PHCs), 97 tests at Community Health Centers (CHCs), 111 tests at Sub District Hospital (SDHs) and 134 tests at District Hospital (DHs). All CRM states except Mizoram have implemented the NHM- Free Diagnostics Services.

In order to improve the operationalization of Free Diagnostic Initiative, NHM launched the program on Biomedical Equipment Management and Maintenance Program (BMMP) in 2015. Additionally, a technical document to support the State/UT's in public-private partnership (PPP) monitoring and in-house management of medical devices is brought out in 2019. BMMP has been implemented in 30 States/UTs, of which 24 States/UTs have implemented in PPP mode and 6 States/UTs have implemented through in-house mode. Implementation of this program has helped in providing assured quality diagnostics services in public health facilities, thereby reducing the cost of care and improving the quality of care for poor patients in CRM states. The centralized toll-free numbers and real-time dashboard are available where the program has already been implemented via PPP mode.

Enhancement towards accessibility of life-saving procedure for kidney patients, MoHFW launched Pradhan Mantri National Dialysis Program (PMNDP) in 2016. Hemodialysis services under PMNDP are currently available at district hospital level in 465 Districts in 798 Centers deploying 4727 machines as on 31st October 2019 (Source: DVDMS/monthly reports). Furthermore, PMNDP has already been rolled out in 34 States/UTs and is in implementation phase in 02 States. Hemo-dialysis services are available in 20 States/UTs through PPP Mode whereas 14 States/UT are providing services through In-house mode. PMNDP is supported by National Health Mission and is providing free of cost services to BPL patients.CRM teams found dialysis services are implemented at 88% CRM states i.e. in 14 out of visited 16 States/UTs and dialysis services are being provided free of cost to BPL patients in most of the visited States/UTs. Ten CRM states namely Andhra Pradesh, Delhi, Jharkhand, Odisha, Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh, Uttarakhand and Gujarat are operating on PPP mode for dialysis services; whereas 25% states namely Manipur, Tamil Nadu, Mizoram, and Nagaland are providing dialysis services by In-house mode. PMNDP is under-implementation in 2 CRM states i.e. in Meghalaya and Chhattisgarh.

To rapidly strengthen public health facility safety in terms of diagnostic radiology and to equip public health facilities to address concerns related to radiation safety, NHM has emphasized AERB safety guidelines. Out of 36 States/UTs across India, only 4 states (Assam, Kerala, Uttar Pradesh and Tripura) have implemented Atomic Energy Regulatory Board Program for obtaining "License of Operation" for Public Health Facilities while tender is in progress for 2 states (Arunachal Pradesh and Maharashtra). The compliance to AERB licensing in 16 states visited during CRM is less than 5%. As per the AERB radiation protection rules 2004, no diagnostic X-ray equipment shall be operated for patient diagnosis unless License of Operation is obtained from the competent authority. Infrastructure is found inadequate in most of the visited health facilities across the country. The machine operators are unaware of radiation safety norms.

Key Findings

- All CRM states except Mizoram have implemented the NHM- Free Diagnostics Services, rest of CRM States namely Andhra Pradesh, Delhi, Jharkhand, Manipur, Meghalaya, Odisha and Uttar Pradesh have executed the laboratory services in public private partnership mode; whereas State of Bihar, Chhattisgarh, Rajasthan, Tamil Nadu, Madhya Pradesh, Gujarat and Uttarakhand have in-house model to provide laboratory services.
- CRM states namely Andhra Pradesh, Delhi, Jharkhand, Madhya Pradesh, Odisha, Rajasthan and UP have outsourced CT services. Moreover, CRM states namely Andhra Pradesh, Meghalaya, Odisha, Rajasthan, UP and Uttarakhand have outsourced the Tele-radiology services for X-ray reporting.
- The number of tests which are provided free of cost to patients are variable in the CRM states

due to state policies and availability of resources like Equipment, HR and Consumables, some states have outsourced only higher level of tests.

- It is observed in some CRM states that NHM notified diagnostics tests are not available free of cost to all the beneficiaries who visited public health facilities and some fees is collected for explicit categories of tests from the patients. This may be due to lack of awareness or lack of proper documentation. This can significantly add to out-of-pocket expenditure. Greater awareness of free diagnostics (like the free drug scheme) will ensure there is less financial hardship on poor patients.
- In many CRM states, there are no fixed policies or common exercises for External Quality Assurance Scheme (EQAS) and Internal Quality Control (IQC) in the state. Most of the facilities are not using any mechanism for quality assurance and it is observed by the CRM team that the maximum number of facilities did not have any Standard Operating Procedures (SOP).
- In some facilities of the CRM states, it is noted that radiology equipment such as X-ray machines are lying idle due to lack of trained technicians to operate them and most of the radiation facilities are not AERB certified.
- CRMstatesnamelyAndhraPradesh,Chhattisgarh, Jharkhand, Madhya Pradesh,Mizoram, Manipur, Meghalaya, Nagaland, Odisha, Rajasthan and Uttar Pradesh haveimplemented Biomedical Equipment Maintenance and Management program in PPP model.CRM states namely Gujarat, Tamil Nadu and Delhi have an in-house system for biomedical equipment maintenance and management.
- CRM states i.e. Bihar and Uttarakhand have planned to undertake BMMP activity as per guidelines but the tender failed multiple times. Currently, these states manage medical devices by the conventional method of engaging AMC/ CMC with the vendor.
- Implementation of BMMP programs in most of the CRM states/UTs has shortened the turnaround time to repair the equipment in the CRM states. However, in most of the states the registration of complaints for equipment maintenance through online or toll free number is either delayed or not properly registered.
- Corrective maintenance, preventive maintenance, calibration, user training, toll-free number-based complaint logging, a website-based summary on all the medical equipment till the level of district hospital are made available after the initiation of the BMMP program. Above mentioned features are common for elevenstates/UT which implemented the program via PPP mode and others do not have all the program features.
- It is found that some CRM states like Madhya Pradesh, Meghalaya, and Mizoram havedifference in the amount of equipment as per BMMP dashboard which is physically available in the facility.
- In CRM states like Nagaland and Manipur, itis noticed that staff in the public health facilities are unaware about the key aspects of the BMMP program and responsibilities of service providers.
- In few of the CRM states, there is no robust monitoring framework since the beginning of the rollout of the BMMP by state. State-level meetings are conducted rarely where state program nodal officer and service provider representatives participate.
- Adequate space (120sq.ft. space) is available for performing dialysis at most of the dialysis centers except in Rajasthan for proper functioning.
- Community awareness regarding the National Dialysis Program is found to be excellent in most CRM States/UTs.
- Dialysis services are not free for patients in Bihar and tendering is in process in order to make dialysis services free to BPL patients.
- Availability of Nephrologist (fortnightly visit) is a key concern in most of the facilities visited by the CRM teams.
- Dialysis services are not being provided to positive patients at some dialysis centers like

SDH, Dahod, Gujarat and DH, Khandwa, Madhya Pradesh; are not taking seropositive patients whereas in Nagaland, HIV positive patients are not getting dialysis services despite high prevalence of HIV in Nagaland.

- Issues with seepage, water logging in the dialysis unit are observed at DH, Chhindwara, Madhya Pradesh which is a source of microbial growth and increases chances of infection.
- In Meghalaya, the PMNDP is yet to be implemented since the tender to outsource the dialysis services has failed three times.
- Records regarding quality of dialysis service delivery (Kt/V or URR record) are available except in Nagaland.
- Most of the States/UT where the CRM team visited observed that X-ray machines/Radiation facilities are without license from AERB.
- TLD badges, PPE for radiation safety and IEC regarding radiation safety are found missing in many visited facilities by the CRM team.
- Lead aprons are not used during X-ray exposure and instead are found crumpling in shelves.
- Absence of lead door, control room and Mobile Protective Barrier is observed.

Recommendations

- Nodal Officers at State& district level need to be identified for managing and ensuring availability ofdiagnostics, equipment maintenance, dialysis, AERB certification etc.
- The hospital In-Charges (I/C) and Managers should be sensitized to oversee the functioning of these equipment and services through a defined checklist while taking daily rounds.
- Laboratory information system that is linked with electronic health record (EHR) for all laboratories should be initiated by the states.
- To ensure competency among laboratory and otherdiagnosticservicesinductionandrefresher trainings need to be organized for laboratory supervisors/Managers/Radiographers and technicians.
- Awareness among community and even service providers needs to be organized about the free diagnostic, dialysis and equipment maintenance program.
- A clear strategy and institute monitoring mechanisms for PPP should be in place to avoid irrational utilization of services. Prescriptions of 'individual/single tests' in PPP should be monitored closely by the State.
- A system for verifying the assets which are physically available in the facility against the BMMP dashboard at least once every month should be devised.
- The service provider should be advised to synchronize calibration schedules with NQAS assessment, renewal of license for blood bank or renewal of AERB registration etc.
- Dialysis services should be provided free of cost to all BPL patients for reducing OOPEs.
- Availability of Nephrologist, visit on fortnightly basis, must be assured at every dialysis centre with immediate effect.
- The dialysis centers should be providing adequate space as defined in the guideline for all dialysis patients with isolation rooms and separate equipment for seropositive patients.
- Records to evaluate the quality of dialysis service delivery (Kt/V or URR record) should be maintained. Also, performance of microbial testing, water testing etc. on regular basis needs to be done.
- National Dialysis Program Dashboard needs to be created and maintained for monitoring and evaluation purposes.
- Measures should be taken to reduce waiting time for patients availing dialysis services.
- Sharing of monthly progress report on PMNDP by all Nodal Officers with MoHFW.
- IEC and social awareness camps for free dialysis services for BPL patients may be appropriately displayed at each health facility for proper utilization.
- Diagnostic X-ray equipment should not be operated for patient diagnosis unless License

of Operation is obtained from the competent authority.

- States must prioritize for up-gradation/ development of infrastructure based on the essential needs and explore by self (using e-lora site) or through empaneled agencies obtain AERB clearance for radiological units.
- Training has to be imparted to radiology technicians for effective usage of radiology equipment.
- Units should always be operated from the control room or standing behind the Mobile Protective Barrier (1.5 mm lead equivalent) or fixed protective barrier (such as a wall).
- States should display warning signage for pregnant ladies entering the X-ray room and IEC for radiation safety may be appropriately displayed at each health facility.

State Specific Findings: Free Diagnostics Initiative (FDI)

Andhra Pradesh

- Drugs and diagnostics are available and free for all.
- Facilities of Digital X-Ray and Tele- radiology are available at District Hospitals.
- Well-established mechanism for Quality Control and Assurance of Drugs procured is in place. This is done through conducting "Quality Check" from NABL Accredited Laboratories.
- National Free Diagnostic Initiative Program has been implemented in Andhra Pradesh in PPP mode for all level of HCFs (PHCs till DHs) with Medall. The basket of tests offered by in-house laboratories and outsourced tests are well-demarcated. Rs 235 per patient are paid to the service provider by the State Government for the laboratory tests.
- Underutilization of in-house services and overutilization of outsourced services noticed.
- During the visit it is found that maximum share of lab test lies with out-sourced lab. Many times tests available at facilities are also done by the out sourced lab.
- Some equipment in the in-house laboratories like Auto Analyzer, autoclaves are found to be non-functional and in need of repair and maintenance.

Bihar

- FDI program is running in in-house mode but only limited number of tests is available in health facilities.
- Availability of Laboratory Technician (LT) is a key challenge in expanding the range of diagnostics. Semi auto analyzers & a LT are provided at APHCs in Bhagalpur district just 2 days before CRM visit. Hub & spoke model for diagnostics has not yet started.
- Malaria Slide test, Urine analysis, Stool Analysis etc. are not done even at DH level. Fee for ECG is being charged at DH Bhagalpur.

Chhattisgarh

- Free diagnostic services are available in the state through in-house mode.
- Diagnostics at PHCs are only limited to Rapid Diagnostic kits & slide preparation for Malaria.

Delhi

- National Free Diagnostic Initiative Program has been implemented in Delhi.
- Essential drugs & diagnostics are available for VBDs, Leprosy, Tuberculosis and Viral Hepatitis. HIV testing of all TB and ANC cases is being carried out.
- JSSK is partially being implemented in both the districts visited. Free diagnostics such as Ultrasound, ECG, etc. and referral transportis not being provided to the beneficiaries.
- OOPE reported to the extent of Rs 1000-3000, in urban slums at Todapur.

Gujarat

- State is providing FDI services through in-house mode.

- Most SHC and PHCs visited are found to have 05 out of 07 tests recommended in 2015 guidelinesand 11 (out of 19) lab tests. HWC-PHCs and HWC-SHCs are yet to be upgraded to include additional tests as recommended in National Free Diagnostics Initiative guidelines.
- Range of diagnostic services available at CHC and SDH level laboratories is narrow. In Fatehpura CHC, cell counter is made available a week before CRM visit; and it is not functional yet as none of the technicians are trained to use the machine.
- Hub and spoke model not yet established limiting the number of diagnostic tests in all facilities.
- Lab at DH, Dahodhad good range of functional services, although CT scan facility is not available in the entire district.
- Infection Management protocols are not being adhered to by LTs while taking sputum samples.
- VIA screening test is not available at any PHC in Dahod district; because none of the medical officers and ANMs are trained to perform VIA cervical cancer screening test.
- UPHCs have a Laboratory Management Information system (LMIS) mechanism under Ahmedabad Corporation, but LTs need training in it.

Jharkhand

- The state follows a mixed model with both in house and PPP mode available for diagnostics. PPP is with MEDALL Corporation for pathology tests and Health Map for radiology. However, the tests provided by the MEDALL (PPP) are not free for APL patients, leading to OOPE for them. For instance: Dengue test cost Rs. 750 in private lab in Basai, while it costs Rs. 700 at MEDALL lab, therefore the amount makes a huge dent in the patient's pocket.
- The expenditure on diagnostics made a huge dent in the patient's pocket and led to compromised health outcomes. For e.g. an old man did not get tests done for his children at DH Gumla as for one child he had to pay Rs. 1000 for Dengue and Chikungunya test.
- Essential diagnostics list of state isnot available in the field.

Madhya Pradesh

- The state has prescribed 25 essential tests to be available at the level of HWC-PHC. But due to shortage of LTs, out of 25, only 9 tests (the rapid tests) are performed at these centers.
- At some places a Hub & spoke model has been established. A CHC Lab has been identified as a hub for the PHCs in the area. A helper is paid Rs. 300/day for transporting samples and collection of results within same day.
- E-Aushadhi platform has been effectively implemented for medicines and equipment in some facilities.
- Shortage of X-ray technicians has also been noticed.
- Lab information Management System and Dashboard need to be developed for all health facilities

Manipur

- State is providing lab tests under PPP mode, 53 lab tests for both DH and CHC and 34 tests at PHC level. The tests have been outsourced at Rs 250 per patient.
- Real-time dashboard is available to monitor the FDI- Lab services.
- Diagnostic services such as CT scan are not available at DH level. Also, there is non-availability of comprehensive lab services 24x7 at PHC and CHC level.
- Free Diagnostic Initiative (Tele-Radiology services) is currently not available in the state.
- Till 22nd October 2019, 19562 patients have availed the lab services from service provider (Krsnaa diagnostics) whereas 83839 tests have been performed.
- State launched mobile laboratory on a bike (Lab-bike) in Feb 2019 at PHC/CHC level, to

provide about 36 laboratory investigations at the doorstep of the people; but hasn't been used till now.

Meghalaya

- Diagnostic services at HWCs-PHCs, CHC and DH is provided by state in collaboration with Krsnaa diagnostics under PPP. A total of 51 free diagnostic tests (including HbA1c) are available under PPP at HWCs-PHC. The hub lab for Krsnaa laboratory is in Khanapara, Guwahati.
- Usually results are available within 1-2 days but delays up to 3 days in delivering laboratory report are reported. The turnaround time varied facility-wise depending upon the distance from Krsnaa diagnostics Headquarter in Khanapara.
- Diagnostic test provided through PPP service provider are completely free, whereas in-house are billed such as Hemoglobin Rs 30 and Blood grouping Rs 50 at PHC.
- LMIS is yet to be operationalized in the state (in-house labs).
- Tele-radiology service are available in DH but due to lack of radiologist, test reports are available in 6 hours and approximately only 6-7 reports are done in a day.

Mizoram

- The program has not been implemented in the state yet. The in-house laboratory provides 11 pathological tests in OPD hours and charges user fee from Rs 20 to Rs 350 from patients.
- Critical values and range for lab tests are not defined and displayed in pathology.
- The X-ray and USG are also chargeable as per the type and body part of the patient.

Nagaland

- The diagnostic services are provided through in-house mode but only limited diagnostic tests are available in the health facilities.
- It is also observed that certain tests at SC, PHC and CHC are free to all beneficiaries; however, at District hospital none of the tests are free.
- In DH Kiphire, none of the basic radiological tests are available, even thoughKiphire is an aspirational district, far from the State capital and a difficult to reach area.
- CT and MRI services are not available in both the districts visited.
- The procurement of reagents and consumables of lab and x-ray services is being done at facility level. The rapid diagnostic kits are supplied from State Head quarter but the quantum and frequency of supply is not adequate to meet the demand.

Odisha

- State has introduced free diagnostic services under Nidan scheme. 64 tests at DH, 40 at SDH and CHC, 20 at PHC and 11 type of test at Sub-center have been identified under NIDAN.
- Both PPP and in-house modeis functional- only advanced tests at DH level are outsourced.
- The lab technicians at in-house labs have been trained for conducting integrated lab testing for various programs. Their average daily load per LT is more than 100 tests that too without an auto analyzer which is commendable.
- DH Phulbani has established an Integrated Public Health Lab which will conduct both public health as well as clinical lab tests. Lab services will shortly be shifted to the newly created public health lab.
- At DH Mayurbhanj, a good system of sample collection from wards has been established, wherein, central lab is intimated about the tests to be done on admitted patients. The team from laboratory visits wards to collect the samples and also delivers reports over there.
- It is also observed by the team that in one case at Mayurbhanj the doctor is waiting for blood report for 2 days, but report is not delivered. In depth assessment revealed that central lab is supposed to send sample to sentinel lab, which is not done. Thus there is a communication gap between the treating team, central lab and sentinel lab.

Rajasthan

- Rajasthan is one of the first states to launch free diagnostic services in year 2012 under a flagship scheme called Mukhya Mantri Nishulk Janch Yojana to all patients & at all health facilities.
- In addition, 39 advanced tests have been outsourced to a service provider. But these complex advanced tests (Cytology, cultures, biopsy etc.) are found highly underutilized.
- A LIMS is used for daily monitoring of number of tests conducted at each facility.
- Reagents and consumables are purchased locally by the health facilities. Annual rate contracts are established for equipment, reagents and consumables by the state corporation.
- Tele-radiology services for X-ray reporting are implemented in the state since 25-09-17 at 50 DH/SDH/Satellite Hospitals by Krsnaa Diagnostic Pvt. Ltd. and Ruby Alicare Pvt. Ltd.
- As per agreement the service provider had to maintain the record of digital case register for discontinuity of services but no record is found during the visit.

Tamil Nadu

- The State has free diagnostic service scheme in place as per the GoI guidelines. For diagnostics in the Universal Health Care blocks, Hub and spoke model is being used.
- 138 diagnostic tests are notified by the state to be provided at various levels.
- Shortage of LT is observed in both PHCs visited viz. Saram and Dhadapuram in Villupuram. Lab services at these health facilities are provided 2 to 3 days in a week by LTs deputed from nearby health facilities.
- Only two LTs are found working in the 177 bedded Tindivanam GH where Cell Counter, Electrolyte Analyser, 2 Semi Auto Analysers and a Urine Analyzer are available.
- X- Ray, USG and CT scan services are available in district level institutions. USG machines are registered under PCPNDT Act.
- CT scan services are available at Rs. 500 / case and additional Rs. 300/ case for contrast CT is to be paid. Generally it reimbursed under CMHIS or given free of cost to poor patients.

Uttar Pradesh

- The state has implemented Free Diagnostics in PPP mode in DH.
- It has been observed that Diagnostic services at DHs are very good providing more than 75 tests. Around 7000 to 8000 tests in a month are done in the district.
- Laboratory of District Male Hospital, Bahraich is ISO certified.
- Labs at the peripheral level facilities are either not functional or are providing limited number of tests (only point to care test) and the staff available is highly underutilized.
- Pathology services at CHC and PHC are inadequate and hence cases are referred either to private sector or to higher level health facility leading to lost to follow up and high OOPE.
- High out of pocket expenses on USGs, CT scan and other specialized diagnostic tests at the peripheral level is also seen.

Uttarakhand

- Diagnostic tests are performed free of cost in BPL cases and other category patient have to present Ayushman card for availing free diagnostic services.
- Lab technicians at in-house labs have been trained for conducting integrated lab testing for various programs. Their average daily load per LT is more than 100 tests.
- State should withdraw the user fee from all the health facilities.

State Specific Findings: Biomedical Equipment Management and Maintenance Program

Andhra Pradesh

- During CRM visit, no equipment maintenance and repair plan is seen in place as the state has decided to shift from PPP mode to In-house model on lines of Tamil Nadu.
- During the visit several equipment like radiant warmer, Auto Analyzer, autoclave etc. are found non-functional in need of repair and maintenance.

Bihar

- The establishment of a state-wide Bio-medical Equipment Management & Maintenance Program (BMMP) via PPP mode is in process.
- Awareness about equipment maintenance & management program is low and no equipment inventory is maintained. Further, many non-repairable equipment are observed in the visited facilities. No condemnation policy is found in place.

Gujarat

- Calibrations of measuring equipment are not done in any of the facilities visited.
- Annual maintenance is found with the new equipment with warranty; however after expiry of the warranty, no AMC isdone in most of the facilities visited.
- Preventive maintenance plan for all the equipment of the facility may be ensured.

Jharkhand

- State has rolled out the program in August, 2017 in PPP mode with Medicity.
- Mapping of all the health facilities in the states has been undertaken and an online dashboard is created to track the equipment.
- The service provider comes on call in 1 day and fixes the equipment.
- Calibration is done once in a year during March-April, rest of the calibrations is done at the time of equipment maintenance and staff is aware about the toll free number.
- Preventive maintenance is done in DH, calibration schedule is given to the nodal officer in DH, Gumla.
- The old and dysfunctional equipment are discarded in storage areas for condemned equipment.

