









# 14<sup>th</sup> Common Review Mission Report 2021

## ABSTRACT

The National Health Mission (NHM) denotes a coordinated effort towards health systems' reforms in the country. The report demonstrates that all States that were visited have taken challenges despite dealing with COVID-19 pandemic to make remarkable improvements. 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.



This report has been synthesised and published on behalf of the National Health Mission by its technical support institution; National Health Systems Resource Centre (NHSRC) located at NIHF campus, Baba Gangnath Marg, New Delhi-110 067.

We gratefully acknowledge the contributions made by consultants and officers in the NHM Division of the MoHFW. We also place on record our deep appreciation and gratitude to participants from other Ministries, Public Health Institutions, Civil Society and Development Partners who have all contributed to this Common Review Mission Report.

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**Government of India**  
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### MESSAGE

This report of the 14<sup>th</sup> Common Review Mission (CRM) conducted in 12 States and one Union Territory presents the findings by multidisciplinary teams of public health experts. These experts were drawn from Representatives of Central and State Governments, Regional Directors of Health & Family Welfare Departments, Officers from other Central Ministries and NITI Aayog, Civil Society Organizations and Development Partners. The strength of Common Review Mission has been the collation of different perspectives from the field brought together by the multidisciplinary teams. Another strength is that a sample of public health institutions across all levels get evaluated, thus, helping in building a comprehensive overview of the public healthcare service delivery.

The CRM visits were undertaken in November 2021, and the CRM teams have reported on whole range of program components of health systems along with the management of COVID-19 pandemic, including both outcomes as well as the processes. They have assessed the efficiency and effectiveness of programme implementation as structured through the mechanism of annual NHM PIPs and constant support provided during the pandemic. The CRM exercise has also evaluated the underlying policy environment in the states in terms of commitment towards various components of processes, innovations and strategies adopted for National Health Programmes and State, District and Block-level innovations.

The review teams held detailed discussion with people who are recipient of services, officials and policy planners at the state level, as well as with service providers and representatives from civil society and non-government organizations in the districts. It is encouraging to note that 14<sup>th</sup> Common Review Mission has reported multiple positive observations, especially expanded range of comprehensive primary health care services in HWCs both in rural and urban areas, details of secondary care services and cross-cutting issues in public health care system.

The recommendations made by the teams have taken a holistic view of the health system, including reform processes and aspects of infrastructure, human resources for health, service delivery and community process on one hand and framework of governance, management and accountability on the other. It is expected that States would take cognizance of 14<sup>th</sup> CRM observations and initiate necessary recommended steps.

**Date** : 23 September, 2022  
**Place** : New Delhi

**(Rajesh Bhushan)**







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### MESSAGE

The 14<sup>th</sup> CRM was conceptualized with health systems strengthening approach in the context of the challenges and enhanced focussed interventions planned and implemented during the pandemic period, along with the assessment of service delivery at the community and primary healthcare level. Over the course of the last thirteen Common Review Missions, a steady improvement in the public health infrastructure has been observed and the investment on health have had a significant impact on healthcare access and outcomes.

Focussing on the technical and financial support provided to States and UTs to manage the challenges caused by the COVID-19 pandemic, patient and community-centric care approach, tools/simple checklists were developed to be used during the interaction with care providers and community members. This helped to understand the health-seeking behaviour of the community, the provision of quality services to people by the system, along with the awareness of the community regarding the pandemic and national health programmes.

Another focus of the CRM was to undertake an assessment of the status of NHM, its key strategies and priority areas; delivery of comprehensive primary healthcare through Ayushman Bharat – Health and Wellness Centres (AB-HWCs); analyses of opportunities and challenges with respect to strengthening health systems and assess interventions/ strategies undertaken at the State, District/ Sub-District and Community level.

It is important to note that diagnostic and patient transport services have improved and are further being strengthened. The establishment of corporations, strategic purchasing, and innovative PPP models for procurement of drugs and consumables have eased procurement challenges in most of the states which in turn has enabled patients to get the required medicines at the healthcare facilities and reduce out-of-pocket expenses.

It is encouraging to see that the vision of universality, equity and affordability continues to guide the states in the implementation of the National Health Mission (NHM). The participation of MoHFW and State Officials, Public Health Experts, NITI Aayog, representatives from academic institutions, research agencies, civil societies, and development partners, in CRM brings in multi-stakeholder perspectives on the assessment of the implementation of NHM and State programmes. Their involvement enriches this exercise and provides CRM with an independent assessment and makes it a learning platform for all.

I thank all the CRM Team members for enriching this report with their valuable observations and inputs.

  
(Roli Singh)

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#### MESSAGE

Dated: 11<sup>th</sup> October 2022

The 14<sup>th</sup> Common Review Mission (CRM) was organized at the time when India was going through the challenges of managing the COVID-19 pandemic along with maintaining regular healthcare services for citizens at large. Efforts of all the States and Union Territories along with the Central Government were focused to expand the reach of healthcare services and enable health systems to ensure quality service delivery.