Madhya Pradesh

- The program has been contracted out under PPP model through AIM Healthcare (Consortium

of AOV, Instromedix & Mass Biomedical), up to the level of DHs (i.e. DHs, SDHs, CHCs and PHCs) with effect from 12 January 2017 and all the equipment under BMMP are found tagged.

- E-Aushadhi platform has been effectively implemented for medicines and equipment in all the facilities visited.
- Some mismatch of data is found in DH Chhindwara- 471 equipment are available whereas 494 should have been in place as per the equipment inventory available.
- Semi-Automatic biochemistry analyzer is non-functional at CHC Mohkhed.
- X-ray machines are available in CHC Chaurai but X-Ray technician is not available.
- Quick condemnation methods should be adopted for Nonfunctional and Non Repairable equipment.

Manipur

- Manipur has implemented BMMP in PPP mode by engaging TBS (India) Pvt. Ltd.
- Tagging of 1948 biomedical equipment has been completed by TBS, whereas, some equipment like BP apparatus, ECG machine are found untagged at DH, Bishnupur. Also, weighing scale and radiant warmer are found untagged at DH, Chandel.
- IEC for the program is not present at any of the facility. Also, calibration records of equipment are not found at any of the visited facilities except at PHC, Komlathabi.
- Some equipment such as OT light, Eye testing equipment, radiant warmer are found non-functional in DH Chandel, where the issue had been raised to the state but is still unresolved.
- TBS proposed 14 equipment under 'Beyond Economic Repair (BER)' category to the state. Though, state has created a condemnation committee for taking decisions on BER equipment, the 1st meeting is still pending.
- Till 23rd October 2019, TBS has received 322 calls on toll-free number; out of which 223 calls have been resolved. However, some equipment such as OT light, Eye testing equipment, radiant warmer are found to be non-functional in DH Chandel, where the issue has been raised to the State but still unresolved.
- The service provider should focus on completion of all historical non-working calls.
- Need to increase awareness regarding toll free numbers and BMMP. State should review the service provider's performance.

Meghalaya

- Meghalaya has implemented BMMP in PPP mode by engaging TBS (India) Pvt. Ltd. It is found during the visit that apart from corrective maintenance, scope of agreement on other services like calibration, preventive maintenance, user training etc. is not known to the head of institutes.
- Awareness of toll free numbers is limited to only the head of institute and other staff members are not involved in raising breakdown complaints on toll free numbers. Toll free number is also not accessible every time.
- PHC managed by PPP service provider had no demarcation of government owned medical equipment (records are also not available) from those that are supplied by Karuna Trust. Maintenance of medical equipment by Karuna trust is also poor.
- Service reports of equipment tagged by TBS Pvt. ltd are found in the facility but it is not clear whether the ownership of those equipment are with the government.

Mizoram

- BMMP program has been implemented in the state and facilities are linked with the program by means of toll free number.
- There is no equipment tagging and online equipment inventory management system functional in the facility. The inventory is managed manually by the storekeeper.
- The staff is not aware about BMMP Guidelines, upkeep time, downtime and turnover time of equipment. The repair time logbook is not maintained by staff.

- The BMMP should be streamlined by bar-coding of each equipment and having an online real time mechanism for complaint registration and repair.
- State should have a centralized inventory management system for indenting, procuring and quality checking of equipment, drugs and consumables.

Nagaland

- BMMP has been launched in PPP mode with M/s Faber Sindoori at the rate of 9.88% for comprehensive maintenance activities.
- The service provider has tagged the equipment from PHC up to DHs, but the state has recently excluded all PHCs from the scope of services. It is observed that there is no mechanism in place to ensure the upkeep time of the PHC's equipment.
- To monitor the services of the equipment, the provider has installed a toll-free number and a real-time dashboard. But, the facility staffis not found aware of the dashboard monitoring and call logging. The complaints are being made by directly contacting the service provider's engineers.
- On analyzing the breakdown call volume it is found that the numbers of calls logged by the facility are very less.
- The procurement planning is also not being done through the inventory data of equipment available on the dashboard. Also, the supply of equipment is not rationally done. For instance, in Kiphire district, new autoclave machines are kept unused and un-installed at the facilities.
- State may deploy a dedicated nodal officer at state and district level to ensure the monitoring of services. It is requested to create user awareness about the program among all healthcare professionals via appropriate government order.

Odisha

- The centralized BMMP has recently been implemented in the State and the bar coding has been done. However, it is not yet fully operational in terms of maintenance of equipment, functionality of call center, information and knowledge about it to the service providers.

Rajasthan

- State is running the BMMP program successfully under PPP mode with L1 bidder, Kirloskar Technology Private Ltd (KTPL).Post-program implementation,the breakdownmaintenance and preventive maintenance of the equipment has improved.
- Fluorescence microscopes which require regular monitoring and maintenance are unmapped. However, binocular microscopes are included in the scope.
- Whenever a new equipment is installed, the district health officer inspects and physically verifies the equipment, thereby reducing the chances of mismatch in total asset values.
- Initially, when the numbers of breakdown calls are few, the nodal officer created a WhatsApp group and around 406 calls are resolved in four days. Now, the same WhatsApp group is also used for the monitoring of everyday summary of calls received and calls closed.
- It is suggested to encourage use of medical devices data (after making dashboard real time) for decision making/planning and increase awareness of the program among all the staff.

Tamil Nadu

- BMMP program is running in the state of Tamil Nadu through in-house mode.Tamil Nadu Medical Services Corporation (TNMSC) purchases and distributes all the required equipment and bio-medical equipment in the State.
- HMIS State portal for inventory management is being used with a centralized call center for bio-medical equipment and the inventories. One Biomedical Engineer (BME) is available in each district for procurement requisition, installation and maintenance of the equipment.
- The equipment handling medical, para-medical staff is trained by the BME.

Uttar Pradesh

- The BMMP is implemented in PPP mode in June 2018 across the state at a rate of 4.84% of asset value. The service provider has developed a real time dashboard and provided a toll-free number where complaints can be registered and viewed from anywhere.
- In most of the facility visited equipment are found mapped and tagged with barcode.
- A mixed response is found in terms of turnaround time. Few facilities reported that engineers do not come often, however few facilities have reported that it gets resolved within the stipulated time.

National Overview: District Hospital Strengthening

A well-resourced District Hospital provides secondary health care which includes a range of curative, preventive, promotive, rehabilitative and palliative care services to the community within the district. Strengthening District Hospitals for assured and comprehensive secondary care services and developing it as a hub for pre-service and in- service training is one of the focused activities of MoHFW. GoI guidelines on 'District Hospital Strengthening' are disseminated in 2017. Establishing multispecialty care at DHs as per Indian Public Health Standards (IPHS) with assured critical care services (emergency, functional OTs, SNCU,NICU,PICU, Obstetric and general HDUs and ICUs etc.) and developing it as a knowledge hub for initiating medical (DNB/CPS), paramedical and nursing courses are some of the core activities under DH strengthening.

During 13th CRM, implementation of District Hospital Strengthening guidelines, PM-JAY and initiation of medical/paramedical/nursing courses are reviewed in 16 states.

Key Findings

- Critical care services including emergency surgical services are either limited or unavailable in district hospitals across all states visited. As per the provisions of DH strengthening guidelines, RKS of district hospitals are empoared to hire specialists for strengthening their specialties and running courses. However, none of the states visited had utilized this provision.
- Very few states are utilizing their district hospitals for training needs of the service providers.
- 232 seats in 142 District Hospitals across 14 states in the country have been accredited for DNB programme however, in the states visited for CRM, 84 seats in 58 District Hospitals across 6 states are found accredited for DNB programme. CPS has been initiated only in Madhya Pradesh and Odisha.
- Most of the district hospitals visited are conducting ANM/GNM courses. Some states like Odisha are also planning to initiate BSc courses in GNM schools. However, none of the states had any definite plan for initiating para-medical courses in the DHs.
- TMIS portal is not being used in any state adequately for deciding training load and posting of trained personnel at various levels of health facilities except in Odisha.
- Post-training follow-up, supportive supervision and mentoring remains a weak area.
- States like Delhi, Gujarat and Jharkhand had their district hospitals empanelled under PMJAY. Also, ArogyaMitras are available at empanelled hospitals in MP and Manipur.

Recommendations

- Clinical care at secondary level facilities need strengthening in terms of quality of care, expanded spectrum of inpatient services and increased range of diagnostics services.
- Comprehensive district wise roadmap after assessing the training need of various service providers along with its linkages with service delivery plan at all levels of health facilities needs to be drawn in consultation with State and District Programme Officers.

- High focus states like UP, Bihar and Jharkhand can ensure availability of trained manpower by strengthening their DHs and accelerating initiation of medical/paramedical and nursing courses.
- Priority action is needed for converting nursing schools into nursing colleges. Opening of new ANM schools also need to be restricted as focus of states should be on initiating 4 year nursing programs as per INC.
- In lieu of shortage of specialists, MBBS doctors could be trained to handle emergency and other critical areas like HDUs, SNCUs, PICUs, NICUs, and ICUs etc.
- States should also think about initiating post basic nursing programs in their DHs. This will ensure provision of trained manpower in critical care areas.
- PMJAY empanelled Hospitals attached to teaching institutions (medical, PG and DNB courses) are entitled for 10 per cent higher packages. States should utilize this low hanging fruit and develop their district hospitals as knowledge hubs.
- Accreditation under NQAS is approved for getting gold certification under PMJAY, so, states need to accelerate the accreditation process for all DH and SDH.

State Specific Findings

Andhra Pradesh

- 22 seats in 17 District Hospitals have been accredited with NBE for initiating DNB courses.
- Secondary level public health facilities are empanelled under PM-JAY.
- State needs to utilize their DHs for imparting training to all cadres of service providers.

Bihar

- 21 district hospitals are being strengthened and developed as Model District Hospitals.
- State is in the process of initiating DNB/CPS courses as funds are sanctioned in RoP '19-20 for the same.
- State has secondary level facilities empanelled under PMJAY.
- There is no systematic plan in place for training service providers. Post-training follow-up, supportive supervision and mentoring also remains a weak area.

Chhattisgarh

- State is in the process of initiating DNB/CPS courses as funds are sanctioned in RoP '19-20 for the same.
- Secondary level public health facilities are empanelled under PM-JAY.
- Critical care at secondary level facilities needs strengthening in terms of quality of care and expanded spectrum of inpatient services.

Delhi

- The LHMC Hospital is empanelled under PMJAY. 11 ArogyaMitras are available in the facility.
- Only one Mother and child hospital is accredited with NBE to run DNB course in two specialties – Obstetrics & Gynaecology and Paediatrics.
- Due to overburdened tertiary care facilities, there is a dire need to strengthen secondary care facilities in the state.

Gujarat

- Critical care services including emergency surgical services are either limited or unavailable in public health facilities, as noted in both the districts. In Dahod district, there are no private surgical facilities, thus making DH the only centre in the district with emergency surgical facilities. Other private healthcare services empanelled under PM-JAY are fewer in number, and none exist in remote blocks. Thus, public health facilities at block levels, if made functional, would help reduce inequity in care in these areas.
- In Dahod district, all blind persons, irrespective of their socioeconomic status, are included as beneficiaries of PM-JAY scheme.

Jharkhand

- 170 CHC, 13 SDH and 23 DH are empanelled with PMJAY. Aarogyamitra are available at the facilities. 102 cases at CHC Basia& 180 at CHC Sisai had been identified by the Aarogya mitras. At DH, claims worth Rs. 3 crores have been made.
- The state is not providing insurance through any other scheme.
- Only 1 DH is strengthened to provide DNB while the DHs in districts visited are not providing any DNB course.
- 7 DHs have been strengthened as Program Study Centre for Bridge course.

Madhya Pradesh

- District Hospital Chhindwara and Khandwa are empanelled under PMJAY with separate corners available for people to get themselves registered under the scheme. AarogyaMitras are available in the facility.
- At DH Chhindwara, a total of 2,061 cases and at DH Khandwa, a total of 1590 cases till date are treated and managed under the scheme.
- District hospitals regularly conduct short duration trainings of staff on managing biomedical waste and on behaviour management.
- The state has initiated CPS course.

Manipur

- DH Chandel and Bishnupur are empanelled under PMJAY. AroyaMitras are available at the facility.
- DH Bishnupur has facilitated 46 patients under PMJAY till date whereas 56 patients have been assisted under PMJAY at DH Chandel.
- Medical, paramedical or nursing courses have not yet been initiated in the state.

Meghalaya

- Almost all government hospitals in state are enrolled in PMJAY, except five hospitals - Warmash PHC, Unitri PHC, Mahwathi, Mawlashai and Kydrain. Total 109 PHC, 27 CHC, 12 DH, 1 regional medical college, 1 medical research institute are enrolled under PMJAY.
- Total cases treated or managed under PMJAY in government facilities since the beginning is 31,330.
- None of the DHs in state are found to be conducting DNB/CPS/Nursing certificate and diploma course.

Mizoram

- Secondary level public health facilities are empanelled under PM-JAY.
- DNB/CPS courses have not been initiated in the state yet.

Nagaland

- AB-PMJAY facility is available in 5 health facilities of Phek District including 01 DH, 03 CHC and 01 PHC. Expected number of beneficiaries is 1.15 Lakh in the district and 22% e-cards have been issued till 20th October 2019.
- PMJAY is not completely cashless to the beneficiaries at DH. It is observed that, nearly 90% beneficiaries are purchasing medicine or consumables from open market and submitting Prescription Voucher for reimbursement.
- Documentation at DH is very poor. No register of patient details is maintained at the PMJAY help desk at the HCFs. Many vouchers are found without any serial number and name of the patients and prescription kept for reimbursement are made on a small paper without any signature or stamp.

Odisha

- The State has initiated CPS courses in 11 DHs and proposed 3 centres for midwife training. There is also a plan in place for initiating BSc courses in GNM schools. However, there is no definite plan for initiating para-medical courses in district hospitals.
- SIHFW Odisha is the nodal institute for supporting state/districts and conducting various

capacity building trainings of service providers. TMIS portal is not being used adequately for deciding training load and posting of trained personnel at various levels of health facility. Post-training follow-up, supportive supervision and mentoring remains weak.

- State has not implemented PMJAY, but their BSKY scheme is operational with 197 hospitals empanelled so far. Besides this, all government hospitals also provide free services under BSKY. The scheme is operational for both APL and BPL families.

Rajasthan

- DHs have been merged into Medical Colleges in various districts. However, no training support is provided to the in-service staff.
- At present DHs are not conducting any courses in the selected districts.
- AB-PMJAY has been integrated with the state flagship scheme "BSBY" and implemented under the name of "Ayushman Bharat – Mahatma Gandhi Rajasthan Sisthya Bima Yojana" since 1st September 2019. All 982 private hospitals and 519 government hospitals, which are empanelled under BSBY, are automatically empanelled under new integrated scheme.

Tamil Nadu

- 31 districts have been selected for DH strengthening in the state including Virudhunagar.
- PMJAY is rolled out on 23rd September 2018 by the name of PMJAY-Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS).
- There are currently 1169 public health facilities empanelled with the scheme.

Uttar Pradesh

- 22 districts have been selected for DH strengthening in the state. State is also planning to roll out CPS courses.
- PMJAY is rolled out on 23rd September 2018 under the name of Mukhya Mantri Jan ArogyaAbhiyan (MMJAA). There are currently 596 public health facilities empanelled with the scheme.

Uttarakhand

- Critical care services including emergency surgical services are either limited in scope or unavailable in the DHs visited.
- Medical/Paramedical or nursing courses have not been initiated in the state. HR crunch in the state can be addressed by initiating such courses.

State Specific Findings: Pradhan Mantri National Dialysis Program

Andhra Pradesh

- PMNDP program has been implemented in PPP mode and Dialysis services are free for all.
- Patients suffering from ESRD also get financial assistance of Rs 10,000 /-

Bihar

- Dialysis services available in 17 districts but all patients are charged for the same.
- Tender is in process in order to provide dialysis services free of cost to BPL patients.

Delhi

- Dialysis program has been implemented in 3 districts of Delhi at 5 centers through PPP mode. Total number of functional Dialysis machines available in the UT is 60.

Gujarat

- About 46 dialysis units with 446 machines have been operationalized throughout the state in collaboration with IKDRC, Ahmedabad and 154 dialysis units with 1248 machines have been operational through *Mukhya mantra Amrutum Yojana*; all these units are distributed in all 33 districts. More than 180,000 dialysis sessions are conducted in year 2018 throughout the state in PPP mode.

- At SDH DevgadhBaria, five machines are installed under PPP model. To undertake activities smoothly, IT based patient registry is maintained and services are free to all. Tele medicine data is shared with Institute of Kidney Disease, Ahmedabad for further management.
- Nephrologist visits are not taking place at Dahod affecting the smooth delivery of services.
- In Civil hospital Surat, 02 out of 08 machines have been reserved for seropositive patients, whereas seropositive cases are not being provided with dialysis services in SDH Dahod.
- DH, Dahod is yet to operationalize dialysis services; likely after construction of the new hospital building complex in next 01-02 years.

Jharkhand

- Presently, the program is operational in 8 districts in PPP mode (including West Singhbhum) which include Medical Colleges.
- MoU has been signed with another PPP partner for providing services in rest 16 districts and will be operational in phased manner by March 2020.

Madhya Pradesh

- Mode of dialysis service delivery is through PPP mode and free for BPL patients.The service is rendered is from 8 am to 7 pm.
- Seropositive patients are not taken at the facilities visited and there are no nephrologists.
- Poor functionality of the dialysis unit is observed in the District Hospital Chhindwara.
- There are issues with seepage, water logging in the dialysis unit which requires immediate attention and action. Record register is maintained wherein number of dialysis procedures is documented.

Manipur

- Seven DHs including Bishnupur and Chandel have already created prerequisite infrastructure and trained manpower for starting dialysis services. However, machine installation is still pending.
- Expanding dialysis to 5 DH under PPP with Fairfax India Charitable Trust is being undertaken.
- 10312 free dialysis sessions had been carried out in RIMS and JNIMS hospitals.

Mizoram

- Mizoram Dialysis services are provided through in-house mode but there is a need for proper arrangement for space so that the 3 idle dialysis units can function properly.

Nagaland

- The dialysis service is implemented through in-house mode with 2 dialysis centers and dedicated Hemodialysis unit for Hepatitis (B&C) cases. However, there is no dedicated unit for HIV positive cases even though Nagaland is a high prevalence state for HIV.
- A Nephrologist from a private hospital visits both the dialysis centers once in a month.
- There is a dedicated RO plant for positive cases; however, no records are found for analysis of quality service delivery (Kt/V or URR record).
- Dialysis services are free for BPL patients whereas APL beneficiaries are availing the dialysis services at the rate of 1100 Rs. per session.

Odisha

- In Odisha, dialysis program has been implemented in PPP mode.
- All the staff is efficient in their roles and responsibilities. Record keeping and registersare also well maintained but dialysis machines are not optimally utilized. One dialysis machine can undertake at least 5 cycles of dialysis in 24 hours so if required additionally trained staff /nurses can be deployed to ensure optimal utilization of dialysis machine.
- Clinical parameters for monitoring the quality of dialysis need to be prepared and monitored.

Rajasthan

- The program has been implemented in PPP Mode in all 33 Districts deploying 86 dialysis machines. (At each centre - State government provided 2 Dialysis Machine, RO Plant, Cardiac Monitor, 2 AC, 2 Motorized bed).
- Adequate space (at least 120sq. ft. space) is not available for performing dialysis. Dialysis RO water tank is kept with the dialysis machine where the dialysis is performed in DH.
- One technician and two nursing staff are available for 2 dialysis machines in each of the visited facility. However, Nephrologist is not available to oversee dialysis unit in DH Churu.

Tamil Nadu

- The dialysis program has been implemented through In-house mode in all 32 districts including aspirational districts Ramanathapuram and Virudhunagar.
- The services and all consumables including Dialyzer is provided free of cost. Each dialyzer is used up to 8 times and patient wise kept in a box. PFS 2000 IU/1.5 ml Erythropoietin is provided once a week to patients free of cost and blood transfusion is also done if necessary. Fistula is made at either Chennai or JIPMER for patients of Villupuram district.
- A Medical Specialist heads the dialysis unit at the Kallakurichi DH as there is no Nephrologist in Villupuram.
- Separate room is found available in both the districts for provision of dialysis for seropositive patients and services are provided on 24X7 basis.
- Interaction with community members in the field showed that awareness regarding dialysis in government facility is not very high. In Virudhunagar a few families reported using private facility for dialysis unlike Villupuram where awareness and utilization of government services is much better.
- High waiting period is also observed in both the districts visited. More dialysis machines may be put in the Dialysis Unit to reduce patient waiting period.

Uttar Pradesh

- The program has been implemented in PPP Mode in 41 out of 75 districts with 42 Centers deploying 378 machines including four aspirational districts.
- PMNDP is not yet implemented in Bahraich district and is functioning in PPP mode at DH, Meerut.
- A 10 bedded (7 Seronegative and 3 seropositive) hemodialysis unit is available in DH. 10 patients undergo dialysis everyday (Monday to Saturday) in 3 shifts.
- A designated Nodal officer is available to monitor the dialysis services including the equipment functioning and records maintenance.
- A Nephrologist visits the unit once a week and Tele-facility is available where contact with Nephrologist from BHU can be made any day.

Uttarakhand

- The program has been implemented in 6 out of 13 districts with 7 Centers deploying 79 machines. It has been implemented in both the aspirational districts Udham Singh Nagar and Haridwar.
- Free services are provided to BPL card holders only.

National Overview: Blood Bank/ Blood Storage Unit

Assured blood transfusion services are critical in reducing mortality and morbidity. 'National Blood Policy' is launched in 2007 to reiterate the Government's commitment to provide safe and adequate quantity of blood, blood components and blood products. Under this, only licensed blood banks are allowed to collect, process, store and transport blood and blood components. State Drug Controllers are authorized to approve blood

banks and blood storage units. Sale or purchase of blood/blood products otherwise is strictly prohibited.

Moreover, crucial policy decisions such as setting up a Blood Bank in every District Hospital and a BSU at FRUs and other secondary care facilities are taken by the GOI to reduce or prevent untimely deaths that occurred due to lack of availability of blood.

13thCRM noted most of the DHs had blood banks with adequately maintained infrastructure and requisite equipment. However, licensing of the same is still a matter of concern. Despite relaxing the norms for setting up of blood storage units, availability of approved and operational blood storage units is found to be inadequate in most of the CRM visited states. One of the major reasons for the same is inadequate linkages and ownership by the mother blood banks.

Recently in 2016, GOI also launched e-Raktakosh- a centralized Blood Bank Management system to connect, digitize and streamline the work flow of blood banks across the nation. During 13th CRM, only three states viz. Delhi, Jharkhand and Madhya Pradesh are found to have e-Raktakosh implemented.

Many other issues are noticed in states such as inadequate calibration and maintenance of blood bank equipment, unavailability of blood component separation unit and lack of effluent treatment plans that need priority attention to ensure round the clock supply of safe and secure blood and blood components in all the health facilities.

Key Findings

Collection of blood

- Collection of blood is occurring in both ways (voluntary and replacement donation) in most of the states except Andhra Pradesh, Mizoram, Nagaland and Tamil Nadu where it ispurely voluntary.

Availability of services

- Availability of blood services have seen improvement in most States/UTs however, in 06 States (Nagaland, Mizoram, Meghalaya, Uttar Pradesh, Rajasthan and Bihar) availability of blood has been reported as a concern.
- Even though mother blood banks are functional in most of the states visited, they did not meet the requirement of BSUs at peripheral first referral units (FRUs), except in AP & TN.
- Poor linkages between mother blood banks and dependent blood storage units remained a serious concern in providing emergency maternal care. Reported maternal deaths of severely anaemic women in the states of Jharkhand, Rajasthan and Uttarakhand could have been prevented with proper coordination between the BBs and BSUs.
- Blood Component separation units are functional in the states of Delhi, Jharkhand, Madhya Pradesh and Tamil Nadu.

Accessibility of services

- Free blood service to BPL patients and JSSK beneficiaries is reported in most of the states except in the states of Chhattisgarh, Gujarat and Manipur.
- Access to safe blood continues to be limited especially in rural areas of states like Uttar Pradesh, Rajasthan, Uttarakhand, Jharkhand, Bihar, Chhattisgarh and the states in the North East. Relatively better access to blood services is reported in Andhra Pradesh, Delhi, Madhya Pradesh, Odisha and Tamil Nadu.

Statutory and Regulatory Compliances

- Blood banks in the states of AP, Delhi, Jharkhand, Manipur and Nagaland had license in place.
- Blood bank equipment is not found calibrated in most of the states visited except UP.
- Liquid waste management system for discarding blood samples is not found functional in almost all the CRM states visited.

Blood bank management system

- e-Raktkosh is functional in the states of Delhi, Jharkhand and Madhya Pradesh for

effective management and monitoring of blood transfusion services.

- None of the states reported blood transfusion reaction except Chhattisgarh.

Recommendations

- States need to develop a road a map with set timeline regarding establishment of BB/ BSUs to ensure equitable and round the clock availability of blood in all the health facilities.
- All the equipment in Blood bank/Blood storage units should be covered under equipment maintenance plan.
- Blood Component separator units at BBs may be initiated for optimal utilization of Blood.
- Proper implementation of Laboratory Information Management System for documentation of test results & monitoring, live availability of blood stock across all the district blood banks, blood group stock and list of blood donors should be registered with the blood banks.
- Adopt appropriate liquid waste management system for discarding blood samples. Also, states must have a robust mechanism in place to monitor istage of blood and blood products
- Training and performance evaluation of the staff (EMTs, blood banks etc.) to be done regularly.
- Should have a SOP in consonance with DCG(I) following safe blood practices.
- Collection of blood from regular (repeat) voluntary non remunerated blood donors should constitute the main source of blood supply. So, states should focus on IEC and social awareness.
- Blood needs to be transported under proper cold chain maintenance from the linked mother blood bank to the Blood Storage Units (BSUs).
- There is a need for supporting states in renewal of licenses and in roll out of online platforms (e.g. e-Raktkosh) for management of blood services.
- Licensing &coordination with private blood banks is also required.
- Voluntary donations to be promoted to meet the free blood bank requirements of the health facilities, particularly for those who are brought to the health facility with emergency conditions.
- Operationalization of Blood Storage Unit at FRUs is an urgent need for making FRUs functional.
- Regular reporting of transfusion reactions (on its occurrence) by the clinicians
- There is a need to enhance blood access through a structured network of centrally coordinated, efficient and self-sufficient blood transfusion service to ensure round the clock availability of blood.

State Specific Findings

Andhra Pradesh

- Adequate number of BCTU (Blood collection and Transport Unit) is available in both the districts. These are utilized for conducting Blood donation Camps and transporting units to Blood Banks.
- Regular donation camps (15-20/month) are conducted with good collection (200-250 units/ Camp).
- Only whole blood is utilized, as there are no Blood Component separator units available.
- Enough quantity of all blood groups including rare blood groups is available. Also, List of persons with rare blood group are available with the blood banks.
- Blood Storage and Blood banks are functional in almost all FRUs visited.
- All Blood Banks and Blood Storage units are having valid licenses. Blood is being issued without replacement.

Bihar

- In the state, only 7 institutions namely; PMCH Patna, SKMCH Muzaffarpur, ANMMCH Gaya, JLNMCH Bhagalpur, NMCH, Patna, SH

Lakhisarai and SH Shekhpura had valid licenses, while licenses for rest 27 banks are under the renewal process

- State has total 84 blood banks, 18 blood component separation units & 58 blood storage units. Out of total 84 blood banks, 40 are supported by NACO while rest are private. 5 districts still do not have blood bank namely- Araria, Arval, Banka, Sheohar&Supaul.
- Number of BBs & BSUs is found insufficient in the state. In district Begusarai, blood bank is functioning without any license. The blood is screened for HIV & other diseases by RDK only in absence of an Elisa reader machine.
- In Bhagalpur, one Blood bank is present (in Medical College) & 08 BSUs. Blood Bank is supplying Blood Units to only 03 BSU on a routine basis.

Chhattisgarh

- State has 16 NACO supported and 36 non NACO supported blood banks.
- 75-80% of blood is collected through replacement. Most of the Blood storage units are found to be non-functional.
- Processing fee is charged despite approval of funds under NHM.
- Instances of slide based cross matching, storage of antigens & reagents in blood bank refrigerator; blood transfusion reactions etc. are noted.

Delhi

- In the state, 73 BBs are functional, out of which 12 are Regional Blood Transfusion Centre (RBTCs). Necessary regular supplies like blood bags and kits are available.
- 20 of these blood banks are NACO supported, 9 as RBTCs, 2 as Model Blood Bank, 12 as Component Separation Units, 4 as District level Banks and 2 as Major Blood Banks.
- The department has in place, a SOP in consonance with DCG(I), following safe blood practices.
- No processing charges are collected from patients of Blood Dyscrasia (e.g. Thalassemia, Sickle Cell Anemia, Hemophilia etc.), HIV and BPL patients.
- Approximately 5.86 Lakh unitsare collected during 2018-19, as per WHO, annual requirement for donated blood units is 1% of the population i.e. around 1.92 lakhs per annum in Delhi.
- Reporting is done on E-Raktkosh and SIMS.
- All Blood Banks are managed by respective hospitals/management.
- At community level, it is informed that prior to admission for delivery of pregnant women, blood deposition/replacement is the responsibility of patient's family.
- Delhi Government has mandated 4th generation ELISA for HIV in all blood banks.
- Both voluntary and replacement donation is done; voluntary Blood Donation is 48.7%.

Gujarat

- At DH Dahod, whole blood units are charged as Rs: 1400/- per unit or Rs: 1000/- per unit even with replacement from a donor. This included ANC cases, SCD patients and BPL patients. Ironically, the labour room staff and gynaecologists in the department knew about it but not the district team until CRM team highlighted the matter.
- No Blood Storage Unit is functional at UCHCs in Surat district at present even after having reasonable delivery load in the facility.
- OOPE is reported for blood transfusion services in the state.
- E-raktakosh has not been rolled out in Dahod district.

Jharkhand

- 49 blood banks are registered with NACO under SIMS. No BSU is registered in the state. State has adopted a Blood bank management app developed by Jharkhand Space Application Centre in 2016 & e- raktkosh by CDAC in 2017 which provides real time information about availability of blood. State needs to integrate application by JSAC & e-raktkosh.

- The blood bank in DH Gumla and DH West Singhbhum are visited. The blood is taken mostly voluntarily & sometimes on replacement. Many NGOs and local bodies helped in blood donation.
- Blood bank had a separate building with clean, hygienic, proper BMW disposal. Cell component separator is available in 2 government blood banks& 7 private blood banks. It is required at least in all DH in state.
- Poor referral linkages, non-functional blood storage units and non-availability of blood in blood banks resulted in two maternal deaths due to severe anaemia.
- Blood Banks or Blood storage units at both the referral hospitals are non-functional in Gumla district. They are functional only in DH Gumla, DH West Singhbhum & CHC Manoharpur among facilities visited. They had the equipment to store the blood. But no staff is trained in its utilization.
- Blood storage machine is dysfunctional in Sisai and is never repaired. In Basia, it is not working for past 18 months, due to power failures.
- No blood bank stock register isavailable in Gumla. There is no knowledge on field regarding e-raktkosh.

Madhya Pradesh

- New blood component separation units had started in Shahdol, Sagar and Ujjain and are already functional in Chhindwara, Satna and Elgin hospital Jabalpur.
- The blood banks are integrated on e-Raktkosh. Also, monthly activity camps are carried out as part of the yearly plan.
- Adequate supply of whole blood, packed red cell, platelet and fresh frozen plasma is available.
- For the BPL families, blood is made available free of cost whereas APL people are charged a nominal fee of Rs. 1,050 per unit.
- For strengthening blood services in Madhya Pradesh, target for collection of voluntary blood donation has been set to 5.5 lakh. One blood bank officer has been approved from NHM at each district blood bank to improve voluntary blood collection.
- All blood bags including double/triple/quadruple bags RC has been done and budget has been allotted to blood banks.
- At DH Chhindwara, blood bank is running on e-Raktkosh. Near expiry of blood is being given without exchange in the district hospital.
- No separate units for blood storage are available at DH. Staff of twelve people is working to cater the blood needs of people. All the required equipment is available in the blood bank.

Manipur

- In Manipur, access to safe blood is being made available through a network of 5 licensed blood banks. 4 in government sector: RIMS, JNIMS, DH-Churachandpur, DH-Thoubal; and 1 in private sector. Functional blood storage units are available in Bishnupur DH and Tamenglong DH.
- Unavailability of Blood Bank services in most of the designated facilities is a major concern. In 24x7 PHCs most delivery cases are found to be referred to higher centres due to more faith in Medical Colleges and their proximity.
- No blood bank facility is available at Bishnupur and Chandel districts. Only Bishnupur DH has Blood Bank Storage facility, which is providing services on demand, at a transit time of 1 day and charges Rs 300/- per unit from the patient.
- License for operationalization of Blood Storage Unit at DH, Bishnupur has been obtained from DHS, Manipur which is valid till 05.11.2019 so renewal process needs to be initiated. For Chandel district, DH Chandel infrastructure for blood bank facility is ready with 2 MOs and 3 SNs trained but at present, patients are referred to DH Thoubal for blood transfusion and donation.

Meghalaya

- 8 Blood banks and 8 BSUs are functional in the state. One more Blood Bank & 2 BSUs are awaiting license approval.

- Blood bank at the District Hospital Tura caters to the entire Garo Hill region, thus access is an issue. Also, facilities for component separation need to be operationalized.
- Blood banks in DHs are found to be functional. It is also observed that the DH is the sentinel site for diagnosis of JE & Chikungunya.

Mizoram

- Voluntary Blood donation especially by the students, is observed.
- Availability of BBs and BSUs below district level remains a serious limitation in establishing CEmONC services. This is on account of ill equipped and poorly functional FRUs at sub district levels resulting in large number of avoidable referrals to higher level of health facilities.

Nagaland

- The State had only three functional blood banks- Naga Hospital Authority Blood Bank, Dimapur District Hospital blood Bank and Dr Imkongliba Memorial District hospital Blood Bank.
- The Blood Storage unit has been licensed by Drug Controller of the State. During the visit to Naga Authority Hospital Blood Bank, it is reported that the blood banks had a regular supply of blood bags but no assured supply of TTI Kits and grouping reagents. The Blood component separation unit has not been established based on the required set up procured by the department.
- None of the districts had assured blood bank services. As of now, the blood is made available on case to case basis and largely dependent on voluntary donations at District hospital level. The tests are performed with rapid kits to ensure safe blood transfusion.

Odisha

- There are 51 blood banks functional at the level of DH & SDH. The blood banks are well managed and technical protocols are being adhered to.
- As per HMIS, 69745(31.3%) units of blood are issued on replacement in the year 2018-19 and total number of blood units issued in the year 2018-19 is 222985 units.
- Blood Storage units at the level of CHC in Mayurbhanj are not functional.

Rajasthan

- Visited blood banks had voluntary donation as well as replacement donation.
- Adequate number of blood banks and BSU are not available in the state. Non-functional blood storage unit is major issue in operationalizing the First Referral Units (FRUs) in the districts.

Tamil Nadu

- There are 89 blood banks and 304 blood storage units in the State. Blood separation facility is available in one blood bank in Villupuram and 4 blood banks in Virudhunagar.
- Blood donation camps are conducted in collaboration with NGOs and colleges. During 2018-19, 56,262 units of blood are collected through donation camps and through voluntary donors. State does not follow the blood replacement for provision of blood to patients.
- In Virudhunagar district 4 BB and 11 BSU are functioning while Villupuram has 3 BB and 17 BSU. Blood separation facility is available in 1 BB in Villupuram and 4 BBs in Virudhunagar.
- Blood is supplied free of cost to the patients admitted in the public institutions while charged Rs.500 per unit to those in private facilities.

Uttar Pradesh

- Free blood services are available for all including thalassemia patients.
- Blood Banks in both districts has good infrastructure, availability and utilization of blood.
- Equipment is being calibrated at regular intervals. Blood collection through camp is low (7% in Bahraich district; 50% in Meerut district). Blood is mostly collected through replacement.

- None of the BSUs are functional in both the districts. Also, 2 CHC-FRUs in Bahraich and Meerut are conducting elective C-Section however their BSUs are found to be non-functional. During the 8th CRM visit in 2014 as well, these BSUs are reported as non-functional in Meerut district and they are still the same.
- From 1st April 2019 to 20th Oct 2019, a total of 4583 units of blood are collected and tested for HBsAg, HIV, HCV, Malaria and VDRL. Out of these 4120 units, 66 units are discarded because 44 units are positive for HBsAg, 1 unit ispositive for HIV and 18 units are found positive for HCV.

Uttarakhand

- Blood bank of DH Rudrapur is located 20-21 km away from the health facility. Also, Blood separation unit is not available in the blood bank.
- Both the CRM districts visited had availability of 24*7 Blood banks and blood storage units.
- District Hospital does not have all groups of blood always. Due to lack of blood in blood bank, one maternal death occurred while patient is referred to Medical College in the previous week of the visit.

National Overview: Ambulance & Referral Services

Emergency Medical Service (EMS) is a critical component of any health system to ensure faster access to pre-hospital medical care, medical transportation to patients/beneficiaries and critical care at the health facilities. EMS is not merely a transport service for moving a patient from one location to another. It actually connotes appropriate medical care received by a patient from trained professionals for his/her timely transportation to an appropriate healthcare facility during an emergency, thereby ensuring greater chances of survival.

Under NHM, Dial 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma and accident victims. It transports patients through Basic Life Support (BLS) and the Advanced Life Support Ambulances (ALS) during all kinds of medical emergencies. Currently 9344 ambulances are being supported under 108 emergency transport systems and 10017 ambulances are operating under 102 patient transport (NHM MIS).Along with that, 5484 empaneled vehicles are also being used in some States to provide transport to pregnant women and children e.g. Janani express in MP, Odisha, MamtaVahan in Jharkhand, Nishchay Yan Prakalpa in West Bengal and Khushiyoki Sawari in Uttarakhand (Source: NHM MIS).

In almost all CRM visited states, good awareness and knowledge regarding ambulance and toll free number is found in the Community, ASHAs, ANM and other field staff. However, the response time varied from state to state. The deployment of ambulances based on population norms or geographical location for a sparsely populated area is not adequately followed by states. In most of the states, there is inadequate supervision and review of technical parameters like infection prevention protocols, maintenance of vehicles, their response time etc. None of the states have implemented Government of India guidelines or advisory for a monthly check by district supervisor.

Key Findings

- An overall improvement in ambulance service availability and accessibility is seen in all the states. Majority of the community members had knowledge of 108 and 102 Ambulance services.
- The availability of ambulance services are found good in states like Andhra Pradesh, Uttar Pradesh,Madhya Pradesh, Gujarat, Tamil Nadu and Delhi.
- **TalliBidda Express** in Andhra Pradesh, **Mamta Vahan** in Jharkhand and **Jaccha Baccha Vahan/ Bike ambulance** in Madhya Pradesh are some of the special initiatives take by the states.
- However, the timeliness of service, quality of training of EMTs, Equipment maintenance varied across states. States like Bihar, Chhattisgarh,

Uttrakhand, and Odisha reported delay in services and thus need improvement.

- In states like Meghalaya, Mizoram and Nagaland, the condition of the existing ambulances is poor. The vehicles are in dilapidated condition and are majorly used for transportation of drugs and vaccine from the drug warehouse to designated health facilities and as a transport vehicle for Medical Officers.
- State like Manipur does not have provision of 108 at all; only 102 patient transport facilities are available.
- None of the visited states are getting ambulances checked/verified by the district level competent authority. Most of the equipment in the ambulances is not being used, indicating that they are used as transport vehicle only and not for stabilizing patients.

Recommendations

- Ambulance services in states should be organised in a way that there is universal access to the entire population through a systemic response mechanism particularly during emergencies.
- Rational deployment of ambulances should be done. Location or point of deployment of ambulance should be determined both by the density of population as well as the time-to-care approach (access to health facility within 1 hour) as the case may be.
- All ambulances should be analysed on a monthly basis on various performance indicators and utilization of vehicle like number of calls received and number of calls dropped, percentage and number of dropped calls responded, average response time per call with minimum and maximum duration of attendance, number of trips and total kilometers travelled per day for each ambulance.
- Every month district anaesthetist or an authorized district nodal officer should check each ambulance in the district and give certification for operational status of all equipment and availability of drugs as per the list.
- The log book should be properly maintained on a daily basis. The record should also indicate change of oils, tyres and other fittings requiring periodic replacement.
- Regular training of EMTs (6 weeks training for ALS, 4 weeks for BLS and 2 weeks for JSSK ambulances) in handling basic emergencies like trauma, spinal injuries, coma, heart attacks, poisoning, snake bites etc. in ALS ambulances and in providing life support while being deployed in BLS should be conducted.
- Differential parameter for Capex and Opex should be worked out for all states, hilly terrain regions and smaller UTs with sparse population.

State Level Findings

Andhra Pradesh

- Ambulances 108 are working well in the state. Community did not find any difficulty in availing ambulance services.
- State has 'Talli-Bidda Express' for providing drop-back facilities to pregnant mothers.
- Feeder Ambulance is a unique innovation, observed in Vishakhapatnam that permits transport of sick patients from hilly and remote areas to hospitals.

- Knowledge, skill, and competency gaps seen in 108 technicians. No training in the last 3 years.

Bihar

- Around 115% improvements in ambulance utilization – from ~3.0 patients per ambulance per day in January 2018 to 6.4 patients per ambulance per day in August 2019.
- Total count of patients served by ambulances increased by 149% during January 2018 to September 2019, from 60.6 thousand in January 2018 to 150.8 thousand in September 2019.
- However, delay in call response of 102 services is observed. Local unionization of ambulance drivers/ Emergency Medical Technician (EMTs, led to frequent ambulance strikes which further accentuated the problem.
- EMTs are available but emergency preparedness is not optimal as the basic resuscitation equipment is found packed in cartons.

Chhattisgarh

- Condition of Dial 108 ambulance is poor & drugs have not been supplied in 2 months due to transition of vendor.
- ERCP advice seen only for 10-20% trips in remote area.

Delhi

- CATS ambulance services are available for inter facility transfer 24*7; however urban slums (Especially Todapur) are devoid of the service due to address issues and are less aware about it.
- This led to out of pocket expenditure (Rs 300- Rs 500 approximately). The community preferred autorickshaw to carry the patient.

Gujarat

- Ambulances /108 vehicles reach up to all the villages on call at all times of the year, except for some hamlets that are not well connected by roads or are located at geographically difficult and distant terrains. These ambulances do reach up to nearby hamlets in same village.

Jharkhand

- Total of 337 ambulances are available in the state (0.98 ambulance/lakh) [BLS: 289, ALS: 40+ 10 NHAI ambulances]
- Good utilization of ambulances is seen in the state.
- Provision of Mamta Vahan with private providers is a good initiative but after some revision in MoU and decreased remuneration being provided to the vendors, the community faced issues in drop back facility.
- The ambulances in the state are mostly used for MNCH services (52%), accident and other incidences (28%) and 4% for communicable diseases and fever, 4% for abdominal pain and 12% for NCDs.

Madhya Pradesh

- A total of 606 EMRI 108 & 737 Janani Express ambulances are being linked to a centralized call centre. 75% pick up and 43% drop back facility to pregnant women is being provided. A robust Grievance redressal mechanism is in place through 104 call centre which is linked to the CM Helpline.
- Good innovative practices like JACHCHA BACHCHA GADI/ BIKE AMBULANCE as part of Janani Express is functional in areas which are inaccessible through four wheeler ambulances/ vehicle.

Manipur

- Only 102 ambulance services are available in the state. In total, only 40 vehicles are available in the entire state. Call Centre services for ambulance has been outsourced on PPP mode.
- In DH Chandel, there are 4 functional 102 ambulances out of which one is reserved for JSSK beneficiaries; whereas 2 ambulances are functional at DH, Bishnupur.
- OOPE is reported from some areas ranging from Rs 1000-1800 depending on the referral to RIMS, JNIMS and Thoubal DH for Chandel district.