Ministry of Health and Family Welfare in coordination with the National Health Systems Resource Centre (NHSRC) undertakes the Common Review Mission (CRM) to review the progress of National Health Mission (NHM) implementation. CRM has established itself as a key evaluation mechanism under the National Health Mission. It provides us with a situation analysis and serves as a co-learning process for both evaluators and implementers. Previous CRMs have played an important role in reminding us of the concerns and consequences of high Out-of-Pocket Expenditure (OOPE). CRMs provided us with a platform to see and evaluate the progress made on various schemes launched by the Government of India to specifically reduce OOPE, such as National Free Drugs and the Free Diagnostics Service Initiative, Pradhan Mantri National Dialysis Programme, Quality Improvement and upgradation of District Hospitals.

It is heartening to know that States and UTs have made sustained efforts to strengthen secondary care services and States are adopting innovative approaches to engage Specialists at the District Hospitals. Improvement in urban healthcare services through urban HWCs is also observed in these visits. However, the range of specialist services at many District Hospitals still needs to be strengthened along with infrastructure. Further, efforts towards the diseases targeted for elimination, like Tuberculosis, Leprosy and Kala-azar, need to be more comprehensive.

The 14<sup>th</sup> Common Review Mission provided a valuable understanding of strategies/schemes implemented by the State Governments. The CRM teams include officials from various technical divisions of MoHFW, NHSRC, public health experts, and technical leads from the healthcare sector. I thank all experts for participating in the 14<sup>th</sup> CRM 2021 and all the participating States/ UTs for successfully conducting this significant event. I am sure that States/ UTs would use the CRM findings in order to strengthen the health systems and enable mechanisms to ensure improved health outcomes.

(Vishal Chauhan)

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#### **MESSAGE**

The National Health Mission has brought immense improvement to the public healthcare system in India. To assess the progress made with respect to the reach and quality of services being offered to people, a robust mechanism is set up as annual Common Review Mission (CRM). NHSRC takes pride for providing continuous technical support to Ministry of Health & Family Welfare (MoHFW) for facilitating and organizing the CRM activities. Over the years, CRM has played a key role as a monitoring mechanism to assess the progress of all the programmes implemented under NHM. The present report of the 14<sup>th</sup> CRM reflects tremendous efforts made by the States and UTs to take on the challenge of keeping up regular healthcare services while dealing with the COVID-19 pandemic.

The 14<sup>th</sup> CRM covered 12 states and one UT, providing an opportunity to review the recent development in policies and programmes, and governance issues, to take stock of the present situation and adopt appropriate mid-course corrections, if required.

Targets to operationalize Ayushman Bharat - Health and Wellness Centres are being achieved before the stipulated time, work on Communicable and Non-Communicable Diseases; strengthening of secondary care through District Hospitals is also progressing as planned. All these interventions will lead our country towards a better-established public healthcare system with people getting promotive, preventive, curative, palliative and rehabilitative services near their doorstep, as guided by our National Health Policy - 2017.

The improvements in key indicators in the field of maternal and child health, diagnostic services, availability of free drugs, improvement in obtaining feedback from patients on received services, strengthening of ambulance services and reach of field level workers like ASHAs and ANMs have been validated in all the covered states. We must learn from such gains and sustain these for further improvements.

CRMs play a lead role as a monitoring exercise, particularly for addressing NHM implementation and achievements. I would like to convey my appreciation to all the team members who undertook this mammoth exercise and helped in the preparation of this report. I am sure it has been an enriching experience for all involved and the observations and recommendations of the 14<sup>th</sup> CRM will help to move NHM forward.

[Maj. Gen. (Prof.) Atul Kotwal]

**Date: 7<sup>th</sup> October, 2022**  
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# Abbreviations

<b>AGCA</b>	: Advisory Group on Community Action
<b>AMTSL</b>	: Active Management of Third Stage of Labor
<b>ANC</b>	: Ante-Natal Care
<b>ANM</b>	: Auxiliary Nurse Midwife
<b>ANMTC</b>	: Auxiliary Nurse Midwife Training Centre
<b>APHC</b>	: Additional Primary Health Centre
<b>API</b>	: Annual Parasite Index
<b>ARC</b>	: ASHA Resource Centre
<b>ART</b>	: Anti retroviral Treatment
<b>ASHA</b>	: Accredited Social Health Activist
<b>AWC</b>	: Anganwadi Centre
<b>AWW</b>	: Anganwadi Worker
<b>AYUSH</b>	: Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
<b>BCC</b>	: Behaviour Change Communication
<b>BEmONC</b>	: Basic Emergency Obstetric & Neonatal Care
<b>BMO</b>	: Block Medical Officer
<b>BMWM</b>	: Bio-Medical Waste Management
<b>BPHC</b>	: Block Primary Health Centre
<b>BPM</b>	: Block Programme Manager
<b>BPMU</b>	: Block Programme Management Unit
<b>BPL</b>	: Below Poverty Line
<b>CAH</b>	: Community Action for Health



<b>CBOs</b>	: Community Based Organizations	<b>HRIS</b>	: Human Resource Information System
<b>CEmONC</b>	: Comprehensive Emergency Obstetric & Neonatal Care	<b>HSC</b>	: Health Sub-Centre
<b>CHC</b>	: Community Health Centre	<b>ICDS</b>	: Integrated Child Development Scheme
<b>CMO</b>	: Chief Medical Officer	<b>IDSP</b>	: Integrated Disease Surveillance Project
<b>CMOH</b>	: Chief Medical Officer Health	<b>IEC</b>	: Information Education Communication
<b>CRM</b>	: Common Review Mission	<b>IMNCI</b>	: Integrated Management of Neonatal and Childhood Illnesses
<b>CT-Scan</b>	: Computed Tomography Scan	<b>IMR</b>	: Infant Mortality Rate
<b>DH</b>	: District Hospital	<b>IPD</b>	: In Patient Department
<b>DHAP</b>	: District Health Action Plan	<b>IPHS</b>	: Indian Public Health Standards
<b>DLHS</b>	: District Level Household Survey	<b>IUCD</b>	: Intra-uterine Contraceptive Device
<b>DOTS</b>	: Direct Observation Therapy – Short course	<b>JSSK</b>	: Janani Shishu Suraksha Karyakram
<b>DPM</b>	: District Programme Manager	<b>JSY</b>	: Janani Suraksha Yojana
<b>DPMU</b>	: District Programme Manager Unit	<b>LHV</b>	: Lady Health Visitor
<b>DTC</b>	: District Training Centre	<b>LLIN</b>	: Long Lasting Insecticide Treated Nets
<b>DWCD</b>	: Department Women & Child Development	<b>LR</b>	: Labor Room
<b>EDL</b>	: Essential Drug List	<b>LSAS</b>	: Life Saving Anaesthesia Skills
<b>EmONC</b>	: Emergency Obstetric & Neonatal Care	<b>LT</b>	: Laboratory Technician
<b>EMRI</b>	: Emergency Management and Research Institute	<b>MB</b>	: Multi-bacillary cases
<b>FMG</b>	: Financial Management Group	<b>MCTS</b>	: Mother and Child Tracking System
<b>GNM</b>	: General Nursing Midwife	<b>MDR</b>	: Multi-drug Resistant (TB)
<b>HMIS</b>	: Health Management Information System	<b>MIS</b>	: Management Information System
<b>HMRI</b>	: Health Management & Research Institute	<b>MHW</b>	: Male Health Worker
<b>HR</b>	: Human Resource	<b>MMR</b>	: Maternal Mortality Ratio
<b>HRD</b>	: Human Resource Development	<b>MMU</b>	: Mobile Medical Unit
		<b>MO</b>	: Medical Officer

<b>MoHFW</b>	: Ministry of Health & Family Welfare	<b>PPP</b>	: Public Private Partnership
<b>MOIC</b>	: Medical Officer In-charge	<b>PRI</b>	: Panchayati Raj Institutions
<b>MoU</b>	: Memorandum of Understanding	<b>PWD</b>	: Public Works Department
<b>MPW</b>	: Multi-purpose Worker	<b>RCH</b>	: Reproductive and Child Health
<b>NFHS</b>	: National Family Health Survey	<b>RDK</b>	: Rapid Diagnostic Kit
<b>NGO</b>	: Non-Government Organisation	<b>RHFWTC</b>	: Regional Health & Family Welfare Training Centre
<b>NHSRC</b>	: National Health Systems Resource Centre	<b>RHP</b>	: Rural Health Practitioner
<b>NICU</b>	: Neonatal Intensive Care Unit	<b>RKS</b>	: Rogi Kalyan Samiti
<b>NIHFW</b>	: National Institute of Health & Family Welfare	<b>RKSK</b>	: Rastriya Kishor Swasthya Karyakram
<b>NPCB</b>	: National Programme for Control of Blindness	<b>RMP</b>	: Rural Medical Practitioner
<b>NLEP</b>	: National Leprosy Eradication Programme	<b>RMSCL</b>	: Rajasthan Medical Services Corporation Limited
<b>NRC</b>	: Nutritional Rehabilitation Centre	<b>RSBY</b>	: Rashtriya Swasthya Bima Yojana
<b>NRHM</b>	: National Rural Health Mission	<b>SBA</b>	: Skilled Birth Attendant
<b>NUHM</b>	: National Urban Health Mission	<b>SDH</b>	: Sub Divisional Hospital
<b>NVBDCP</b>	: National Vector Borne Disease Control Programme	<b>SHC</b>	: Sub Health Centre
<b>OPD</b>	: Out Patient Department	<b>SHSRC</b>	: State Health Systems Resource Centre
<b>PCPNDT</b>	: Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex-selection) Act - 1994	<b>SIHFW</b>	: State Institute of Health and Family Welfare
<b>PHC</b>	: Primary Health Centre	<b>SNCU</b>	: Special Newborn Care Unit
<b>PHN</b>	: Public Health Nurse	<b>SPMU</b>	: State Programme Management Unit
<b>PIP</b>	: Programme Implementation Plan	<b>STG</b>	: Standard Treatment Guideline
<b>PMU</b>	: Programme Management Unit	<b>TB</b>	: Tuberculosis
		<b>VHND</b>	: Village Health and Nutrition Day
		<b>VHSNC</b>	: Village Health and Sanitation and Nutrition Committee



## Mandate & Methodology of **14<sup>th</sup> Common Review Mission**

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# Mandate & Methodology of 14<sup>th</sup> Common Review Mission

## Background

The 14th Common Review Mission (CRM) was organized in challenging conditions when the country was recovering after the second wave of COVID-19 pandemic and central and State Governments were making all efforts to prepare for any future challenges along with efforts towards maintaining all public health care services. The CRM was conducted from 11th Nov to 18th Nov, 2021 (in twelve States and one UT), to review the implementation progress of the National Health Mission.