- There is an urgent need to start ALS and BLS ambulances in the state.

Meghalaya

- There are 3 categories of ambulance service in the state; 108, donated ones (e.g. MLA) and those purchased/owned by the government. They run on an average 110 kms/day. An average of 2 trips per day is made by the ambulances.
- The ambulancesare mostly 10-15 year old and largely used for transportation of MO and staff.
- Facility based ambulance receives very few calls, community also informed that ambulance breaks down on the way to higher facility and hence offers unreliable emergency services. JSSK patients are provided free ambulance services.
- Neither facility based ambulance nor 108 ambulances are found to have undergone monthly operational certification process.

Mizoram

- Improper mapping of ambulances under National Ambulance Services is seen.
- There is no ambulance at District Hospital Mamit (this DH recently received one ambulance donated by TATA Trust).

Nagaland

- The ambulance service is underprovided due to poor conditions of vehicles. These vehicles are 6-8 years old and are in need of replacement.
- These vehicles are ambulances which are majorly used for transportation of drugs and vaccines from the drug warehouse to designated health facilities and as a carrier for Medical Officers due to unavailability of vehicles for them.
- OOPE on referral transport is observed (INR 10,000 for Kiphire to Kohima and INR 12,000 from Kiphire to Dimapur)
- 102 call centres is non-functional. There is no IT-based infrastructure available which is essential to operate the centre.

Odisha

- The State is running two types of ambulances – Emergency Medical Ambulance Service and Referral Transport Service (1 per 1.2 lakh population).
- At remote areas in both districts, interaction with tribal women showed satisfaction with ambulance services. However, due to connectivity issues, 108 and 102 ambulances could not be accessed at all times.
- At Kandhamal, in addition to twelve 108 ambulances and eight 102 ambulances, the district has engaged 1 delivery van, 13 auto and 5 bike ambulances to access hard to reach areas.
- Most of the equipment are not being used, indicating that they are used as transport vehicle and not for stabilizing patients.

Rajasthan

- State has operationalized 701 BLS patient transport ambulances and 34 ALS ambulances.
- Ambulances are dispatched in 38% of the total calls received.
- The average response time is 15minutes in urban and 17minutes in rural areas. The average distance travelled is 118 km/ambulance/day.

Tamil Nadu

- 1 ambulance is available per 1 lakh population.
- Pregnant women are aware of the 108 Ambulances and drop back facilities.
- Neonatal ambulance for transporting the emergency cases is available in both the districts (except in GH Tindivanam)
- First responders i.e., 108 drivers and paramedic staff in the ambulance are trained.

Uttar Pradesh

- The State has a total of 2200 “108” ambulance and 2270 “102” ambulance.
- The State has shown incremental improvement in utilization of ambulance services.

- During the interaction with the beneficiaries mixed response is found in terms of response time of ambulance. In Bahraich, at some places ambulances took around 30 to 40 minutes.
- Monitoring of ambulances is an area of concern. None of the ambulance visited is found to be monitored by district nodal officer.

Uttrakhand

- The State is running two types of ambulances – In house ambulances donated by the clients or through CSR and other through National Ambulance Services. Both types of ambulances are distributed per 1.20 lakh population.
- Awareness about 108 is observed at all levels even at the community, however delay of around one and half hour is observed even in emergency conditions.
- Ambulances are being used to carry logistics of the health facilities.
- Drivers of the ambulances are not trained for any emergency management.

National Overview: Mobile Medical Units

Healthcare service delivery through Mobile Medical Units (MMUs) under NHM is a key strategy to facilitate better access to public health care particularly for people living in remote, difficult, under-served and unreached areas. Deployment of MMUs is based on population norm with 1 MMU per 10 lakh population and a cap of 5 MMUs per district. However, further relaxation of norms is permissible on case to case basis, where existing MMUs served over 60 patients per day in plain areas and 30 patients per day in hilly areas. As on 30th September, 2019, 486 districts are equipped with Mobile medical units under NRHM and 28 districts with MMUs under NUHM. A total of 1599 MMUs under NRHM and 39 MMUs under NUHM are operational across the nation.[1]

1 https://nhm.gov.in/New_Updates_2018/Quarterly_MIS/sept-2019/National_Overview.pdf

Even though number of districts equipped with Mobile medical units has increased from 426 (31st March, 2013) to 486 (31st March, 2019),adequate actions for operationalizing primary care health facilities in the states are found to be lacking. MMUs are a temporary mode for providing outreach services in remote areas where public health facilities are not adequately functional. So, while deploying MMUs, states need to also plan for strengthening HWCs and PHCs in that area. During CRM visits, it is also found that there is variable performance of existing MMUs ranging from around 10 to 25 trips per day and approximately from 500 to 1500 OPDs per month.

Key Findings

- MMUs are found functioning well in Gujarat, Jharkhand, Madhya Pradesh, Manipur and Odisha. Although, irrational deployment of these units is reported in Jharkhand.
- Distribution of MMUs is not uniform in many districts of Andhra Pradesh, Bihar, Delhi and Mizoram.
- MMUs provide their services as per monthly visit plan as reported in Gujarat, Jharkhand and Tamil Nadu.
- Utilization of MMUs is variable in different states. Number of trips performed by MMUs range from 10 to 25 trips per month.
- MMUs are primarily being used for treating minor ailments & conducting ANC, PNC and Neonatal Care. However, Geriatric care is being given through MMUs in Jharkhand which is appreciable.
- Health education and counselling services given through MMUs are found to be limited.
- Opportunistic screening is being done by MMUs in few states such as Jharkhand while estimations of Hb, Blood sugar etc. are being performed in Gujarat, Madhya Pradesh, Nagaland and Odisha.
- Diagnostic facilities through MMUs are found to be limited in most of the states. However, Hub and spoke model is utilized in Gujarat for diagnostic services in coordination with CHCs.

- Referral linkages with higher facilities arefound to be inadequate in most of the states, specifically in Jharkhand and Nagaland.
- The MMUs in difficult terrain halt during nights while providing services to hard to reach population as reported in Nagaland.
- Some of these are operationalized by multiple agencies like Multi Sector Development Plan of Department of Welfare for SC/ST & Minorities in North East District in Delhi, GVK in Gujarat, HLLFPPT in Meghalaya and Uttarakhand.
- The MMU services needs availability of at least one Medical officer. However, half of the required MOs are missing in the MMUs of Nagaland. Coordination among the staff is seen to be good in Gujarat and Jharkhand.
- Old and damaged MMUs are being reported in Jharkhand and Manipur.

Recommendations

- Since MMUs are not the sustainable mode of assured service delivery, states need to develop a comprehensive plan or road map with a well-defined timeline to operationalize health and wellness centres and PHCs to provide assured preventive, promotive and curative health care services.
- Rational distribution needs to be done for existing MMUs and required number of MMUs need to be provisioned as per requirement of the states.
- In states where MMUs are showing remarkable performances, old and damaged MMUs need immediate repair and replacement to provide hassle-free service delivery.
- In-service training of MMU staff needs strengthening in most of the states.
- Regular performance monitoring and evaluation need to be done to assess the status and functionality of existing MMUs in the states.
- MMUs can also be utilized for health education and generating awareness on communicable diseases.

State Specific Findings

Andhra Pradesh

- State has 292 functional MMUs and each of them perform around 48 visits, 1113 OPD per month.

- MMUs have not been functioning since 2 months in Vishakhapatnam. However, they are reported to be working well in Kadappa.

Bihar

- No MMUs are functional in Bihar except in Darbhanga.
- In the state, a total of 8 MMMs are reported, which are there only in Darbhanga District.

Chhattisgarh

- There are 30 MMUs in place in the state, running through a private organization.
- MMUs cover around 25 villages per month.

Delhi

- 2 Mobile Units are operationalized under Multi Sector Development Plan of Department of Welfare for SC/ST & Minorities in North East District.
- Mobile Medical Units should be provided for hard to reach areas, such as Yamuna Khadar slums in East Delhi.

Gujarat

- Total 06 MMUs are deployed in Dahod district; which is a good number according to population norms suggested by MMU operational guidelines.
- MMUs have a well-documented monthly visit plan to cover about 18 remote villages per week. Every day MMU visits 03 villages, spends average time of 2-3 hours in each village and serves about 30-60 patients per day on outpatient basis.
- MMU team includes a doctor, pharmacist, one paramedic person, a lab technician and a driver. Effective task sharing between MMU team members is noted.
- Hub and spoke model for sputum samples is being followed by MMU; samples are carried to CHC level.
- Vehicles are mostly in working condition. Few issues are observed such as oxygen supply is never utilised before, thus they never refilled the cylinder. Machine for nebulisation is not available, a lady with mild COPD exacerbation happened to visit the MMU during CRM visit and there is little to offer her at the MMU.
- MMU run by GVK use a common web portal for daily data entry. Data including patient name, age, sex, address and diagnosis (symptom complex) is entered by operator either on the spot or on return. This IT backup is good enough to monitor working of the unit, generate monthly reports and keep patient records.
- Spectrum of clinical care services provided by MMU is limited - capable of dealing with URI, minor pain etc. and other ailments often remain underserved, underdiagnosed. Many chronic illnesses, family planning services could be easily included to increase the range of services.
- During the visit, CRM team noted an average consultation time of about 02 to 04 minutes by the doctor and about 15 seconds to 01 minute time for counselling by pharmacist. Lack of patient counselling and community education limits the potential effectiveness of MMUs.

Jharkhand

- In the state 89 MMUs are functional out of 98 with a defined route chart for all MMUs. All the three MMUs are operational in Gumla& 3 out of 4 MMUs are operational in West Singhbhum. MMUs are providing service in underserved areas and excellent services to geriatric population and pregnant females.
- OPD per trip is 95 in Chaibasa& 25 to 60 in Gumla. The HR available in an MMU comprised of 1 doctor, 1 pharmacist, 1 lab technician, 1 GNM, 1 ANM and 1 driver.
- Diagnostics available in MMU are Pregnancy test kit, MP- kit, Hb test, BP and Glucose strips.
- Rational deployment of MMUs is absent. Patient referral for MP/ TB is poor. The linkages between the MMU OPD and PMSMA are missing. The drug supply is inadequate to the MMUs and their services are rendered useless without medication.

- The MMUs are old and in poor conditions with a leaking roof and non-functional lab equipment. The state has multiple MoUs with private providers for MMUs that needs to be streamlined.

Madhya Pradesh

- There are 150 operational type 1 MMUs with GPS, online biometric attendance, online software and patient entry provisions.
- Visits are done as per pre-defined route plan approved by the BMO.
- Services provided through MMU are primary health care services, ANC/PNC, Lab Test-Hb, RBS, Urine test, Blood slide, Sputum Collection, Audio-Visual IEC etc.
- MMUs are working 24days/month/MMU providing healthcare service delivery to on an average 1440/MMU/month (60 patients/day/MMU)
- 1 Medical officer, one ANM, one lab technician, one driver are deployed in each MMU.
- There is one MMU in Khandwa and four in Chhindwara districts of Madhya Pradesh.
- On an average, 1122 and 1564 OPDs as well as 357 and 325 laboratory tests per month are being conducted in Khandawa and Chhindwara districts respectively.

Manipur

- State has 9 MMUs which are positioned at every district level (previously Manipur had 9 districts). MMU in Manipur is a 02-vehicle system.
- In Bishnupur, only 11 camps are performed by DMMU till April 2019 in 2019-20.In Chandel, DMMU has performed 26 camps from April-September 2019.
- In Bishnupur, MMU service is now not available as vehicles are out-of-order and state is planning for condemnationand thusmay need to purchase new vehicles as per requirement.

Meghalaya

- Four MMU units are operational in Meghalaya under state/NHM and three via PPP service provider (HLL FPPT).
- Average trip varied from 16-22/month.

Mizoram

- State has 9 functional MMUs but their performance is found sub-optimal.
- The MMU services are not available for the catchment area of facility visited.

Nagaland

- State has a total of 11 MMUs; each district head-quarter has one MMU. The operational guidelines recommend dedicated Medical officer in every MMU; however, more than half Mobile medical units did not have dedicated MOs.
- Though the original MMU had two vehicles, one vehicle is mostly dysfunctional. The single vehicle carries clinical staff along with drugs and limited rapid diagnostic kits. The diagnostic tests include haemoglobin estimation, urine test, blood sugar and pregnancy tests.
- The average number of trips are10-12 per MMU per Month.
- The RBSK team is handling the MMU and are conducting camps together. The number of cases referred and the follow up of referred cases are not done adequately as the MMUs are visiting the village site once a month.

Odisha

- Services delivered through the MHUs include general OPD, ARI, skin, diarrhoea, identification, referral and follow-up of TB, leprosy, malaria and cataract cases. RDT for malaria kits are available.
- MHUs conduct 2 sessions a day for 22 days a month. In Kandhamal, average OPD per day is 64.

- The HR in place includes 1 MO AYUSH, 1 ANM, 1 Pharmacist and 1 Attendant.

Rajasthan

- State has 196 functional mobile medical vans and 06 MMUs.
- Each MMU performs 34 OPDs in one trip per day.

Tamil Nadu

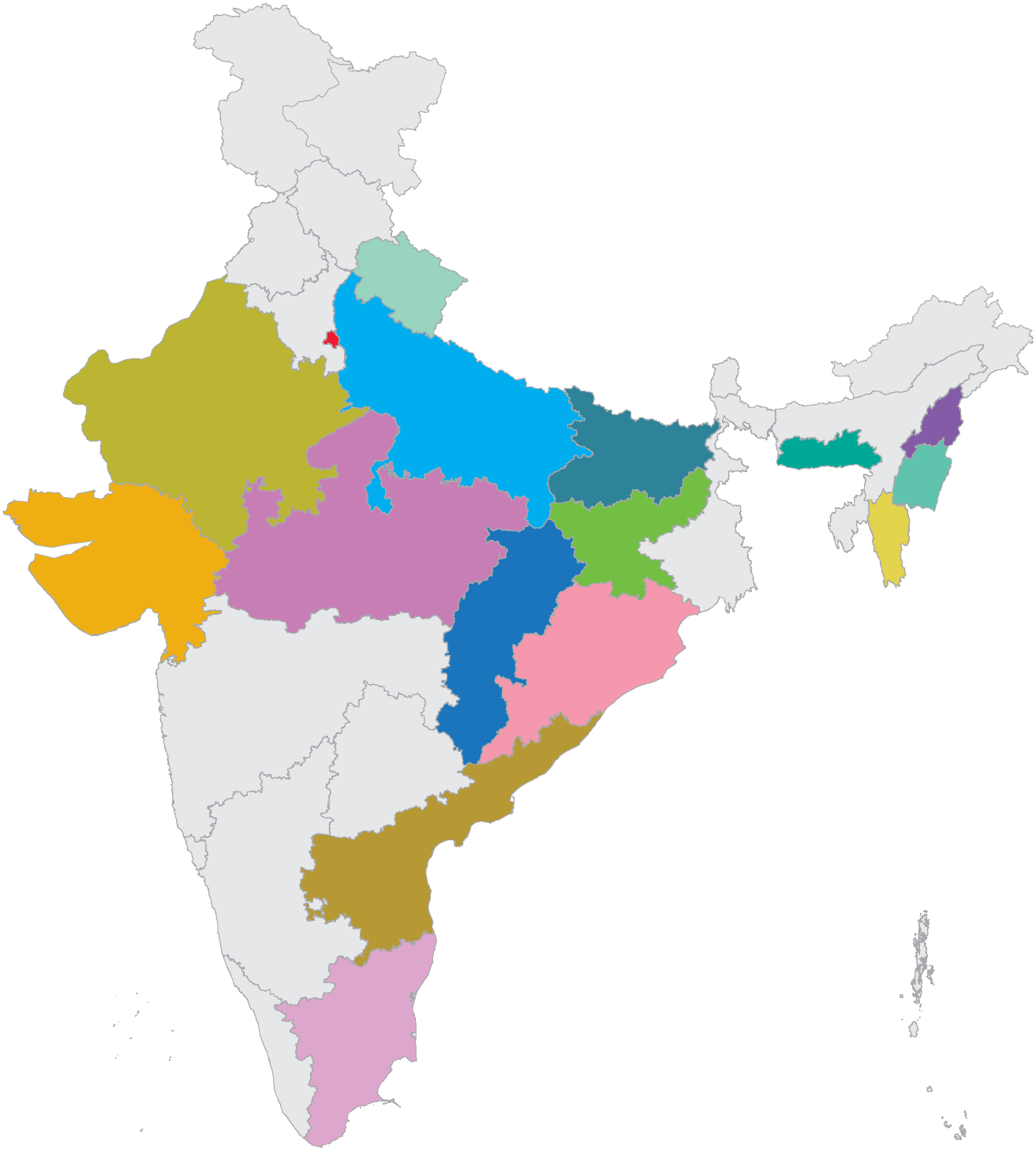
- There are 22 MMUs functioning in Villupuram and 11 units in Virudhunagar. Advance tour plan is drawn and uploaded in the web portal of the district.
- The hard to reach hamlets are identified and the tour programme is drawn to cover all the hard to reach villages of every HSC in the district.

Uttar Pradesh

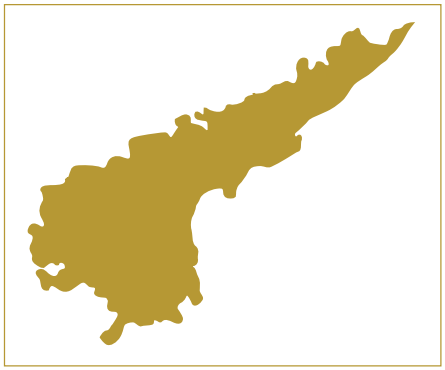
- State has the approval of 214 MMU under NHM.
- As of now, in 53 districts, 170 MMUs are functional.

Uttarakhand

- State has 5 MMUs functional out of 20 MMUs sanctioned and none is fitted with GPS.
- Supporting agency for operationalizing MMUs is HLFPPT.
- Each MMU performs on an average 22 trips and 552 OPDs per month (22 OPD per day)
- Average number of lab investigations performed by each MMU per month is 75.2 tests.
- Each MMU has on an average 1 MO, 1 staff nurse, 1 LT, 1 Pharmacist and 1 driver.



State Possitive and Challenges



ANDHRA PRADESH

Type of Facility	Kadappa District	Vishakhapatnam District
DH	Proddatur	Paderu
SDH/AH	Pulivendula	Araku, Narsipatnam
CHC	Jamnaladugu	Aganampudi
PHC	Muddanur	Ananthagiri, Hukumpetta
UPHC	Nakash	-
SHC	Uppaluru, Thallamapuram (mmu)	Burra, Dosuru, Pedagaru E SC kinchimanda
Villages	Eguvapalli, Mittameedapally	Chappadi, near Barra Champapatti
Others	RIMS	School of nursing, KG hospital, pregnantwomen hostel, Regional training center (m), Vishakhapatnam, District training team, IPP-VI

TEAM COMPOSITION

Kadappa District	Vishakhapatnam District
Dr Teja Ram, Deputy Commissioner (Family Planning)	Dr. Anuradha Medoju, Regional Director AP and Telangana.
Anil Agarwal, Health specialist, UNICEF	Dr B Narasimha Murthy, NLM Member
Dr. Sathuluri Ramchandra Rao, Reader, NIHFW	Dr. SanjanBrahmawar Mohan, Director, BHS
Dr. ShailajaTetali, Associate Professor, IIPH, Hyderabad	Ms. Shraddha Masih, Sr. Consultant, NHM
Mr. Rahul Govila, Financial Analyst, MoHFW	Dr. Narender Goswami, Senior Consultant - MH
Dr. Parminder Gautam, Sr. Consultant, QI, NHSRC	Syed Mohd Abbas, Consultant CP-CPHC, NHSRC
Dr. Daisy Panna, Consultant Epidemiologist, IDSP	Dr. J.H. Panwal, Joint Technical Advisor, FNB (HQ)
Dr. Nitin Bajpai, PSI	

Positives

- "SWACHH BHARAT ABHIYAAN' adopted in true letter and spirit-Clean households, Clean villages (electricity, Water supply, LPG, toilets, road connectivity), Clean facilities- Culture of Cleanliness.
- **FREE** Drugs. Diagnostics and Dialysis services available for **ALL.**

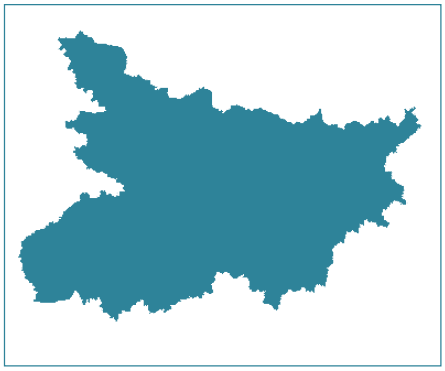
- Excellent coordination with Education & WCD Departments.
- State-of-Art DEIC at RIMS.
- All Blood units are issued without replacement.
- 97% institutional deliveries. Use of RFID tages in newborns.
- Good functional IT infrastructure for Drugs and Logistics- E-Aushidhi, Telemedicine, Teleophthalmology and Teleradiology.
- Feeder ambulance for receiving PREGNANT WOMEN from hard to reach areas and availability of birth waiting hostel in remote facilities of Aarku valley.
- E-Subcentres with ATM, Teleradiology, ASHA + for BP, ECG, and temperature and non-invasive Haemoglobinometer.
- **Maternal lifeline center**- at KGH medical college for analyzing the maternal deaths and suggesting the critical steps to be taken by the facilities.
- ANC Health Calendar with details of due deliveries and tracking of High-Risk pregnancies.
- MAS is creating awareness about sanitation, nutrition, NCDs, communicable diseases, kitchen garden, and composting.
- ASHAs are active in facilitating services for NCDs, immunization, institutional delivery, identification and referral of malnourished children
- No pendency in ASHA Payments. Recently the government has announced a fixed honorarium to ASHAs from existing Rs 6,000 to Rs 10,000 per month (Rs.7200 fixed and Rs. 2800 linked with performance). Good awareness and utilization of Aarogya Shree scheme seen.
- SQAC, SQAU, DQAC, and DQAU have been constituted.
- The state is providing budgetary support for selected facilities to traverse gaps for NQAS certification.
- Supervisory cadre at Sector/PHC level.
- Grievance redressal through the "**Spandana Program**" every Monday through online / portal. Resolving issues within 3 days.
- 77% decline in malaria cases with no malaria death.