CRM is the most common cited source of information on National Health Mission. As an institution in its own right, CRM not only provides the evaluation information on the National Health Programmes, but also leads to incremental changes and corrective measures at the operational level of the National Health Mission along with providing a platform to States for meaningful interactions.

## Objectives

The fourteenth CRM was conceptualized with a health systems strengthening centric approach in context to challenges and enhanced focussed interventions made during pandemic period and interactions and assessment of service delivery at community and primary level of health care.

Another focus of the CRM was to undertake an assessment of expanded range of services of Comprehensive Primary Health care through HWCs operationalisation and status of NHM and its key strategies and priority areas, analyse strengths and challenges with respect to strengthening health systems and assess interventions/strategies undertaken at state, district/ sub-district, and community level to address equity, accessibility, affordability, and quality of health care services.

Focussing on technical and financial support provided to States and UTs to manage challenges caused by outbreak of pandemic and patient and community-centric care approach, tools/simple checklists were developed to be used during the facility and community interactions to understand the health care seeking pattern of the community and provision of services by the system to cater to the health care needs and the awareness of the community on the pandemic and national health programmes.

## Terms of Reference of the 14th CRM

The terms of reference were designed to capture ground reality faced by public health care system in delivering the services, uptake of new initiatives, strengthening of existing programmes and State specific achievements and good practices taken up to meet the challenges. Information on demographic indicators, relevant Health Managements Information Systems (HMIS) data and district and state health profiles were made available to the CRM teams before the visit.

## Geographical Coverage of 14th CRM

The 14th CRM covered twelve states and one Union Territory. The States were Arunachal Pradesh, Assam, Bihar, Haryana, Karnataka, Mizoram, Odisha, Rajasthan, Sikkim, Tripura, Uttar Pradesh, and West Bengal, and one Union Territory of Puducherry.

## Team Composition

Each State was visited by a team of 14–16 members comprising a mix of the following:

### a. Government Officials

- Officials of the MoHFW, GoI
- Representatives of State Governments (Health Secretary/Mission Director/Director of Health)
- Regional Directors of Health & Family Welfare
- Officers from other Central Ministries and NITI Aayog

### b. Public Health Experts

- Non-official member of Mission Steering Group of NHM
- Non-official member of Empowered Programme Committee of NHM
- Public Health Experts from the 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

including AIIMS and Schools of Public Health

- Non-Governmental Organizations

### c. Representatives of Development Partners

### d. Representatives of Civil Society (from amongst the following)

- Representatives of Advisory Group on Community Action
- Representatives of National ASHA Mentoring Group

### e. Consultants from various divisions of the Ministry

## Method

To conduct review of implementation of NHM programmes by the CRM teams along with critical analysis of secondary data collected at the national level and provided by the state.

Teams were provided background material like CRM Agenda, Terms of Reference, Guidelines, MIS Reports, Factsheets, Survey reports (RHS, SRS, NFHS, HMIS) etc. Other reference material includes specific reports and studies for the state and districts, data collected from the state with respect to the To Rs, and relevant findings from past CRM reports.

The CRM teams receive briefings at the State and districts on progress made by them on all NHM programmes. Subsequently, field visits were conducted for next three to four days.

Facilities visited were DH/ SDH, two CHCs/Block PHCs (HWCs), two PHCs (HWCs), at least two Sub Centres (HWCs).

Interview were held with ASHA, AWW, ANM, VHSNC members and community representatives, including beneficiaries and also interaction with community in two villages.

Focus Group Discussions were held, one with ASHAs; one with community (SC/ST/underserved hamlet / slum) to assess reach and access of health services to these communities and their experiences and one with RKS representatives.

The teams visited an Urban PHC (HWC), Urban CHC, and interview ASHA, MAS members, urban slum community members including beneficiaries, and NUHM teams at the District/City Headquarters.