Challenges

- Palpable preference of community for Private facilities resulting in High OOPE.
- CPHC and HWC yet to be operationalized in true sense.
- Weak Micro planning and execution of RMNCH services during outreach.

observed (132 Days as on 30.09.2019) for the 1st Tranche of F.Y. 2019-20.

- The Statutory Audit Report for the FY 2019-20 is pending.
- DHAP has not been circulated in the Districts. Low utilization of funds is observed.
- HPDs must receive at least 30% more budget in comparison to other Districts but the same has not been done from State Level. RCH: 38.43%, NVBDCP: 17.30%, NLEP: 17.98% and NCD: 22.07%.
- CFMS in place of PFMS which ultimately effects on controlling over Central share
- Lack of preventive and promotive healthcare in urban health as there are weak outreach activities.
- LR practices: Use of oxytocin for induction, reusable mucous sucker, Rough towels for Essential newborn care.
- High C-Section Rate around 40%. Both in Public & Private facilities.
- IEC in community and public places.
- Family Planning services limited to OCP and sterilization.
- Despite having adequate supervisory staff- Supportive supervision is not evident.
- Lack of a comprehensive strategy to address anaemia.
- No existing mechanism for biomedical equipment maintenance.
- RBSK screening done under PPP mode is oriented towards screening only. Very few screened children are referred to and followed up.
- Mifepristone is not available. D& C is preferred over MVA
- NCD screening is limited to DM and HTN.
- NO 'Forecasting' module in E-Aushidhi, resulting in over indenting, overstocking, and expiry of drugs. Cu-T are found in kits of ASHAs and 6 antibiotics at Sub centre.
- No cadre of ASHA facilitator/Block level ASHA coordinator.
- Only One facility LaQshya Certified.
- Inordinate delays in completion of constructions e.g. Additional Block and Boundary wall at CHC Badvel is pending since August 2012.
- Depilated building, Uncleanliness, Rayachoti CHC. Broken tiles, Chipped plasters, cracks, seepage, loose hanging wires at AH Pulivendula
- No DNB course started.DH not being utilized as Training Centres.



BIHAR

Type of Facility	Bhagalpur District	Begusarai District
Medical College/DH	JLN Medical College, District Hospital, Bhagalpur	DH Begusarai
SDH/RH	SDH Naugachiya RH Sultanganj	SDH Ballia
CHC/BPHC	CHC jagdishpur CHC Shahkund	PHC Khodavantpur PHC Barauni
PHC/UPHC	PHC Kharik Urban HWC Hussainabad	APHC Chhaurahi UPHC HWC Bishnupur UPHC HWC TeliyaPokhar APHC HWC Amari
SHC-HWC	HWC Dholbajja, HWC Salempur HWC Dariyapur, HWC Karhariya, HSC Radhanagar, HSC Pasraha	HSC BadaKhodavantpur, HSC Barbighi, HSC Bhoja,
Village	Marcos Pachiyari Tola, Salempur, Boregaon Muslim Tola, Pasraha Maha Dalit Tola	Barbighi, Bhoja, Simatiya, Shahpur deah

TEAM COMPOSITION

Bhagalpur District	Begusarai District
Dr Pradeep Khasnobis, CMO-NFSG, DGHS (Team Leader)	Dr Rajesh Kumar, PGIMER
Dr Deepika Sharma, Senior Consultant, QI-NHSRC	Dr Ritu Chauhan, NPO-IHR, WHO
Dr Santosh Ojha, Senior Consultant, Maternal Health	Dr PrasantSoni, Sr.Consultant, NUHM, MOHFW
Dr Ranjeet Prasad, Consultant, IDSP	Dr Neha Jain, Senior Consultant, PHA, NHSRC
Dr Kushagr Duggal, Consultant, HRH-NHSRC	Dr Arpita Agrawal, Consultant QI, NHSRC
Dr V. V. Bhakare, Research Officer, Ministry of Ayush	Mr. Samarjit Chakraborty, Programme Manager, AGCA

Ms. DeepikaMahalwal, Asst. Technical Advisor, Food & Nutrition Board, WCD	Mr. Jayant Mandal, Finance Officer, NHM, MOHFW
Ms. Charisma Nongsiej, Research Officer, IIPH-Shillong	Dr Kailash Kumar, Regional Director, ROHFW, Patna
	Dr Dilip Kumar, Joint Director, PRC, Patna
	Ms. AnishaTirkey, Officer-I/C, Community Food & Nutrition, WCD

Positives

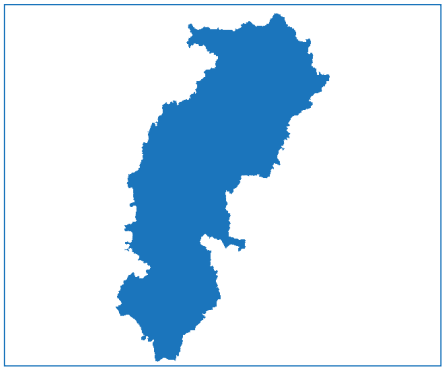
- Model Immunization Centres to improve routine immunization coverage.
- Roll out of Birth companion across all facilities as part of Respectful Maternity Care (RMC)- Privacy, Prasav Sakhi (Birth Companion) with provision of gown to the Mothers at many facilities. Also, a separate colour coded (Red, yellow & green) triage area for labour cases and use of colour-coded band (Red, yellow & green) seen at the District Hospital- Bhagalpur.
- An initiative of AMANAT Program to impart Skill and knowledge to the Labour Room Nurses & Doctors.
- Six District Hospitals (DH Purnea, DH Sitamarhi, DH Saran, Sheohar, DH Supaul,
- DH Vaishali and two Medical Colleges (NMCH Patna & ANMMCH, Gaya) are declared as 'Bottle feeding free hospitals"
- Dedicated Family Planning Counselling Corners with CCTV monitoring upto APHC level.
- Dedicated Call center in Bhagalpur (18003456267) for reporting Maternal Deaths, following which maternal and child death audit is done in the presence of DM. (65 deaths reported in 2018-19, earlier, no Maternal Deaths are reported)
- Upari Aahar Abhyas Diis (UAAD) is implemented state-wide in all AWWs to strengthen the complementary feeding practice
- Take home ration, hot cooked meals provided to the beneficiaries under POSHAN Abhiyaan. CBE like Annaprashan/god-bharai has resulted in improved nutrition status among both mothers & newborns.
- Availability of Free drugs & diagnostics services at all the visited UPHCs.
- Centralized functional grievance redressal system as 104 toll free number is available
- Labour Rooms are well equipped with trained HR, Fixed Day Services, adequate sterile trays and implementation of RMC components

Challenges

- Issuance of Gold card for PMJAY is being done at a slow pace (9%). Discrepancy between the actual beneficiary & and those eligible under PMJAY noted.
- RBSK, HBNC, and Adolescent health programs need urgent attention.
- Line listing and follow-up of High-Risk Pregnant women including categorizations of anaemic women not being done as desired.
- Inadequate curative medical & laboratory services at peripheral facilities leading to high referrals to DH or MC college level and OOPEs. Presently even diarrhea cases are being referred to DH from PHCs/CHCs.
- Non-functional BSUs observed in both the districts. Renewal of Blood Bank licenses to be undertaken.
- Delays & unavailability in 102 ambulance services noted. Referral services through 102 Ambulances needs strict monitoring to improve service quality.
- The ANM training school at Begusarai requires urgent attention as students are staying in unhygienic and overcrowded conditions.
- AEFI monitoring and reporting need attention.
- Limited HTN & DM-2 screening is done at the periphery through HWCs. Lack of training on NPCDCS for all levels of the workforce.
- National programs for NCDs like NTCP, NPHCE, NPCB, NOHP, National programme for control of Fluorosis, National Iodine control programme

are either nonstarters or performing minimally.

- Low notification of TB cases in both private and public health facilities is seen. Microscopy for Malaria not found even in district Hospitals.
- Training and data reporting (both routine and EWS) to be initiated after strengthening of IDSP through filling of key vacant contractual positions.
- National Viral Hepatitis Surveillance Programme & National Rabies Control Programme are nonstarters.
- None of the ASHA had HBNC kits. Lack of support from ASHA facilitators observed. Although rural ASHA is trained on module 5, 6 & 7, their re-training is very much needed. Urban ASHAs are given only induction trainings.
- RKS meetings are not done regularly. Participation of community representative in VHSNC and Rogi Kalyan Samiti is minimal. VHSNC are not engaged in Village health action plan preparation. Underutilization of untied funds is seen.
- Non-Adherence to latest BMW rules noticed. Sensitization of staff for BMW guideline 2016 and its amendments, Infection prevention & control and Quality program needed.
- Major crunch of skilled HR seen at all levels. Redeployment of MOs/Specialists from low caseload facilities to high caseload facilities may be considered to address HR issues.
- Delay in payments to the beneficiaries under JSY, Nikshay observed.
- Funds not released for infrastructure maintenance due to pending ASEs & UCs for last 4 years.
- Birth & Death Registration, COTPA implemented partially. CEA implemented in 2016 but not effective. PCPNDT (1994) needs initiation.



CHHATTISGARH

Type of Facility	Rajnandgaon District	Korba District
DH	Medical College Hospital, Shankarpur	District Hospital, Dholiparoa
CHC	CHC Mohla, CHC Dongargaon, CHC Chhuikhadan, CHC Ghande	CHC Katghora, CHC Korbi
PHC	PHC Pandadah, PHC Salhewara	PHC Churi, PHC Tuman
UPHC	UPHC Shankarpur	Rani Dhanraj Kunwar Devi UPHC
SHC-HWC	HWC Dangarh, HWC Dumertola, HWC Tappa, HWC Khamera, HWC Tilairwar, HWC Rampur	SC-HWC Ral, SC-HWC Hungra
SHC	SC Dewarighat	-
AWC/VHND/UHND	-	Hunkara AWC , Vakabura, Ral, Amgaon (Bata)

TEAM COMPOSITION

Rajnandgaon District	Korba District
Dr. Sumita Ghosh DC (MH)	Dr. Prabha Arora, ADG
Dr. Aparna Pandey, Sr. RD	Prof. DA Nagdeve, IIPS
Dr. Himanshu Joshi, RO, MoAYUSH	Mr. Sandeep Sharma, Senior Consultant, HCF, NHSRC
Ms. Sumitha Chalil, Sr. Consultant, NHM	Ms. Tasha Mahanta, Consultant HRH- NERRC
Ms. Sapna Upadhaya, Consultant, WCD	Dr Vaibhao Ambhore, SPO PATH
Mr. Sanjay Kumar Gupta, Consultant, NVBDCP	Dr. Ravinder kaur, Project Director - Save the children
Mr. Mantu Kumar, Financial Assistant, MOHFW	Dr Bhumika Talwar, Senior Consultant, MH
Dr. Kirti Saharan, Junior Consultant, Maternal Health, MoHFW	Mahendra Behra,State programme manager, Care India.

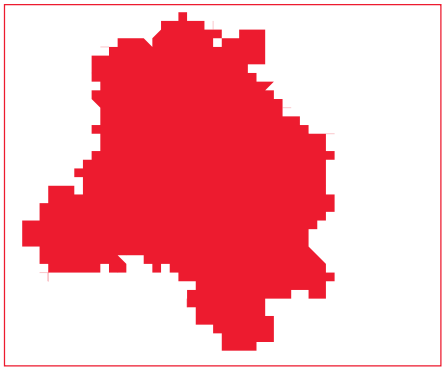
Positives

- A motivated workforce with extensive community support.
- Awareness and demand generation for Maternal & Immunization services in the community is found good.

- The Mitanins are working at the grass-root level in large numbers for creating awareness & mobilizing the community to the health system for their health needs.
- Labour rooms are found to be as per the MNH tool kit, clean with toilet facilities. Standard protocols are followed in general.
- A comprehensive plan for upgrading HWCs is in place
- Training of ANM as Yoga instructors (4 days training), Zumba, Music therapy, etc. noted
- Partners are roped in for technical support.
- Good state human resource creation pool with 5 recognized institutes for ANM and MPREGNANT WOMEN, 95 institutes for Staff Nurses, and 6 Medical Colleges.
- Good utilization of MMU by elderly persons seen.
- Accounts books are available in all the facilities. Money is transferred through PFMS (>80%).
- Bottom-up planning is operational in the state. DHAP is prepared even the Block ROP prepared in consultation with the Block.
- Signage, citizen chatter, layouts are displayed at most of the facilities. Programme specific IEC visibility is good all across the state and in the facilities
- Liquid waste management system, Deep Pit, and sharp pit seen across facilities.
- Authorization by Pollution Control Board for 57 out of 63 facilities in Rajnandgaon
- The urban population is around 58 lakhs, the program has reached a population of 20 lakhs and is being expanded to other areas.
- Mapping of the notified and non-notified slums are done.

Challenges

- 38/814 functional HWCs not fully compliant (branding, tab, lab services unavailable). Huge HR gaps, stock-outs of IFA, Zinc, Oxytocin, Misoprostol, and MgSo4.
- Treatment adherence for NCD patients is missing in HWCs and Teleconsultation is limited to phone consultations with PHC MOs/AMOs.
- The absence of a refrigerator at many SCs resulted in improper storage of oxytocin ampules.
- ANMs are often found not trained in SBA, Daksh, Dakshta, NSSK, FP methods, etc. Even those trained are not adequately informed.
- High-risk pregnancies are not tracked and referral systems for HRPs and complications during labor found inadequate at several SCs and PHCs.
- Family Planning Services lacks focus in terms of availability of drugs, commodities, service quality & counseling.
- Adolescent health activities not visible at any level.
- Follow up of referred patients' for NPCDCS is not adequate.
- School Awareness program is minimal in Korba for tobacco control.
- Visible deformities are observed in most of the children in Filariasis affected villages.
- IDSP cell is none existent at Medical College Rajnandgaon.
- The sputum examination rate under RNTCP is lower than the norm (less than 1% of OPD attendance).
- The number of outreach camps has declined over last year under NUHM, even the health facilities are understaffed.
- High out of pocket expenditure mentioned at the community level due to diagnostic tests and transportation costs.
- Regular meetings are not held among the supervisors, CDPO, DEOs & AWWs regarding the progress of PMMVY & Poshan Abhiyan
- Poor infection prevention practices, low adherence to waste segregation at source, poor condition of buildings, dumping of old materials in clinical areas, etc. – especially at facilities which are not participating in Kayakalp.
- Shortage of HR in the state at all levels, the number of vacancies under regular cadre is way more than the vacancies under NHM.
- Negative growth rate in Health Budget for the period 2018-19 to 2019-20.
- Mechanism for linking ambulances with facilities having emergency services & ensuring preparedness at facilities is missing.



DELHI

Type of Facility	New Delhi District	East Delhi District
Medical College	LHMC &Kalavati Saran Hospital	-
DH	-	Lal Bahadur Shastri Hospital
UCHC	Delhi Cantt. General Hospital Maternity Home Munirka	Maternity home/CHC Patparganj Maternity Home, Khichripur
Polyclinics	Polyclinic Basant Gaon	-
UPHC	DGHC Sashtri Market DGHC Motibagh Seed PUHC Samalkha	DGHC Pandavnagar DGHC Jagatpuri DGHC Himmatnagar Seed PUHC New Ashok Nagar MCW Trilokpuri
Health Kiosks	Mohalla Clinic, Munirka Mohalla Clinic, Samalkha Mohalla Clinic, Old Nangal	Mohalla Clinic,Trilokpuri
AWC/MAS/VHND	KusumpurPahadi, Inderpuri, Sangam slum, Motibagh, Samalkha, Todapur, Kusumpur Pahadi	Kalyanpuri village and MAS IP Extension JJ Colony and MAS MAS New Ashok Nagar
Mohalla Clinic Lab (Hub & Spoke)	Unipath Lab Lajpat Nagar	
Schools	Govt. Girls Sr. Sec. School, Sarojini Nagar	R.S.K.V School New Ashok Nagar
Community	Sangam slum	Yamuna Khadar Slums Kondli Slum Dallupura Village, Vasundhara Enclave

TEAM COMPOSITION

New Delhi District Team	East Delhi District Team
Dr. Neeraj Kulshrestha, Addl. DDG	Dr. Jyoti Rawat, JC, Urban Health
Dr. Sumit Malhotra, AIIMS New Delhi	Dr. Suresh Sharma, Professor and Head PRC, Delhi
Ms. Sneha Mutreja, NHM Consultant	Dr. Anil Kumar, NLM Member
Dr. Sharad Singh, Consultant, CH Division	Dr. Smita Shrivastava, Sr. Consultant, PHA, NHSRC

Type of Facility	New Delhi District	East Delhi District
Medical College	LHMC &Kalavati Saran Hospital	-
DH	-	Lal Bahadur Shastri Hospital
UCHC	Delhi Cantt. General Hospital Maternity Home Munirka	Maternity home/CHC Patparganj Maternity Home, Khichripur
Polyclinics	Polyclinic Basant Gaon	-

Type of Facility	New Delhi District	East Delhi District
UPHC	DGHC Sashtri Market DGHC Motibagh Seed PUHC Samalkha	DGHC Pandavnagar DGHC Jagatpuri DGHC Himmatnagar Seed PUHC New Ashok Nagar MCW Trilokpuri
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Dr Bhupinder Singh, Jr. Consultant, NHSRC	Dr. Amit Katewa, Consultant, NVBDCP
-	Dr. Minal, Junior Consultant - MH
Shri. Arpit Singh, Consultant, NHM- Finance	
Shri Navendra Singh Director (PMMVY), M/o WCD	

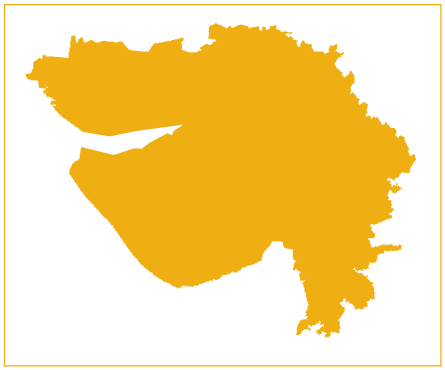
Positives

- MAS members are active and aware of their activities. Their activities consist of spreading awareness regarding cleanliness, menstrual hygiene, JSSK entitlements etc.
- Use of Family planning methods including newer contraceptives being promoted and practised.
- Routine Immunization being provided at all levels. POSHAN ABHIYAN is functioning effectively in the district.
- UDAAN Scheme for out of school adolescent girls is being implemented to promote menstrual hygiene and provide sanitary napkins.
- Most of the National Health Programmes are implemented as a routine practice.
- All essential drugs are available for catering to Non-Communicable disease programs. Essential Drugs & diagnostics are available for VBDs, Leprosy, Tuberculosis and Viral Hepatitis.

- Tobacco control initiatives being taken such IEC and health talks. The state had taken initiative in banning of e-cigarettes.
- NCD training has been provided in several districts to ASHAS.
- DOTS and Microscopy Centres are functional. DBT for nutrition being given.
- House to house survey is being carried out for active case finding of Leprosy.
- HIV testing of all TB and ANC cases being done.
- Mapping of facilities has been done population wise, ANM and ASHA wise.
- Special focus on vulnerable and marginalized population and Outreach activities are being conducted.
- Health awareness activities such as Nukkad Nataks and Health talks are organized in urban slums.
- ASHA grievance redressal mechanism in place.
- Facilities visited are mostly clean and patient friendly with IEC display.
- Some facilities have been awarded Kayakalp Award in districts. NQAS certification of some facilities is in process.
- BMW waste management guidelines being followed at most of the facilities.
- All staff including Medical Officers, Specialists, ANMs and ASHAs trained in different National Programmes.
- Public Financial Management System is used at Delhi Government facilities in both the districts.
- Training for Public Financial Management System has been conducted by State.
- CATS ambulance services are available for inter facility transfer.

Challenges

- Ayushman Bharat is not being implemented in Delhi. The scheme is providing benefits to outstation patients only at Central Govt hospitals like Lady Hardinge Hospital.
- Only 98 MAS formed out of 2500 sanctioned. MAS not given any form of training.
- JSSK being only partially implemented at some facilities, leading to OOPE. The community is unaware of it.
- Special Outreach (need based) not being conducted in slums. UHNDs are not being conducted regularly.
- HBNC not being effectively done and no follow up by ANMs is seen, leading to less detection of LBW, SAM cases.
- Most deliveries are being conducted at Tertiary levels. Maternity Homes and M&CW centres of MCD are not being utilised well, though they have very good infrastructure.
- Mental health, Elderly and Palliative care, Dialysis, Fluorosis control programmes not running.
- PBS (Population based screening) of > 30 years people not being done. CBAC forms are not being filled.
- Emergency, burns and trauma services are not available at primary and secondary care levels.
- Adequate HR to supervise and monitor programmes is not available. Post of District Epidemiologist under IDSP not sanctioned.
- Sputum collection and transport of samples across facilities is not there.
- Rabies and Typhoid vaccines not available since several months.
- Lack of proper drainage system and solid waste management in urban slums. Active collaboration with ULB is not seen.
- Prescription Audits not being conducted. Death audits results not analysed adequately.
- Assembly RKS to be formed and the Jan Sisthya Samiti under it with non-official members is yet to be finalised. Kayakalp award funds not been provided to facilities since last 3 years.
- Facilities having no process of auction of condemned articles to avoid the unnecessary accumulation of condemned articles and istage of space.
- MCW centres not having general OPD for all age groups with no supply of drugs as per EDL including NCD drugs.
- No HR cell and no dedicated HR policy at the State. HR crunch at all levels-from UPHC, M&CW, MH, CHC and DH in the district (especially in East District). High attrition rate of all staff, especially MOs, ANMs and Staff Nurses
- Different remuneration being given to staff with the same designation under different agencies.
- Statuary Audit Report for the Financial Year 2018-19 is not compiled till the date of visit.
- The State has no system of inventory mapping (tagging) of equipment in hospitals/facilities.