## Common Review **Mission Findings**

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**TOR 1:**  
**Primary Health Care**

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# Common Review Mission Findings

## TOR 1: Primary Health Care

### Objective to See

- a. Conversion of HWCs and Operationalization of for 12 packages of Comprehensive Primary Health Care Services (CPHC), both in urban & rural areas.
  - i. Planning, prospective vision for construction and maintenance of HWCs.
  - ii. To understand the gap in implementation of RMNCH+A, RBSK, RKSK, SUMAN, NVBDCP, NLEP, NRCP, NTEP, IDSP, NVHCP, NACP, NPCDCS, NPPCD, NPHCE, NPPC, Trauma & Burn Injuries, NPCBVI, NPPCF, NTCP, NIDDCP, NOHP, NMHP, Free Diagnostic Service initiatives, BMMP, MMUs.
  - iii. Ascertain availability of drugs, particularly drugs for chronic conditions, at HWCs; mechanism of issue to stabilised NCD patients so as to maintain continuity of care, including community perception of drug quality and availability. Wherever essential list of medicines for HWC being followed, and also if state list of essential medicines has been revised based on the NLEM for HWC.
  - iv. Linkage with DVDMS or any state specific IT app for indent/procurement management, stock monitoring till HWC level, and quality control.
  - v. **Diagnostics:** Availability, DVDMS / other IT applications for management, Quality control, BMMP.
- b. Community processes - from the perspective of equity & gender.
- c. Health promotion and wellness initiatives.
- d. A review of all IT applications in CP/CPHC - status, utilization, and challenges.
- e. Referral mechanism - linkages to other levels of care.



## Comprehensive Primary Health Care

### National Overview

The National Health Policy, 2017 recommended an important change from 'selective' to 'comprehensive' primary health care package, through establishment of "Health and Wellness Centres". The policy also recommended establishment of these Centres on geographical norms apart from population norms while advocating a 'gate keeping mechanism' at primary level accompanied by an effective referral, feedback and follow up mechanism. The policy called for a commitment of two thirds of the health budget for primary health care.

In February 2018, the Government of India announced that 1,50,000 Health & Wellness Centres (HWCs) would be created by December 2022, by transforming existing Sub Health Centres and Primary Health Centres to deliver Comprehensive Primary Health Care and declared this as one of the two components of Ayushman Bharat. This was the first step in the conversion of policy articulations to a budgetary commitment. These AB-HWCs endeavor to provide comprehensive primary healthcare closer to home with the principle being "time to care" to be no more than 30 minutes.

Over the past three years, states have made efforts to operationalize AB-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, providing Expanded range of medicines and diagnostics, Upgrading infrastructure aligned with newer IT initiatives such as tablets and desktops, use of CPHC – IT and other application, telemedicine/ information technology platforms, Undertaking activities related to health and wellness promotion and Introducing performance linked payments.

The onset of COVID pandemic had slowed the pace of operationalization of AB-HWCs posing several challenges such as posting of Community Health Officers for COVID care, re-routing of funds for COVID management, infrastructural strengthening etc.

Despite the challenges, in FY 20–21, 74,947 AB-HWCs were operationalized exceeding the March 2021 operationalization target of 70,000 AB-HWCs. Up to the initiation of 14th CRM visit in November 2021, about 79,643 AB-HWCs had been operationalized.

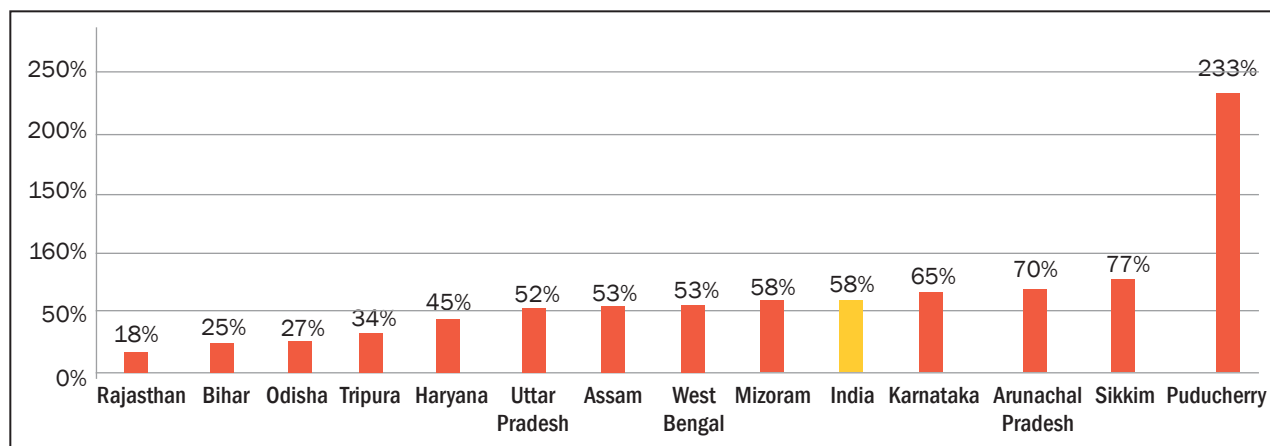
### Key Findings

Conversion of HWCs and Operationalizing for 12<sup>1</sup> packages of Comprehensive Primary Health Care Services (CPHC), both urban & rural areas

### Planning for Operationalizing Health and Wellness Centres

- Of the 13 states visited, all states/ UTs have made significant progress in operationalization of Ayushman Bharat - Health and Wellness Centres to provide Comprehensive Primary Health Care. UT of Puducherry had a target to operationalized 54 AB-HWCs by December 2022 and had already operationalized 126 AB-HWCs by the time of CRM visit which amounts to more than 200% of their December 2022 target. Most of the States/UTs visited rely on the AB-HWC Portal for regular monitoring of HWC.
- An overview of the progress of operationalization of AB-HWCs is shared in the figure 1 below. Nine States and UTs including Rajasthan, Bihar, Odisha, Tripura, Haryana, Uttar Pradesh, Assam, West Bengal, and Mizoram have operationalized less than the National average of 58% AB-HWCs (Status as on 30th November 2021). These states need to prioritize the operationalization of AB-HWCs by ensuring adequate availability of CHOs for SHC-HWCs, infrastructural strengthening supplemented by trained HR, robust drug, and diagnostic supply chains.
- The States have prioritized tribal areas (Karnataka, West Bengal), Aspirational districts (Bihar) and hilly regions (NE States) for upgradation of facilities into Health and Wellness Centres. However, the principle of block saturation was not adhered to in most states. In Bihar, one facility in each block was upgraded as AB-HWC.

<sup>1</sup> The 5/7 packages out of 12 added subsequently would be assessed only on those HWC established for more than 1 year.



**Figure 1: State-wise Status of Operationalized AB-HWCs (Till 30th November 2021)**

- States have prioritized upgradation of rural and urban Primary Health Centres to HWCs to facilitate referral linkages after CHOs have been posted at sub centres. Another reason for prioritizing the PHCs is better infrastructure and requirement of relatively lesser investment in terms of human resources. In some states such as West Bengal, Bihar and Odisha constraints were noted on account of high proportion of vacant positions of MBBS Medical officer at PHCs.

## Infrastructure

- Most of the AB-HWCs visited were functioning in government building, as were prioritized during the initial phase of operationalization.
- Some state specific infrastructural variations were observed. As per the state norms, **West Bengal** had SHC-HWC with well utilized two story structure. The ground floor was dedicated for ANC and other RCH related services and first floor had space for OPD. The first floor also had dedicated laboratory and drug storage space. Some facilities with additional space, had Bangla Sahayata Kendra (BSK) to provide online government service closer to the community.



**Image 1: PHC-HWC Zawlnuam, Mizoram**





**Image 2: AB-HWC Gadhi ka Gaon, District Karauli Set up using a Prefabricated Structure**

- In **Rajasthan** some of the visited AB-HWCs buildings were prefabricated units with limited space for patient waiting area. The prefabricated AB-HWC had one dedicated room for Antenatal Care (ANC) examination. A visited sub-centre in Dargama (Karauli) was in a dilapidated condition and was not suitable for use for delivering the services. It was a potential hazard for the health workers and visitors.
- **Branding:** Most of the Primary Health care facilities visited had branding of AYUSHMAN BHARAT-Health and Wellness Centres. However, a few facilities in Tripura and Mizoram did not have AB-HWC branding. Uniform state specific branding was observed across all transformed HWCs in West Bengal and Odisha. Few facilities in Mizoram and Bihar reported branding on flex banners.
- Well displayed IEC materials in vernacular language were observed across the facilities visited with all priority areas of the population covered. The facilities had displayed citizen charter.
- **Disabled Friendly Infrastructure:** Most of the AB-HWCs lacked disabled friendly infrastructure. Since equity and universal access to services is an underlying principle of NHM and Ayushman Bharat, states need to plan and ensure disabled-friendly infrastructure at AB-HWCs through ramps with railings, specific provisions in toilets etc.



**Image 3: The Dilapidated Sub-centre Dargama in District Karauli**





**Image 4: Yoga Room, APHC-HWC, Simultula, Bihar**

- **Waiting Area:** Almost all the PHC-HWCs and SHC-HWCs had adequately covered and well-ventilated waiting area. Few of the facilities, especially PHCs had arrangements for maintaining physical distancing. Few of the facilities in rural Rajasthan had prefabricated units as HWC with limited availability of patient waiting area. Most of the PHC-HWCs and SHC-HWCs had adequate areas to conduct Laboratory tests.
- **Wellness Area:** The availability of adequate space for conduction of wellness sessions was lacking in most of the visited AB-HWCs. Except for States such as Odisha, Haryana and Puducherry, facilities in most of the States had no area designated for wellness activities. Odisha is establishing multi-utility wing with focus on conducting regular wellness activities across all model 565 AB-HWCs. Few of the PHC-HWCs had herbal garden.
- Despite of presence of wellness room in UPHC in Sachar (Assam), no wellness sessions were conducted in the past year and no documentation was maintained for sessions conducted prior to that. Unavailability of a dedicated Yoga Trainer was a constraint in conduction of regular wellness sessions in Bihar.
- **Electricity Supply:** The availability of electric supply at visited AB-HWCs varied across states. The electricity supply was uninterrupted in Haryana, Puducherry, Bihar,

and West Bengal. Rest all of the States visited had interrupted power supply without backup facility. Issues of electricity supply and internet availability are adversely affecting services. e.g., at APHC - HWC, Mawai in Fatehpur - Refrigerators, autoclave, radiant warmer were not functioning due to lack of electricity. On the other hand, varying alternatives such as use of energy-efficient bulbs (CFL) were reported from Mizoram and solar panels were used at PHC Jhalania in Fatehabad district of Haryana for power back up.