GUJARAT

Type of Facility	Dahod District	Surat District
DH	Zydus Medical College & Hospital	Civil Hospital Surat
SDH	Devgadbariya	Mandwi
CHC	Katwara, Fatepura, Garbada	Bardoli, Umarpara, Kaadol,
UCHC	----------	Bathana, Katargaon
PHC	Retiya, Lalat, Bordi, Nagrala, Kathla, Antela, Salara,Ghughas, Madhwa, Panchwada, Gangurdi, Bordi	Uva, Banskui, Kavdi
UPHC	Dahod-1, Chakaliya Road	Bardoli, Palampur, Umra, Mandawi, Khokhara
SHC-HWC	Usarvan, Ghughas-2	Surali, Bamani, Uva, Mota-1, Mota-2, Amalidabda
SHC	Antela 2, Ruvabari, Dangariya, Sahda, Bharsada	
AWC/VHND/UHND	Jalat (Dahod), PTC College (D.Baria), Nani Salara (Fetehpur)	AWCs-Palanpur, Aksha Nagar, Surali, Vasuki, Naren, Karuali, Uchavan, Pinpur
Private Health facilities	Urban Hospital Dahod, Sonal Children Hospital, Gandhi Children Hospital, Rhythm Hospital	

TEAM COMPOSITION

Dahod District	Surat District
Dr.RajaniVed, ED, NHSRC (Team Leader)	Sh. Mahavir Singh, Govt. Official, DD, MoAYUSH
Sh. Vijay Gopal Mangal, Govt. Official, M/o Tribal Affairs	Dr. ChandanaDey, Govt. Official, Sr. RD
Dr. Amit Dhage, Consultant, CP-NHSRC	Dr. KL Sahu, State Official, Ex-Directorr MP
Dr. SushantAggrawal, Consultant, QI-NHSRC	Raj Kamal Sharma, Consultant, PHP&P
Dr.Kushagra Duggal, Consultant, HRH-NHSRC	Ms. SudiptaBasa, Sr. Consultant, NUHM
Dr. Mahesh C Kaushik, Consultant, NVBDCP-NCDC	Ms. PumaniKalita, Consultant, CP –RRCNE
Sh. B S Chauhan, Consultant, Family Planning Division	Ms. Akshita Jain, Finance Asst.

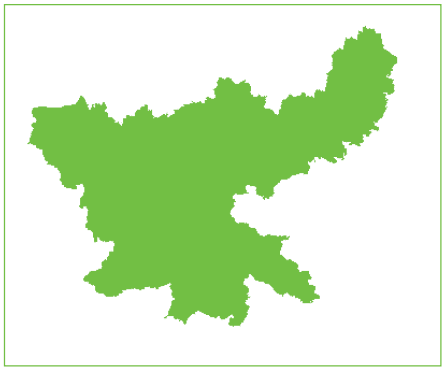
Dahod District	Surat District
Dr. Anil Nagendra, Development Partners, SPM, NIPI	Dr. Nilesh Deshpande, Development Partners, National Coordinator (MP) - UNFPA
Ms.Dipa Nag Choudhary, Civil Societies / NLM -	Mrs. Gayatri S Desai, PRC, Vadodara, Assistant Director
	Neha Sharma, MoWCD, Consultant

Positives

- RMNCH+A continues to be an area of focus and NCDs have been included in all HWC
- RBSK teams well integrated into the HWC, with CHOs aware of team visits.
- No backlog of cataract surgeries in Surat district, while this backlog has decreased significantly in Dahod district,
- The state has effectively used NGO and private sector to address and overcome the backlog of cataract surgery.
- Vulnerability mapping completed in urban areas in both districts.
- Innovation and Learning Centre- Charutar Arogya Mandal's intensive on the job mentoring in selected HWC, yield results in terms of more confident CHOs, improved patient satisfaction, better community outreach and innovations such as patient support groups.
- ASHAs are valued for their contributions and are seen as an integral part of the health system. There is a strong ASHA resource centre at the state level
- Management of BMW is found satisfactory in most of the facility and outsource agency is collecting waste from all level of facilities on a regular basis
- Special efforts such as interviews on fixed days every week for medical officers is a good initiative givena large number of vacancies of MBBS and specialist doctors
- In Dahod, about 100 beneficiaries are being called regularly for follow-up, with a 50% response rate to track in-state migrant populations for RCH services.
- Blind persons are included in PM-JAY insurance scheme, registered and given cards.

Challenges

- Emergency C-section services are available only at DH and SDH in Dahod district, none in private hospitals, while abortion services are available only at DH, Dahod, and are offered only in few months- December to February, mostly during sterilisation camps
- There is limited tracking and follow up of patients with HTN/DM
- Screening not being offered to all as per protocols; limited to those with symptoms
- The clarity in task allocation frontline workers and CHOs leads to duplication of work and inefficiency
- Strengthening of hand-holding support during practical training and hospital postings for CHOs are needed
- MAS members are in place in both districts but there is no training and supportive supervision for these members.
- 39% of ASHA get Rs. 3500 or less per month – indicating low functionality, but this is not being reviewed periodically
- The state needs to undertake an exercise to rationalizing HR; there are multiple District Programme coordinators, laboratory technicians and counsellors with duplication of functions
- District planning in Dahod needs to be based on data and programmatic review.
- TB ward in District Hospital Dahod has bedside central oxygen supply for all 09 beds, but there are no 24-hour attendants, monitors, emergency tray/kit and relevant IEC material.
- At DH Dahod, whole blood units are being charged Rs1400per unit or Rs1000per unit with replacement from a donor, this includes ANC mothers, sickle cell disease patients and all BPL.



JHARKHAND

Type of Facility	Gumla District	WestSinghbhum District
DH	Sadar Hospital	Sadar Hospital
CHC	Basia, Raidhih, Sisai	Chakradharpur
PHC	No functional PHC in the district	Hatiya
UPHC	Azad Nagar	Hindchowk, Chakradharpur
SHC-HWC	Silam, Shivnanthpur	Pampara, Sharada, Ruppungutta
AWC/VHND/UHND- Villages	AsniTetatoli	

Team Composition

Gumla District	West Singhbhum District
Dr. GowriN. Sengupta, Asst. Director, DGHS, MoHFW	Dr.RathiBalchandran, Asst. Director, Nursing Division, MoHFW
Dr. Manas Roy, DADG (NCD division), DGHS, MoHFW	Dr. BinodPatra, Addl. Prof, Community Medicine and Family Medicine, AIIMS, Bhubaneswar
Dr. AjitkumarSudke, PiramalSisthaya	Dr. Rajeev Agarwal, Development Partner, UNICEF
Dr. Hitesh Deka, Guwahati	Dr. KrushnaSiramanwar, Consultant, NHM Maharashtra
Mr. Vinit, Govt. official, Ministry of Tribal Affairs	Ms. Shruti Pandey, Govt. official, Ministry of AYUSH
Dr. ApurvaKohli, Consultant, MoHFW	Mr. Lakhmi Chand Govt. official, Ministry of WCD
Ms. Harsha Joshi, Consultant, CP- NHSRC	Ms. Shifa Arora, Consultant, PHA- NHSRC

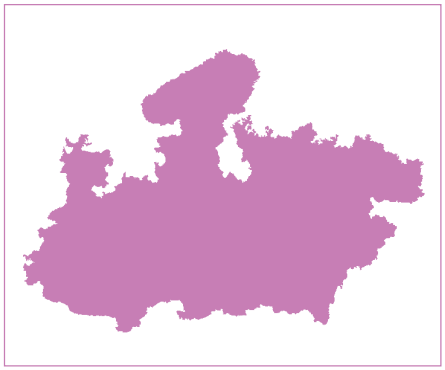
Positives

- The state had operationalized around 22% of primary healthcare facilities as Health and Wellness Centres and existing HWCs had good infrastructure along with branding.
- All Labour rooms and Operation Theatres are well maintained, protocol posters displayed, SBA and Dakshata trained SN and ANMs are posted at labour rooms and, essential equipment, delivery trays, NBCCs, and standard case sheets are available.
- All facilities visited had functional ILR and deep Freezer, connected with EVIN, updated records, and no stock out of vaccines.
- Facility based new-born care services expanded through 19 SCNUs providing level II services to more 8200+ babies annually

- A network of 96 Malnutrition Treatment Centres with an average 60% occupancy for management of SAM children.
- Universal Screening of TB/ANC cases done. ICTC is available at DH and SDH.
- Adequate infrastructure and HR availability at UPHCs. Training of MAS members is completed and MAS members had a good understanding of their roles.
- Payment of incentives to Sahiyasis streamlined and Sahiyas reported receiving incentive amount monthly by 15th of every month
- Good support structure- SahiyaSathi, BTT, STT available in rural and urban areas.
- Participatory Learning Action- a well implemented program with good participation from the community and involvement
- Quality certification of facilities and Kayakalp initiated
- Optimal HR training under National Health Programmes
- Skill India institute trained personnel are being utilized at HWCs as Yoga Instructor.
- Home Visits being undertaken to attend mothers of high risk pregnancy and sick children by AWWs.

Challenges

- Community members not aware of Health and Wellness Centre and no change observed in utilization at SHC-HWCs (OPD: 10-12 per day), despite the posting of CHOs since one year.
- No structured weekly schedule being followed at SHC-HWCs. CHOs had less involvement in RMNCH+A+N services, communicable diseases-service delivery for National Programs and in outreach activities- VHND, VHSNC.
- Challenges faced in maintaining the continuum of care due to the limited number of functioning PHCs due to a shortage of HR and infrastructure.
- Universal screening for NCDs is not yet started.
- Poor quality of training under CPCH
- Weak tracking of High Risk Pregnancy; the gap between ANC one and ANC 4 (89% to 59%) in both districts.
- Limited functioning of FRUs due to non-functional blood storage units and lack of specialists, leading to high unmet obstetric care and no focus on LaQshya.
- Poor Referral linkages between facilities leading to delays and high maternal and child deaths. Maternal Death reporting less than 50% and death reviews less than 25%; Child death reporting and reviews even lesser.
- Community interaction revealed poor awareness about Nikshya Poshan and DBT.
- Vulnerability Mapping under NUHM not conducted and limited Coordination with Municipal Corporation observed in both the districts.
- Neither of the districts had functional One Stop Crisis Centre; VISHAKHA guidelines not being followed at any of the districts or in any facility.
- Lack of sustained commitment for Quality of healthcare services-Kayakalp certified facilitiesand model facilities once certified seem to lose interest
- Poor practices for Biomedical waste management
- Acute shortage of medical and para-medical staff in the state; HRIS and TMIS is not in place in the state and district
- RoP sent to districts in fragments and financial progress against approval is not monitored at the district level.
- Essential drug list not available at many facilities. Stock outs for more than 2 months reported. Prescription of brand names by doctors led the patients to buy from local stores as many drugs unavailable at the DH leading to OOPE.
- The Diagnostics are charged both in-house (free in one block and charged in another) and through MEDALL and are free only for BPL patients, PMJAY beneficiaries, and patients under various national programs like pregnant women under JSSK, TB patients under RNTCP. The patients undergo high OOPE on diagnostics due to user fees. No emergency diagnostics are available in the state.
- Duplication of service delivery at PHC with telemedicine services, in partnership with Apollo: Telemedicine services are available where MO is already available and no standard protocols being followed during teleconsultation.



MADHYA PRADESH

Type of Facility	Khandwa District	Chhindwara District
DH	DH Khandwa	DH Chhindwara
SDH/Civil Hospital	-	CH Susar
CHC	Pandhana, Khalwa, Harsud, Mundi	
PHC/UPHC	Bogaon, Pipluden, Ashapura, Ramnagar, Sanjaynagar	Boargaon, Aarogyam PHC Mohgaon
SHC/HWC	Barisarai, Rustampur	KhuraujiKhurd, Linga
VHND	Degrees	-
Community/FGD	Kumarkheda village, PiplodhBhagava village.	Linga, Nagari, Binjhawada, Bichua village Tamia Block (FGD)
AWCs	Degrees, Ramnagar	Sindhauli, Nagari, Binjhawada

Team Composition

Khandwa District	Chhindwara District
Dr Dinesh Baswal , DC(MH),MOHFW, (Team leader)	Dr R K Vyas , Sr RD, NVBDCP, MOHFW(Team leader)
Dr HarjeetRai, Divisional nodal, MH-NHM, J&K	Dr Suresh Kumar Rathi, Associate Professor, IIPH
Dr AtulWatharkar, Senior consultant ,NVHCP	Mr K P Singh, PSI
Dr NikhleshParchure, PRC,MP	Mr Saurabh Raj, AGCA
Dr Utpal Das, CARE India	Dr KalpanaPawalia, Consultant, PHA-NHSRC
Ms Sruti Sridhar, Dell Technologies	Dr ShivaliSisodia, Consultant,QI- NHSRC
Mr VikasSheemar, Sr Consultant, NHM,MOHFW	Dr RajanRawat, Tata Trust, MoWCD

Positives

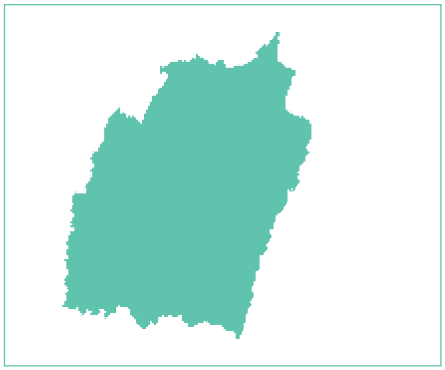
- Focus on the wellness component in HWC with the inclusion of YOGA instructors and trainers. Presently, 65 PHC-HWCs are providing YOGA and wellness sessions to the community regularly. Standardized Internal Branding package used at all HWCs.
- Both the districts visited had well placed maternal health services with a higher rate of institutional deliveries (State is Awarded

1st prize in lowest out of pocket expenditure for deliveries in govt. institutions).Good Initiatives-HRP Portal, Dastak Program, Care companion, Roshini clinics, Aanchal corners,andUdita Scheme.

- One window service for NCD clinic – Registration, consultation & Investigations all in a single location at the District NCD clinic, Chindwara. “Man Kaksh” Initiative – District level counselingcenters established.
- Drugs, diagnostics, and other logistics are available in adequate quantity under all Communicable Disease Control Programs. Adequate availability of Anti Rabies vaccine at all facilities.
- Well established Gram Arogya Kendra (GAK) adjacent to the AnganwadiCentres which performs similar activities as VHND but is managed by ASHAs on non-VHND days. ASHAs are valued for their contributions and are seen as an integral part of the health system.
- In Kaykalp 50% of DH have scored more than 70% in the FY 2018-19 and the internal assessment of most of the facilities have been completed for the FY 2019-20. 31 DH has been developed as per AERB Norms
- The state has initiated HRMIS for the management of existing HR. The HRMIS is not yet functional with all its modules.
- HR Management through apps likee-vittapravah, & Loksewa app for easy an uninterrupted flow of salary and monitoring of funds till block level.
- E-Aushadhi platform has been effectively implemented for medicines and equipment at all the facilities visited.

Challenges

- There is a severe shortage of Lab technicians in both the districts that are visited. CHOs/MLHP are yet to be posted in the state. The Health and wellness centers identified in the district are not fully functional. NCD screening of the targeted population is very low.
- Quality of ANC services, completeness of MCP cards, and HRP identification are compromised. Non functional FRUs seen at the peripheral level. Blood transfusion services are available only at the DH level.
- High prevalence of malnutrition and Infant mortality rates in the state. The high dropout rate of adolescent girls from schools.
- Implementation of the RNTCP program is very low in the field due to lack of HR and districts have not formulated any strategy/action plan to achieve the target of TB free blocks/districts. The National Leprosy eradication program is also not progressing well.
- Quality assurance- the Kayakalp program is implemented only upto DH and CHC level and awareness about NQAS and Kayakalp program is not much amongst the field functionaries.
- Non-Adherence to the protocol for collection and transportation of BMW by the outsourced agency (Krupa Istages for Chhindwara DH/ Hoswine Incinerator Ltd for Khandwa DH) seen, requires regular monitoring.
- HRMIS is not fully functional in the state. The state is having a deficiency of HR in almost every program which is affecting the program output. False reporting and duplication of data in most of the facilities.
- Assured referral services missing especially in remote and tribal areas.



MANIPUR

Type of Facility	Bishnupur District	Chandel District
DH	DH,Bishnupur	DH, Chandel
CHC	CHC Moirang	CHC Chakpikarong
PHC	PHC Oinam, PHC Kumbi	PHC Komlathabi
UPHC	UPHC LangolTarung, MantariPukhri	-
SHC-HWC	Thinungei, Phubala, Leimaram, NgaikhongKhullan	KhudeiKhunou, TaraoLaimanai, Unopat, PurumTampak, Leinangching
SHC	LeimapokpamMakha, Oinan	-
AWC/VHND/UHND	AW Centre visited and AWW met - Mayai Bazar, IshokManing Only AWW met – Thinugei, LeimapakpamMaka	AW Centre visited and AWW met - Tarao Laimanai, Lower Tampi (Village near CHC Chakpikarong) Only AWW met - Khudeikhunou, PurumTampakv
Village (community) Visited	Village Oinam, Leimapokpam Village Leimaram, NgaikhongKhullen	Village PurumTampak Village Leinangching, Unopat

Team Composition

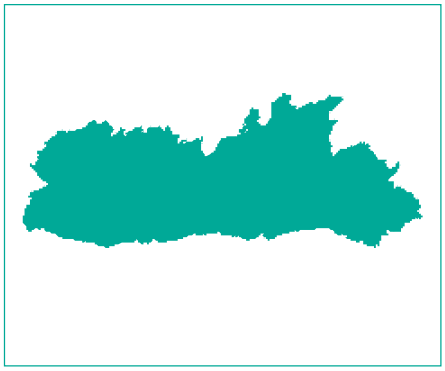
Bishnupur District	Chandel District
Dr. Bina R. Sawhney, Add. DDG-EM, MoHFW (Team Leader)	Dr. Sanjay Mattoo, Joint Director, CTD, MoHFW (Team Leader)
Dr. K. R. Antony, NLM Member	Mr.Raghnath Prasad, Sr. Consultant, RCH
Dr. L. Ashananda Singh, RD, IRHFW, Manipur	Dr. Suchitra Rajkumari, Sr. Consultant QI – RRCNE, MoHFW
Ms. Manasi Chaudhary, National Programme Coordinator (Rajasthan) – UNFPA	Prof. R. B. Bhagat, Professor, IIPS, Mumbai
Mr. Bharat Bhushan Dahiya, Consultant, HCT, NHSRC, MoHFW	Dr. Sidharth Sethi, Consultant, M/o WCD
Ms. Pooja Verma, Asst. Dir. Stat., Stat. Div.	Ms. Nondiya Wanth, Jr. Consultant, NHM, MoHFW

Positives

- Good Awareness among beneficiaries on PTK, ANC, Institutional Delivery, Breast Feeding, the entitlement of JSY & JSSK, and Immunization.
- Service Providers are well trained in providing MCH services and ANMs and staff nurse are trained in Skilled Birth Attendant (SBA)
- Availability of FP commodities at all the facilities and operationalization of FPLMIS seen.
- Daycare Chemotherapy facility is present at DH level.
- Home visit for elderly care in HWC areas by the doctor is a great practice observed.
- Zero dose Immunisation for HBV given to babies of Institutional deliveries
- CBNAAT Machine at both the district for case diagnosis & to detect treatment susceptibility of Rifampicin drug.
- ASHA's are conducting MAS meetings and women are organized against alcoholism. (Meira- Paibi)
- ASHAs are in place in most of the villages and having a good rapport with the community.
- VHNDs are being held regularly in villages supported by AaaganWadi Worker, ANM, and the Village Chief.
- State achievement on control of Malaria i.e. nearing certification of Elimination Status.
- MeraAspataal is implemented in Medical College (RIMS) whereas in the process to implement in DH, CHC, and selected PHC and HWCs.
- LR and Maternity OT of DH-Bishnupur is NQAS certified at the state level under LaQshya.
- In FY 2018-19, all 7 DHs (100%) took part in Kayakalp's internal and peer assessment, 81% of health facilities took part in Kayakalp assessment, of which 29% received the award.
- PC-PNDT act and RBD act are appropriately implemented in the state.
- Implementation of BMMP, FDI- Laboratory, Free drugs, and Dialysis services in the state.
- Infrastructures of all visited HWCs have been established, branded, and maintained well.

Challenges

- IEC is not in the local language, thereby hampering effective program implementation.
- Non availability of SNCU, NRC at the DH Chandel, and Bishnupur.
- Pick-up and drop-back facility by 102 is not up-to the level in Chandel.
- Non-availability of Comprehensive Abortion Care below District Hospital
- Lack of awareness about newer contraceptives (Antara) among the front line workers
- Awareness to dispel the Myth of Killing dog after it bites somebody
- Inadequate number of DMCs for RNTCP seen. Also, TB cases notification in private sectors is low.
- Training of VHSNC and RKS members should be undertaken for capacity building and community ownership.
- Usual delay in the release of ASHA incentives is about 6 months
- Swacch Sisth Sarvatra not yet implemented in the state
- PSS and measurement of KPIs not being done in most of the visited facilities
- Wide disparities in the salaries paid for the regular and contractual staff under NHM exists which is demotivating for NHM staff.
- No data validation of HMIS data after uploading at the block level. It is done at the state level every two years.
- Calibration and preventive maintenance record of equipment not found at any of the visited facilities
- Low awareness of Adolescent Friendly Health Clinics and low health-seeking behavior by Adolescent girls
- Annual review of service provider performance for programs implemented on PPP mode by the state authority.
- None of the facilities visited by the CRM team is AERB compliant.