- **Water Supply:** Most of the States had potable drinking water for patients, visitors, and staff at AB-HWCs. However, chlorination or quality testing of water was not observed. In Assam at the PHC-HWC level, well-built rainwater harvesting systems were in place. Running water was not available in many of the facilities in Cachar, where a person was hired to bring a can of water daily to the facility.
- **Separate Toilets:** Almost all the facilities visited had toilet facilities. However, most of the states did not have separate toilet facilities for male and female visitors, except for West Bengal and few scattered facilities viz. HWC Digaon at Jalore, Rajasthan, West Phaileng PHC in **Mizoram** and **UPHC in Cachar**, Assam.
- **Boundary:** The intact boundary was not found in facilities of Assam, Rajasthan (Karauli) and Bihar (Jamui). The state of Assam has resorted to public donation of land for SHC. However, with no boundary wall, the land is getting encroached resulting in poor access to some SHC- HWC. It has also compromised wellness activities at the facility



**Image 5: Separate Toilet for Male and Female at PHC West Phaileng, Mizoram**

## Human Resources

- **Community Health Officers at SHC-HWC:** In all the visited states (except Puducherry), Community Health Officers were mostly from the GNM/B.Sc. Nursing background. States of Tripura and Haryana reported CHOs from BAMS background. States like Uttar Pradesh, Karnataka, Odisha, Rajasthan, and West Bengal have adopted a State Specific CPCH course which is of shorter duration as compared to the six months course run by IGNOU. Odisha and West Bengal are recruiting CHO from the regular cadre of Staff Nurses. In Puducherry, Medical officers are posted in SHC-HWCs as CHOs (mid-level service providers), which has led to the problem of high attrition rate and vacant positions at SC-HWCs.
- **Primary Healthcare Team at AB-HWCs:** Different state-specific models have been innovated and adopted by the states suiting their needs. In Bihar, inadequate HR at HWC-APHC, UPHCs and HSCs was observed. Hence, the state has deployed MBBS Medical Officers and CHOs through a rotational roster of postings to operationalize HWCs.
- In Uttar Pradesh, MO-MBBS at PHC-HWC are deployed from regular service whereas Staff Nurse and Lab technician are appointed through NHM. Due to COVID pandemic, lab technicians were not yet recruited.
- A different model was seen in Tripura which has Urban HWC (SHC) under the UPHC-HWC. These UHWCs (SHC) are functional with a HWC team led by CHO. In Mizoram, sub-center clinics manned by ANM attached to SHC were also reported.

## Training

- As the program is maturing, the states will roll out expanded services in an incremental manner. While the State TOTs on expanded services had been undertaken in most of the states, the pace of training of primary healthcare team members was slow and variable. In Assam, Eye Care training has been rolled out in Namsai district while all the packages have been rolled out for CHOs, MOs

and SNs in Sikkim. Prioritization of training of Medical Officers and CHOs was observed in some states. North-Eastern states such as Sikkim, Mizoram, Arunachal Pradesh, and Assam have rolled out training for many of the expanded service packages.

- West Bengal reported strong implementation of mental health, eye care (Chokher Alo) and elderly care programs at secondary level. However, the service delivery of these programs is not available at primary health care level beyond teleconsultation.
- CRM team interacted with a batch of CHOs under training in District Hospital (DH), Jalore, Rajasthan. Issues like inadequate trainers, lack of resource material and language issues were reported.

## Programme Implementation at Primary Level

- The primary health care facilities visited were largely providing Reproductive, Maternal and Child Health and Communicable disease services including ANC care, immunization, family planning and TB identification and treatment follow-up. The roll-out of newer services such as oral, eye, ENT, elderly, and palliative care had to yet pick up pace.

## Maternal Health

- Pregnancy testing kits (PTKs) were available across the states in both rural and urban areas. ASHAs were aware of PTK methods and advised the women on its use for timely confirmation of pregnancy.
- Strong implementation of PMSMA and VHNDs was observed across the states visited. The community was aware of the need of ANC check-ups and ASHAs were mobilizing the expectant women for timely ANC check-ups.
- However, in Bihar the community awareness on out-reach ANC services was limited and was found to be further disrupted due to COVID-19. Delayed registration of pregnancy, low coverage and poor identification and tracking of HRP was observed in both the visited districts (Jamui and Lakhisarai).

- In some States ASHAs were seen maintaining the line list of pregnant women and high-risk pregnancies. The knowledge of ASHAs on identification of HRPs was found to be nominal. However, in Arunachal Pradesh, Bihar, Mizoram and Rajasthan, line-list of high-risk pregnancies were not being maintained. In Bihar, the identification of high-risk pregnancy (HRP) was low, and SoPs were not in place for the referral and management of identified HRP's. The knowledge among the doctors & nurses on the management of HRPs also needed improvement.
- Few primary care facilities in Assam and Rajasthan reported institutional deliveries at SHC-HWC with trained ANM, CHOs and Staff Nurses undertaking institutional deliveries.
- Most of the facilities practiced respectful maternity care with adequate privacy and provision of birth companion. In some facilities in Assam, there was direct access to the labor room from the waiting area which compromised the privacy of the woman.
- All the facilities had birth dose vaccine available.
- Suman volunteer names were not reported to be visible in any of the primary care facilities. Beneficiaries from Arunachal Pradesh reported expenditure related to institutional deliveries to be between Rs 9000 to Rs 20,000 on account of consultations, USG & other tests, transport, etc.