MEGHALAYA

Type of Facility	RiBhoi District	WestGaro Hills District
DH	Civil Hospital, Nonghpou Office of DMHO	Maternity and Child Hospital, Tura Civil Hospital, Tura Office of DMHO (Meeting with all block accounts manager/PHC)
CHC	Umsning CHC	Selsella, Dadenggre, Phulbari
Skill Lab	Ganesh Das Hospital, Shillong	Female Health Worker Training School, Rongkhon
PHC-HWC	Marnagar PHC Mawhati PHC Warmawsaw PHC(PPP)	Asanang, Jeldopara, Babadam (PPP)
UPHC	Pynthorbah UPHC	HWC, Matchakolgre, Dobasipara
SHC-HWC	Umsawnogkarai	WaramSongma, Baljek, Hallydayganj
VHSND	Govt. Aided Secondary School	Nawalgre UP Graded L.P. School, P.O. Hallydayganj
AWC	BarigoanAnganwadi	WaramSongma,- ICDS Centre, Hallydayganj
Community Interactions	(ASHAs (Rural & Urban), AWWs, Adolescents, VHSNC and RKS Members, Beneficiary Interactions) Slum-Pynthorbah	(ASHAs (Rural & Urban), AWWs, Adolescents, Community Members, VHSNC and RKS Members, Beneficiary Interactions) Slum- Soksanang, Santinagar

Team Composition

RiBhoi District	West Garo Hills District
Sh. Prasanth K S, Sr Consultant, PHA, NHSRC	Dr. Ashoke Roy, Director, NERRC(Team Leader)
Dr Prahlad Kumar, CTD, RNTCP	Dr. S.D. Mazumdar, Sr. RD, MoHFW
Dr. Rattan Chand, NLM Member	Dr. Mohammad Ahmad, WHO-NPO
Dr. M. Jayaram- Sr. Academic Registrar, IIPH, Hyderabad	Dr. RichaKandpal, Sr. Consultant, RCH
Dr. Ajay Takroo, UNICEF	Ms. IshaRastogi, Sr. Consultant, NUHM
Sh. Gyanish Kumar, Consultant- NHM- Finance	Ms. Ima Chopra, Consultant, CP/CPHC, NHSRC
Sh. Ajai Basil, Consultant- HCT, NHSRC	Ms. Ena Joshi, Consultant, WCD

Positives

- The community is found to be empoared, is aware of VHSNC and its activities and in their houses had piped water, in-house toilets, electricity, and drains. There is equity in engagement and there is hardly any male child preference.
- The HWCs are spread out, and they are largely good in terms of infrastructure, space, HR, branding, etc. The proactive role taken up by MLHPs is appreciated and improved functioning after conversion to HWCs is noticeable.
- ASHAs in rural areas are undertaking population enumeration (filling of family folders) and CBAC forms; ANMs are entering their data in CPHC-NCD IT app in tablets and by MO in the MO portal.
- Under Community Action for Health Public hearings or Jan Samwad is being held to discuss various health related issues including review of maternal deaths, denial of health services, basic amenities at Sub Centres, etc.
- VHSNC meetings are held; minutes compiled; various health topics being discussed; VHSNC members are motivated despite lack of funds.
- VISHWAS campaign rolled out in selected villages and solid and liquid waste management being discussed in meetings.
- RNTCP - DOTS centres are functional, medicines available, prophylactic treatment in place for contacts, nutrition support provided, CBNAAT machine available, and utilized.
- Logs and registers are being maintained for Hypertension, Stroke, Diabetes, and common cancers.
- AYUSH services are present. Ayush doctors and medicines of their specialty are available (e.g. Ayurvedic doctor and Ayurvedic medicines).
- Skill labs (DAKSH) are created as per GoI Guidelines in both districts. The trainings are on and mentoring visits are just been initiated.
- A Good System of Medical Records Management with a retrieval facility is available.
- Good implementation of the Birth and Death Registration Act and Disability Act.

Challenges

- Planning of RMNCH Services –by levels of care and in a 'time-to-care-approach' is largely missing. The gap in levels of care is very acute in RiBhoi which does not have a single FRU.
- Malaria – there are a few pockets of falciparum in the State. IRS coverage/ acceptance by the community is quite low. The rubber cultivation is adding to the mosquito density.
- The supply of iodine testing kits is highly irregular (West Garo Hills) and unavailable (In Ri Bhoi).
- JE - Investigation report is coming very late, and this hampers early diagnosis.
- Free Condom Distribution Boxes not found in any facility. Chaayya not available.
- NPCB - Backlogs for Cataract operations and shortage of spectacles noticed. The team could not find optometrists, and there is a huge shortage of ophthalmologists.
- Urban centers are largely operating from rented premises, and some of them are facing space constraints. They are mainly providing only daycare services.
- The infection control practices are not being followed up stringently. (Use of autoclave, zoning in OT, CSSD and mechanized laundry, SOPs, needs improvement. Could see wide use of Cheatle forceps holders, which is not recommended these days).
- The staff handling hazardous waste has been given the only TT. They haven't received Hep. B vaccination and there is no annual check-up that they have undergone.
- In HRH, no training calendar could be found and TMIS is not used. The state does not have an HRMIS.
- Shortage of funds at the District level and in all the facilities visited in both the districts even though sufficient funds are available at the State HQs.
- Huge backlog in payments of demand driven activities (JSY, ASHA incentives, compensation to the contractual staff).

MIZORAM

Type of Facility	East Aizwal District	Mamit District
DH	Civil Hospital	DH Mamit
SDH / CHC	CHC Saitual	CHC Kawrthah
PHC	PHC Darlawn & PHC Khawruhian	PHC Rawpuichhip & Kawrtethawvwng PHC- HWC
UPHC	UPHC ITI & UPHC Zembawk	-
SHC-HWC	-	SC-HWC Rulpuihlim
SHC	SC Rulchawm & SC Sawleng	SC-Tuidam
AWC/VHND/UHND	-	AWC - Rulpuihlim AWC III), Rulpuihlim Village, Schools-Govt. Primary School IV and Govt. Middle school II, Kawrthah

Team Composition

East Aizwal District	Mamit District
Dr. A.K. Puri, DDG, NACO (Team Leader)	Dr. Ritesh Tanwar (DD, Hospital Admin. MP)
Dr. Rambabu Jaiswal (Joint Director - Family Welfare, DHS, Rajasthan)	Dr. Sanjeev Saini (Technical Officer - Central TB Division)
Dr Sanjay Pattiwar (Member – National Learning and Mentoring Group)	Dr. Ashish Bhat (Consultant - MoHFW)
Dr. Rajesh Kumar, Asst Prof. - NIHFW	Mr. Tapas Chatterjee (MoHFW)
Dr Sudershan Mandal (ADDG - Central TB Division)	Dr. Shalini Verma (Program Manager - UNDP)
Mr. Arun Srivastava (Consultant - NHSRC)	Ms. Prepsa Saini (Young Professional - NITI Aayog)
Mr. Mayank Kapoor (Senior consultant- NUHM, MOHFW)	-
Ms. S. Sindhu (Programme Manager – Ministry of Woman and Chil Development)	

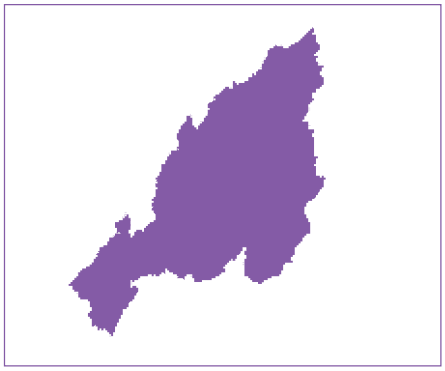
Positives

- External branding as per Govt. of India's design has been completed in HWCs visited.
- Population enumeration and NCD screening at facility and community level initiated.
- Voluntary Blood donation is done regularly especially by the Students
- Well designed OPD waiting areas found in all facilities
- State of the art SNCU is established at Civil Hospital Aizawl. SNCU at Civil Hospital Aizawl has developed a strong mechanism to follow up of SNCU discharged babies.
- Most of the Labour Rooms are found to be good well maintained, clean and hygienic.

- 2 Labour Rooms have achieved LaQshya State Certification.
- All AWWs are well aware of the POSHAN Abhiyaan. All are using ICDS CAS.
- At state headquarter, the Civil hospital is well equipped and providing most of NCD services. The programme for elderly care, blindness and vision, mental health, emergency, burns and trauma, oral health, deafness and NPCDCS seems to be well performing.
- Active State ASHA programme support team (continuity in 5-6 years). All District ASHA coordinators in place. ASHA mobilisers in place at cluster level (1 for 15-20 ASHAs).
- Trainings for VHSNCS have been conducted in 2017. In 2018, VHSNCs and ASHA trained on VISHWAS campaign, of MOHFW.
- Patient Centric Behaviour of Facility's Health Care Workers.
- Civil Hospital Aizawl & ITI UPHC are NQAS Certified.
- Vulnerability assessment done for urban population.
- Mahila Arogya Samiti (MAS) have been constituted and trained, have started functioning.

Challenges

- Limited IEC materials at HWCs. EDL list, list of medicines and diagnostics test, citizen charter, HR not displayed.
- Yoga and wellness activities, health calendar and other services not displayed at HWCs in both districts, and not initiated.
- User fee being charged in DH East Aizwal, & there are limited diagnostic tests.
- Referral transport services for delivery is not available & high Out of Pocket Expenditure
- Family planning services poor. ASHAs had no supply of FP commodities. New Contraceptives are limited to the District Hospital only with poor retention rate.
- Adolescent Health programme weak. Role of peer educators and ASHA in community mobilization negligible. Anemia Mukt Bharat (AMB) program not implemented.
- MCP Cards are being filled up partially, documentation in facilities below district level is poor, standard registers are not being used.
- Line listing of HIV cases with chest symptoms being referred for CBNAAT testing is maintained in ART centre but back referral records not being maintained. Monthly meeting between the TB and HIV department is not happening regularly.
- There is no TB treatment centre in Civil Hospital Aizawl.
- Data is being recorded and compiled under IDSP but not being analyzed for giving feedback
- Transportation & network coverage problem, Weak IEC, and Less special outreach camps conducted, are seen under Urban Health
- ASHA programme support and payment system has major gaps at Block / PHC level.
- ASHA incentives are being paid separately for different programmes & not as consolidated payment, Payments irregular, substantial delays. No Grievance redressal system for ASHAs.
- 3 social security schemes for ASHAs, announced by Hon. Prime Minister not implemented.
- No/poor record keeping systems and minutes of the meetings of VHSNCs and RKS
- Disposal of BMW, not as per Rules. Some facilities have no authorization from State Pollution Control Board.
- Various Committees and Policies for quality assurance, BMW Management, Sexual Harassment at workplace etc. are not constituted. No Prescription Audits.
- Districts not aware on state HR policy, for recruitment, performance appraisals, carrier progression and posting and transfer. Salaries of NHM staff are delayed by 2-3 months.
- Districts do not have access to Human Resources Information System (HRIS). Attendance registersare not properly maintained and have no bearing on salary processing.
- There is no Nodal Officer for trainings in the NHM. Inadequate Infrastructure for trainings.
- Delays in disbursement of funds from State to various Operational level facilities. Financing Systems are poorly managed for incentive schemes like, JSY, RNTCP, ASHA Incentives.
- Direct Facility Purchase being done without Rate Contract.
- Improper Mapping of Ambulances under National Ambulance Services.



NAGALAND

Type of Facility	Kiphire District	Phek District
DH	DH Kiphire	DH Phek
CHC	Pungro	Pfutsero
PHC	PHC- HWC Likimro, PHC Amahator	Khuza, Chizami, Kohima Village
UPHC	-	Seikhazou (Kohima)
SHC	HWC – Chomi, Longmatra, Phelunger, Singerp	Pfutseromi
AWC	Phelunger	Chuzami, Thizama, Chepoketa, Kuza, Kiyake
Community	Community and VHC – Chomi, Likimro, Phelunger, Singerp Church – Pastor : Phelunger and Singerp	Village - Khuza, Khomi, Chepoketa, Chuzami, Bada Basti, Kiyake Church Pastor – Phek sadar
Others	Naga Hospital, Kohima	

Team Composition

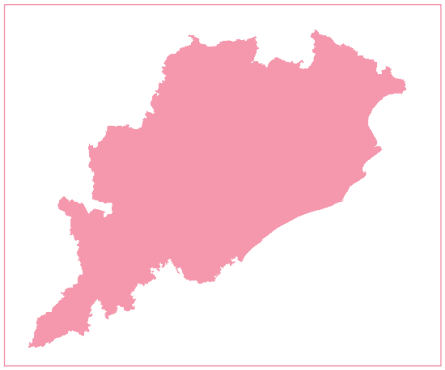
Kiphire District	Phek District
Dr Neha Dumka, Senior Consultant, CP-CPHC, NHSRC	Ms Mona Gupta, Advisor, HRH, NHSRC (Team Leader)
Dr Kapil Joshi, Senior Consultant, RCH division, MoHFW	Dr Ashwini, Senior Consultant, NHSRC
Mr Amlan Majumdar, CARE India	Dr Arindam Saha, Jhpiego
Mr Srinadh, NITI Aayog	Mr Anjaney, Consultant, HCT, NHSRC
Ms Ayushi Rai, Consultant, NHSRC	Dr Ankur Yadav, NIHFW
Dr Manjari Singh, Fellow, NHSRC	Ms Swamili, Consultant, NHSRC
Mr Hari Krishnan, Consultant, Finance Division, MoHFW	Ms Mansi Rawat, WCD

Positives

- Healthy environment and Dietary Habits; lower ailments rates
- Overall good availability of HR, except Specialists
- Active Community participation and ownership-Community is building HWC out of purchasing Scrub typhus diagnostics Kits
- Availability of CHO, medicines, and diagnostics at HWCs. Screening of NCDsdone.
- 100% ASHAs in position in rural areas. AAA coordination at the grassroots level
- VHND conducted on regular basis.
- Health facilities are well maintained, IEC material displayed
- Guidelines, protocols are followed in Paediatric care, Intensive care units in Phek and Kohima
- To improve immunization at birth, the PPC of Kohima Naga Hospital has started providing vaccination at birth (BCG, "0" dose OPV, Hepatitis B) on all days including holidays in the govt and private hospitals.
- For Disease control program: private bikes and free transport used for timely sputum sample deposition in the nearest Designated Microscopic Centre.
- Population enumeration initiated at all HWCs. ASHA and MPREGNANT WOMENs are both undertaking CBAC. Medicines for DM and Hypertension are available in HWCs.
- Institution delivery in Urban PHCS/CHCs, all have NBCC.
- District Quality Assurance (DQAC) is functional
- Pradhan Mantri National Dialysis Program implemented.

Challenges

- Limited state budget, and inadequate NHM budget.
- Lack of training for Service Delivery and Program Management staff.
- High OOPE due to unavailability of medicines, unavailability of primary health care below the level of PHCs, and long distance to health facilities. Poor road connectivity adds to the high cost of availing medical services at public health facilities.
- Delay in salary release, backlogs in ASHA incentives unavailability of residence for CHO/MPREGNANT WOMEN-F, and operational issues with tablets provided to CHOs.
- There is no coordination or integration with other existing programmes at the HWC level. Lack of community awareness on National Health Programs.
- Home Delivery not attended by SBA.
- Rise in HIV+ cases observed, including those in ANC cases is a concern.
- AVD plan for routine immunization is not robust and power back up for the Dist Vaccine store and other cold chain points to be ensured.
- Unavailability of Rapid Response Team at the district
- There is no designated nodal officer at the District for NCD control program.
- UPHC in Kohima Municipal Corporation (KMC) is functioning under NUHM whereas SC of KMC area is under NRHM leading to lack of coordination. State and District level reviews on NUHM inadequate.
- Population coverage by ASHAs in urban areas varies from 4000 to 9000. Community participation in Mahila Arogya Samiti low.
- Ambulances and MMU are not adequate leading to high OOPE and the 102 call center is not functioning properly.
- None of the districts had assured blood bank services. Blood is managed on the case to case basis and largely dependent on voluntary donations at District hospital level
- The health facilities of Phek and Kiphire with X-ray equipment do not adhere to Atomic energy regulatory board compliance for safety
- Biomedical equipment maintenance program: non-compliance not documented
- Poor record maintenance at HWCs
- Prescriptions audits not done.
- Lab and radiology services are not free for all patients
- Mismatch of resources: HR placements-Not as per workload, e.g. too many attendants, dentists posted without a dental chair, Two RBSK teams one vehicle. Irrational Equipment: In one district hospital, three semi-automated analyzers are in place, out of which two machines are non-functional because of nonuse. Drugs and supplies are not as per disease profile.



ODISHA

Type of Facility	Mayurbhanj District	Kandhamal District
DH	Baripada	Phulbani
SDH	Rairangpur and Udala	Baliguda
CHC	Jashipur , Barasahi, Rangmatia	K Nuagaon, Tikabali, Phiringia
PHC	Gudgudia, Deulia, Kushalda	Gochhapada, Kurtamgarh, Bishipada, Barikumpa, Guttingia, Simanbadi
UPHC	Debendrapur(PPP), Municipality Hospital, IRC Village Bhubaneswar, Ambapua(PPP) Berhampur, Aska Road, Berhampur	-
SHC	Bharandia, Mangaovindpur, Jamadiha, Kush	SC- Bishipada, Simanbadi, Padangi
AWC	Kumari Dorapida AWC, Gutingia Block Tikarapada AWC, Talasahi Block Karanjia AWC, Shamakhunta block Badasahi AWC, Badashi block	Phulbani Block-Pitabani 2 AWC, Sainpada, AWC, Dubagada AWC, Rapamutangi SHG, Khajurigaon, Phirgingia Block- Khajurigaon AWC, Phiringia Block Dorapida AWC, Gutingia Block
Villages	Sanjaharana, Kumari, Mangaovindpur	Darpida, Padangi
Schools for RBSK	Banatalapada	Residential High School Novagoan, Malik pada
Others	Prashanti MAS, NadiKhandisahi MAS MaaMangala MAS Badheisahi MAS BadaKhemundisahi MAS	-

Team Composition

Mayurbhanj District	Kandhamal District
Dr. Arun K. Aggrawal, PGIMER, Chd.	Dr. Himanshu Bhushan PHA, Advisor, NHSRC
Dr. Manoj Kumar Gupta, Associate Professor, CMFM, AIIMS Jodhpur.	Dr. SC Aggrawal, DD(NHM)
Dr. S.K Kar, Sr. Regional Director, Govt. of Odisha	Dr. Saurabh Sharma, Senior Program Officer, Bill & Melinda Gates
Dr. Vandana Mishra, Public Health Expert	Dr. Aashima Bhatnagar, Consultant PHA NHSRC
Dr. AdilShafie, Senior Consultant, NHM	Dr. Warisha Mariam, Consultant PHA, NHSRC
Mr. MahtabAlam, Consultant HPIP, NHSRC	Dr. BaluNatha Mote, Consultant, MoAYUSH
Mr. George Philip, PSI	Ms. ManroiChallam, IIPH-Shillong
Dr Neha Naik, Jr Consultant, FP	Mr. Kunal Mukherjee, Consultant, MWCD
Mr. Prabodh Kumar, MWCD	
Mr. Satyajit Sahoo (Fin. Analyst)	

Positives

- Both the districts visited have well placed maternal health services, a higher rate of institutional delivery, implementation of JSSK/JSY, maintenance of partographs, and labour protocols.
- The state has defined the targets for HWCs up to 2022, has plans for cadre creation and career progression for CHOs. Branding of all identified PHC and SC-HWC is completed.
- Universal screening for HTN, DM, Breast Ca and Oral Ca has been undertaken in HWC catchment areas including completion of CBAC forms by ASHAs. Chemotherapy, dialysis, and physiotherapy units have been created in both districts.
- There is an 81% decline in malaria cases in 2018. Adherence to treatment, follow-up, monitoring, and supervision under NTEP is reported well in both districts.
- The state has well functional UPHC and UCHC with good interdepartmental coordination. PPP run initiative "AMA Clinic" which is a fixed day free specialist clinic at UPHC and UCHC level.
- ASHAs are found to be well motivated and trained. HBNC visits and other such assigned tasks are being conducted and supervised.
- Two DH(6%), 2 CHC(0.53%) and 3 UPHC(3.37%) have got NQAS certification. Total 6 DHH (18.8%), 5 SDH (15%), 43 CHC (3.1%), 86 PHC (6.9%) and 42(47%) UPHC have qualified for the Kayakalp award.
- State, district, and block-level Public Health positions have been created. CPS courses are being carried and 47 doctors are enrolled till date. The state has also proposed three centres for midwife training.
- No user charges are being collected at district, CHC, and PHC level.
- Initiatives like NIRAMAYA for free diagnostics, NIDAAN for free drugs, free Dialysis services, MaaGruha (maternity waiting homes), Integrated counseling centres, integration of lab technicians, DAMan for awareness and control of malaria is being provided without any discrimination to anyone and are some of the result oriented best practices in both the districts.

Challenges

- Institutional mechanism for RBSK and RKSK services is a weaker area. New-born screening at birth is not taking place.
- UHND and immunization days are lacking in non-slum urban areas
- There is no block and PHC saturation for HWCs. The treatment provided is mostly curative and lacks preventive and promotive aspects of health.
- In spite of the creation of a district NCD cell, other programmes under NCD have not yet picked up and needs a defined road map for its acceleration. Steps for awareness generation related to NCDs, sanitation, and appropriate health seeking behavior is the dire need of the present.The availability of a higher generation of antibiotics (without prescription rights of CHO), issuing three months stock of medicine for follow up cases, prescription of basic drugs by MOs remains a challenge. The team observed that laundry and dietary services are not as per GOI norms.
- Apart from the malaria programme, other programmes for communicable diseases have not yet picked up and need acceleration through a comprehensive plan.
- Sexual violence and abuse reported from the community need a redressal mechanism.
- There are huge vacancies under various regular cadre for specialist (57%), MO (41%), Staff Nurse (63%), Pharmacist (17%) and Lab technician 30%), dentist (24%), MPREGNANT WOMEN-M (36%), MPREGNANT WOMEN-F (16%) in the state. A similar finding has been observed at Mayurbhanj and Kandhamal and even if the position is filled the selected staff is not willing to join these hard to reach areas.
- The hike in state health budget in 2019-20 over and above 2018-19 is only 3.38% against the norm of at least 10%.
- The facilities visited lack a proper infrastructure with zoning for infection prevention in critical care areas. Emergency, operation theatres, general HDUs/ICUs remain either non-functional or sub-optimally utilized.
- Centralized BMMP is not yet fully operational. The ambulances visited in the district are observed to be used more as a transport vehicle rather than for stabilizing patients as the equipment in the ambulance are not being used and are still in wrapped up condition.

RAJASTHAN

Type of Facility	Churu District	Sirohi District
DH	DH, Churu	District Hospital – Sirohi
SDH	SDH, Sujangarh , Ratangarh	-
CHC	CHC Sahawa, CHC Taranagar	CHC Abu Road, CHC Sheoganj
PHC	PHC Baany, PHC Gaangu	PHC Bharja
UPHC	UPHC Dabla	UPHCSirohi
SHC-HWC	Raiyatunda, Bhanin, Rautula, Jaitasar	KauchhaliSC (Block – Pindwara), ArthwadaSC (Block- Sheoganj)
AWC/VHND/UHND	Bhanin, Jaitasar(I, II) , Rautula, Gangu	AWCs-Palanpur, Aksha Nagar, Surali, Vasuki, Naren, Karuali, Uchavan, Pinpur
Schools	RajkiyaMadhyamikVidyalaya, Bhanin	-

Team Composition

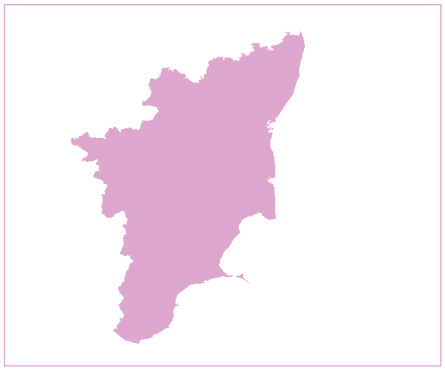
Churu District	Sirohi District
Dr. Raghuram Rao, DD (Central TB div), MoHFW, New Delhi	Dr. Ram Chahar, National Professional Officer (MRH) - WHO
Dr. Prem Lal, Ex CMO, Hardiwar	Dr. Ravichandra C, NTI, Bengaluru
Dr. Pushkar Kumar, Sr. Public Health Specialist - PHFI	Dr. Deepak Saxena, Sr. RD
Dr. Vandana Bhatia, Health Officer, UNICEF, Bhopal	Mr. Daman Ahuja, Programme Manager, AGCA
Ms. Shalini Gupta, Assistant Technical Adviser, MoWCD, New Delhi	Ms. Mohammad Nadeem Noor, National Programme Coordinator (Bihar) - UNFPA
Ms. Nisha Kadyan, Sr. Consultant, MoHFW	Dr. MeenakshiDikshit, PSI
Mr. Mohammad Ameel, Sr. Consultant, I/C HCT Division, NHSRC	Mr. Vinit Mishra, Sr. Consultant, MoHFW
Dr. Poonam, Consultant, PHA, NHSRC	Ms. AishwaryaChoubey, YP, NITI Aayog

Positives

- The currently operational HWCs are found good in terms of branding and IEC.
- For family planning, the basket of choice is available; with the most popular being Antara.
- The infrastructure for labour rooms is good across all the facilities visited.
- Facility level care for Oral Health, Mental Health, Palliative care, Deafness & Elderly programme etc. is observed at DH level.
- Fairly good implementation of RNTCP, IDSP, and NVBDCP is observed.
- The infrastructure and external branding of urban health facilities are optimal and opportunistic as well as population based NCD screening for HT, DM, Oral and Breast Cancer is observed.
- Active participation by ULBs and MAS is observed in all health-related activities. UPHC should expand the provision of services as per the 12 packages: to include services for NCDs, elderly, mental health, etc.
- All ASHAs have good knowledge, are trained and provided with both Drug and HBPNC Kits
- ASHAs are insured under Pradhan Mantri Jeevan Jyoti Suraksha Bima Yojna, Shram Yogi MaandhanYojana. Rogi Kalyan Samiti (RKS) is registered under the Registration of Societies Act.
- Registration of Births and Deaths, Bio-Medical Waste Management, PCPNDT, COTPA, HIV Act are implemented and in place.

Challenges

- The target for the state in FY 2019-20 is 4127 HWCs, however, the State is facing some operational issues (court cases) and is unlikely to meet the current targets. HWCs are lacking in comprehensive service delivery and continuum of care.
- NCD screening is limited only to diabetes and hypertension. In functional HWCs neither regular wellness activities have been initiated nor reporting in NCD application started.
- In PPIUCDs high expulsion rate is observed which indicated inadequate counseling or lack of follow up to 6 weeks.
- Despite good infrastructure, the facilities are sub optimally utilized at sub district level in Churu (FRUs non-functional) including Anganwadis.
- The SNCU beds and HR need to be reviewed based on delivery load (two babies in one bed in Churu increasing risk of cross infections/ sepsis) and service providers need refresher skilling and supportive supervision.
- There is a delay observed in the initiation of Breastfeeding in the labour room and home visits for SNCU discharged babies and low birth weight babies are not completed up to one year of age.
- Low awareness in the community is observed for CDs & NCDs, almost no visibility of the Leprosy and Hepatitis program. 30+ population screening for DM & HT initiated through CBAC but with limited coverage
- There is suboptimal involvement of private sector-enforcement for mandatory notification for TB and schedule H1 implementation.
- The EDL is displayed at facilities and 15 in-house diagnostic tests are available, however, FPLMIS is not being used by the ASHAs and ANMs.
- It is observed that ASHA drug kits are not replenished regularly
- Significant vacancies are observed in the state including the two visited districts in specialist, pharmacist, staff nurse, and lab technicians. Also, the lack of specialist cadre and hierarchy issues are observed as well due to the absence of HR policy in the state.
- The Kayakalp program is implemented in all facilities however, gross cleanliness issues in toilets and water tanks are observed.



TAMIL NADU

Types of Facilities	Villupuram District	Virudhunagar District
DH	Kalli kurchi GH and Medical College, Villupuram	Virudhunagar DH
CHC	Mavadipattu Kariyalur, Tindivanam	Uppathur
Primary Health Centre/ UPHC	Melur, Kilakadu, Saram, Dhadhapuram, UPHC Saram	Nenmeni, Kallurani, M. Reddyapatti, UPHC Virudhunagar, Sivakasi, Aruppakkottai,
Sub Centre/ HWC	Pukkiravaari, Dadhapuram, Sornavur	Nochimedu, Madhavacheri, Chokkalingapuram, Vachhakarapatti, Kulasekharanallur
Anganwadi	Pukkiravaari, Kalrayan, Thirusuzhi, Sonravur	-
Village	Dadhapuram, Sornavur, Janakipuram	-
Schools	GMS Pukkiravaari, Eklavya School Kalrayan Block	-
Others	Ambulances and MMU Drug warehouses in both district Distt Training Institutes in both district Targeted Interventions sites-Brick Kilns, Transgender Community, Commercial sex workers	

Team Composition

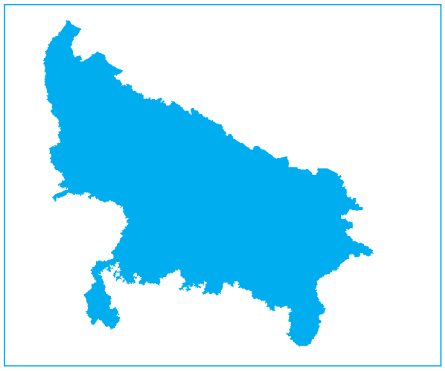
Villupuram District	Virudhunagar District
Dr. Zoya Ali Rizvi, MoHFW	Dr. S. Ravichandran,Chief Director, PRC, Gandhigram
Dr M K Sudershan, NLM, MoHFW	Dr. Roshni Arthur, Sr. RD
Chethana Rangaraju, Public Health Specialist, NTI, MoHFW	Alok Kumar Dubey, RA, NITI Aayog
Dr. Bhaswat Kumar Das, HCF & HMIS - RRCNE	Dr.SameerDeshmukh, Consultant, Mo AYUSH
Sudha Goel, MWCD	Vishal Kataria,Senior Consultant, RCH
Deepak Kumar, Consultant, AH, MoHFW	Ms. BhavyaChaddha (Fin. Asst)
Dr. MandarRandive, Consultant, MoHFW	Dr Rajna Mishra, Sr. Research Scientist - PHFI
Dr Suresh Kumar Kamalakannan, Associate Professor, IIPH Hyderabad	Shobhana Boyle, National Programme Officer (Gender), UNFPA

Positives

- Respectful maternity care is observed in both the districts with the privacy of the women maintained with curtains between two labor tables. The birth companions are allowed in labor rooms.
- Maternal Death Review System is well in place in both districts and death reviews are regularly conducted.
- Both districts have well established PREM (Pediatric Resuscitation & Emergency Management Unit) at DHQ and staff are also aware of clinical/ treatment protocols.
- No OOPE observed or reported on delivery care and childbirth in both the districts. Free Drugs, Diagnostic, transport, and food are provided to the ANC beneficiary and delivered women in both the districts.
- Day Care Chemotherapy services are available at the DH level in both districts.
- A Tele-V-Care Centre has been set up at Narikkudi BPHC. Infrastructure is in place. Fundus Camera Images (using mobile phones) will be taken and it is proposed to send these images to Madurai Medical College or Chennai Medical College. Results would be available in 15 minutes.
- A new initiative started at the DH in Virudhunagar since August 2019 with an MoU with Arvind Eye Hospital, Madurai for newborns< 25 weeks of age, and sick babies; they will be screened for Retinopathy of Prematurity.
- The State has started Urban Polyclinic under NUHM providing specialists OP clinic in a single roof at fixed timings 4.30 PM to 8.30 PM; about 96 UPHCs/UCHCs are selected for this initiative.
- Telemonitoring has recently been started for the MLHP programme for mentoring of VHNs.

Challenges

- Awareness regarding HWCs in the community is noted to be low during community interaction by the team.
- PPIUCD insertion facility is available Block PHCs and above and shows an increasing trend in both the districts. These services should be made available at the HWC-PHC level.
- Follow up of the High Risk Pregnancies (HRP) though listed in the health facilities, is found weak in the community.
- Beneficiaries in Villupuram are not being paid JSY money or Dr. Muthulakshmi MBS if they deliver outside the State e.g.in Puducherry.
- NBSU in Virudhunagar districts are functioning as NBCC only, all newborn even those without any medical complications are routinely separated from mothers.
- No Digital Weighing Scale found in any of the facilities visited in Virudhunagar leading to poor birth weight record maintenance.
- Stillbirth records are neither maintained nor reported as per GoI Guidelines.
- Adolescent Friendly Health Clinics are grossly under-utilized in both the districts (client load < 50 per month).
- Home based palliative care and counseling services are available inVillupuram district; however, in Virudhunagar district, awareness is low among the community, and interactions with them revealed that neither visits by frontline health providers are being made nor training to family members regarding palliative care is being provided.
- There is a considerable backlog of samples to be tested through CBNAAT at both the centres.
- The RKS (Patient Welfare Society) registration has not been renewed for years in most health facilities visited, the last renewal of Virudhunagar DH done in 2007.
- The state has a HR Policy and a HR cell in place, however, a clear transfer policy and performance appraisal mechanism is not fully developed.
- Delay range of 26-84 days (Under RCH Pool and Health System Strengthening) in the transfer of funds from State Treasury to State Health Society (SHS) is noted, while processing time for transfer from SHS to District Health Society (DHS) is about 04-35 days.



UTTAR PRADESH

Type of Facility	Meerut District	Bahraich District
Medical College	LLR, Medical College	-
DH	District Women Hospital Pyarelal Hospital: NRC, Blood Bank, Paediatric Ward, Burns Unit	District Hospital MCH wing - District Hospital
CHC	CHC Mawana CHC- Bhudhbaral	CHC Nanpara, CHC Motipur, CHC Rissia, CHC Chittora
PHC-HWC	HWC-PHC – Paphoonda, HWC – PHC-Rajpura	HWC-PHC-Amba, HWC PHC Mihipurwa
UPHC-HWC	HWC- UPHC- Naglapattu, HWC- UPHC Tarapuri, HWC-UPHC Jahidpur	HWC- UPHC- Bakshipura
SC-HWC	HWC-SC -Incholi, HWC- SC– Chandsar	HWC SC-Madaraha, HWC- HSC Bishupura
AWC	AWC Rajpura, AWC Jaswantpura, AWC Mohidinpur, AWC Lisari2, AWC PrathmikKanyaPathsala, Jahidpur	AWC Jauhara, AWC Bariya 1 & 2, AWC Sasapara
Villages	VHSND: Jaswant Pur,a UHND- PAC Centre Health Kiosk- Lisari	Village Bishupura, VHND Amba
Others	RHFWTC College of Nursing	CHO Training centre at DH Bahraich

Team Composition

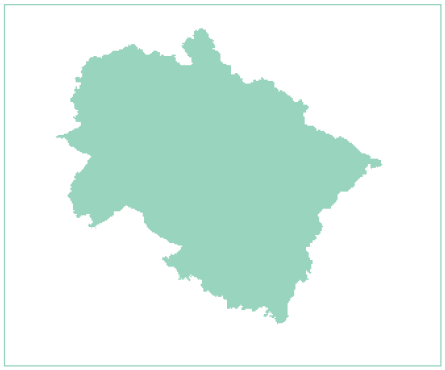
Meerut District	Bahraich District
Dr. Ajay Khera, Commissioner, MCH, MOHFW (Team Leader)	Dr Sheetal Rahi, AC, CH & AH, MoHFW
Dr RenuShrivastava, Advisor, MNCH, CH Division, MoHFW	Dr V.K Chaudhary, Regional Director Health & Family Welfare - Lucknow, MoHFW
Dr Abner Daniel, UNICEF	Ms Sweta Roy, Sr Consultant HRH, NHSRC
Dr Rupinder Sahota, Sr Consultant CP, NHSRC	Ms Pallavi Kumar, Sr Consultant AH, MoHFW
Dr Vishal Kumar, Sr Consultant CH, MoHFW	Mr Anil Gupta, Sr Consultant NHM, MoHFW
Mr Sanjeev Gupta, Finance Controller, MoHFW	Mr Sunish R, Sr Consultant, Tata Trust
Dr Reena Singh, NLM Member	Ms SeemaUpadhyay, Programme Manager, AGCA
Ms Mona Jethwa, Consultant MoWCD	Ms SanjeetaGawri, Centre for Catalyzing Changes
Dr MahenderMourya, Sr Consultant NHM, MoHFW	Dr Ved Yadav, National Consultant (Health Information System and Evidence Generation), WHO
Dr SarangaPanwar, Consultant Trauma & Burns, MoHFW	Ms. K M Visalakshi, Consultant HRH, NHSRC
Dr Mushtaq Dar, SPM, NIPI	

Positives

- Significant increase in the number of OPD Cases after upgradation of facilities as Health and Wellness Centres
- Mental Health Counselling is done in Maan-Kaksh at the district hospital. Outreach activities, including medical camps in jails, at CHC/PHC, training for staffs from CHC/PHC/CHO/School teachers are conducted by district mental health team in Bahraich
- "Buddy Model" being implemented wherein specialists/ EmOC and LSAS trained doctors are posted together to ensure the functionality of CHC-FRU.
- Award system for rewarding best performing workers and officers at the district level, VHSND monitoring through Google maps in Meerut district
- Active involvement of RBSK MHT in identifying children SAM having medical complications to NRCs
- Data generated through IDSP is being utilized at the district to identify Early Warning Signals.
- Hard to reach have been identified and special strategies like school health education regarding prevention and control of leprosy are ongoing.
- Outreach sessions both UHNDs and Special outreach are found to be conducted regularly and micro-plan is available at the facility
- All facilities-CHCs, PHCs and UPHC conduct quarterly internal assessments followed by peer reviews under Kayakalp on regular basis
- Rainwater harvesting system at the PHC Jauhra with a soak pit is in place
- Conducting recruitment drives under NHM regularly. Additional weightage for recruitment under regular cadre is being given to staff with experience of NHM

Challenges

- Delayed registration of pregnancy, very low coverage and awareness of ANC services
- High case of home delivery (approx. 42%) reported in Bahraich.
- Shortage of specialist and unavailability of 24X7 delivery services and C-section at CHC level
- Irregular supply and inadequate stock of all contraceptives, especially newer contraceptive such as Antara and Chayya
- Population Based Screening is low in both districts: 1% of the population is screened for NCD in Bahraich and 3% screening in Meerut
- The general condition of the village for health and hygiene is not good and least involvement of Gram Panchayat is seen in developmental activities of the areas to keep it mosquito free
- Poor TB notification reported from private service providers
- A significant gap in sanctioned Anganwadi Centres against the population that needs to be covered seen. Huge gaps are observed in the service delivery at AWCs in urban areas.
- Urban ASHAs are yet not enrolled in the BCPM-MIS software.
- Urban ASHAs did not have HBNC equipment as they are not trained in Module 6 & 7
- Availability of specialists persists to be a challenge for the state; the bidding process is limited to the recruitment of specialists under RCH
- Irrational deployment of staff leading to unavailability of services
- Absenteeism of staff from the health facilities found a major reason for dissatisfaction among the community. This is leading to OOPE, availing services from local healers/ buying medicines prescribed by the local pharmacy
- Weak notification mechanisms to appropriate authorities for births, deaths and stillbirths. Stillbirth reporting is negligible in district Bahraich.
- Delay in the transfer of funds, a large amount still parked with the government treasury which is to be transferred to State Health Society
- No proper financial management system followed for proper maintenance of Books of Accounts and control records like note sheet, advance register Stock register and fixed assets register at District Health Society
- Labs at the peripheral level facilities are either not functional or are providing a limited number of tests (only point to care test) and the staff available is highly underutilized
- None of the BSUs is functional in both districts



UTTARAKHAND

Type of Facility	Udham Singh Nagar District	Haridwar District
DH	Rudrapur	HMG Male Hospital, CRW Female hospital and Mela Hospital
SDH	Khatima	Roorkee
CHC	Kiccha, Khatima	Bahadrabad, Manglaur
PHC-HWC	Chakarpur, Shantipuri (Sitargnaj)	Rithamandi, Paniyara, Laldhang, Jwalapur
SC-HWC	Haldi (Kiccha), Shantipuri (Sitarganj)	Lathardeva Sheikh, Shubhamagar
Urban Slums	-	Bengali, Madrasi, and HariwanBasti in Haridwar
Villages	Khatima, Sitarganj, Kiratpur	Imikheda, Bahadrabad

Team Composition

Udham Singh District	Haridwar District
Mr. Narsingh Dev, Director, Ministry of Rural Development	Dr. Aruna Jain, Add. Director, NVBDCP
Dr. Archana Pandey, Consultant, PHA, NHSRC	Dr. Sanjeev Tak, State Representative, Rajasthan
Dr. Gaurav Chauhan, Consultant PHP&P, MoHFW	Mr. Ajit KS, Consultant, PHA, NHSRC
Ms. Mitakshi, Consultant, RCH, MoHFW	Dr Preeti Kumar, Vice President- Public Health system Support - PHFI
Dr. Dheeraj Bhatt UNICEF-Health Officer	Dr. Uma Shankar, NTI Bengaluru
Mr. Jaimon Thomas, CARE India	Ms. Phibansuk Lyngdoh, IIPH-Shillong
Dr. Badondor Shylla,IIPH- Shillong	
Ms. Bhavi Gumbar, Consultant, MoWCD	

Positives

- Upgradation of SC-HWC and branding of PHC-HWC is going on in both the districts. Excellent branding of HWCs (external) in both the districts.
- Labour rooms across facilities are developed as per MNH toolkit.
- High Risk Pregnancies are being identified and line listed in both the districts.
- There is widespread awareness of 108 ambulances in the community.
- Maternal Death Reporting & Review is being done at the CMOs level.
- ASHAs are active in the field, have a good community interaction and outreach and Home visits for HBNC and post-natal are being conducted by ASHAs.
- SHGs exist at the village level and are widespread in rural areas. Similarly, some MAS (MahilaAarogyaSamiti's) have been formed in urban areas.
- ICDS – Common Application Software (CAS) application is available with the AWWs. Household surveys are ongoing.
- Dengue outbreak response in the field is perceptible. Door to Door visits and insecticide spraying is observed.
- PRIs are aware and knowledgeable of front line workers in the health & WCD system and showed a willingness to invest in health care infrastructure.

Challenges

- Design of buildings not conforming to NBC (National Building Code) norms – fire safety/ zoning/ hospital acquired infection control in both of the districts. Moreover, poor infrastructure and services at the Nutrition Rehabilitation Centre (NRC) are deterrent for utilisation by the community.
- Urban PHCs are not functional in US Nagar at the time of the visit. In Haridwar, the Urban PHCs are contracted out to NGOs, but the contract is up for renewal.
- Drugs and Vaccines Distribution Management system (DVDMS) is not working/ accessible at the PHC level for the past 3 months.
- Logistic MIS (for Family Planning) has not been launched. Inadequate and irregular supply of FP products leading to stock outs.
- ASHAs are engaged for spraying in Dengue outbreak, instead of ULB/municipal staff.
- OOPE of approx. INR 1000, is being incurred for each pregnant woman for onetime mandatory Ultrasound in pregnancy in public facility (3-4 visits on transport cost). This is found at high load facilities such as the District Hospital in Haridwar. Also, Out Of Pocket (OOP) payment is made by families for drop back services using either facility ambulances or private transport.
- User fees on OPD slips, admissions, diagnostics, investigations (CXR) and referral transport are considerable. Urine pregnancy test (UPT)is also chargeable.
- RKS funds include user fees (50% of the total user fee collection at a facility) untied fund and annual maintenance grant. The utilisation of user fees at facility level has led to under-utilisation of the seed money from GoI, reducing allocations in the subsequent year. Thus user fees, which reflect OOPE borne by patients visiting the facility, appear to be substituting the grants being given by the government.
- Rogi Kalyan Samiti (RKS) - CHC RKS has been held only once in the past year against a quarterly meeting. Chairperson is CDO.
- The distribution of Golden cards in different vulnerable populations is not properly targeted.
- Irrational distribution of Human Resource. Some facilities at the PHC and CHCs (Udham Singh Nagar) showed far higher HR personnel, not commensurate with the patient load.
- Critical gaps in Human Resources. Key cadres suchasepidemiologist,statisticians,entomologist and VBD consultant are not available.
- HR policy for contractual staff is not available.
- Considerable delays with pending payments of ASHAs payment and continues to be through cheque.
- Banks are not sensitized to supporting SHGs and are reluctant to provide loans.
- The AWWs are not members in the VHSNC.

Notes

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

NATIONAL HEALTH MISSION
Ministry of Health & Family Welfare
Government of India
Nirman Bhavan, New Delhi