## Universal Immunization Programme (UIP)

- Across the states visited, the investments and efforts in strengthening UIP had reaped rich dividends. The availability and use of due list and MCP cards was high. The ASHAs and ANMs were aware of the immunization programme.
- The beneficiaries knew the vaccination sites and date of the next vaccination. In Rajasthan, supplementary immunization activities were being carried out to cover the missed out and left out children.

- Utilization of tickler bag was appropriate and ASHAs could explain how they use the tickler bag. The MCP cards were found to be filled regularly.
- The immunization camps were being held regularly. Micro-plan for the same was displayed at the SHC-HWC along with the responsible human resource for the same. FLWs reported some date or venue changes owing to COVID-19 in the micro-plan.
- In Assam it was observed that some SHC-HWCs are delivery points but not a cold chain point resulting in missing zero dose of routine immunization.
- In West Bengal, some of the primary care facilities act as cold chain point. The staff nurses or the in-charges were maintaining the records. All the immunization sites had AEFI record books however some of them were not maintained. No open vials were found being stored for more than 28 days. Staff could explain the procedure of discarding such open vials.

## Child Health

- The knowledge of ASHAs on exclusive breast feeding, demonstration of Kangaroo mother care and danger signs was adequate. The beneficiaries were being educated by the ASHAs regarding the same. Beneficiaries were also aware of initiation of breast feeding within an hour of birth in the states of Assam, Arunachal Pradesh, Odisha, Uttar Pradesh, Tripura, and West Bengal. Regularity of HBNC services was reported in Arunachal Pradesh and West Bengal.

## Family Planning

- Family planning program was in varying degrees of implementation across states. In some of the Northeastern states such as Arunachal Pradesh and Tripura, limited availability of choices of pills and condoms was available; in other visited states, basket of choice approach was available to beneficiaries including the option of injectable contraceptives.

- Despite Mission Parivar Vikas roll-out, some states reported challenges to provide injectable contraceptives till SHC-HWC level. Bihar however has successfully made the injectable contraceptive available till SHC-HWC level. 'Saas Beta Bahu Sammelan' addressing Family planning needs of the community was found to have good visibility and ownership among the service providers and beneficiaries in Uttar Pradesh.
- In Bihar, Community awareness on FP programme was found to be low. Community based counselling and linkage to FP services and choices remain a challenge leading to low awareness and high TFR.
- Barring Arunachal Pradesh and Tripura, FLWs and CHOs in other states were well trained in the 'basket of choice' approach. They could name the approach and explain various choices offered through the approach. CHOs and ANMs are trained in IUCD insertion in Arunachal Pradesh but were not aware of new family planning methods. The community was also aware of various types of contraceptives. PPIUCD was not being done at primary care level.

### Comprehensive Abortion Care

- Abortion services in the form of Medical Methods of Abortion (MMA) were available at PHC-HWC level in states in the form of combi-pack. The service providers – FLWs and CHOs were aware of these methods. Manual Vacuum Aspiration (MVA) and Electric Vacuum Aspiration (EVA) were not observed at primary care level.

## Rashtriya Bal Swasthya Karyakram (RBSK)

- RBSK program was well established in the states. However, due to closure of schools and Anganwadi Centres, the RBSK field activities were reported to be limited. The RBSK MHTs were reported to be well trained and well versed with the screening protocols.

- Tripura reported well organized RBSK activities with efficient Mobile Health teams (MHT).

## Rashtriya Kishore Swasthya Karyakram (RKSK)

- RKSK across the states seems to be limited to menstrual hygiene maintenance, WIFS and occasional AFHC. The awareness about peer educators is limited amongst the beneficiaries. Also, the community-based activities were limited and focused on adolescent girls addressing menstruation.

## Peer Educator Programme (Applicable only for PE

### Implementing Districts)

- Peer educator program was reported from Arunachal Pradesh, Assam, and Rajasthan. The awareness about the program was low across the states. Selection of Peer Educators was completed in Arunachal Pradesh but ASHAs were reported to be unaware about the same. Similarly, in Rajasthan the interaction between peer educators and out of school adolescents was found to be limited.

## Menstrual Hygiene Scheme (Applicable Only for Districts

### Implementing MHS with NHM Funds)

- Menstrual hygiene scheme was observed to be well implemented in Bihar. State has a provision of distribution of Rs. 300 per year which is transferred to girls' account (Class 8th onwards) for purchase of sanitary napkins. However, none of the girls were aware of the money being transferred to the accounts. It was found that the accounts are mostly operated by fathers, which makes it difficult for the girls to ask their fathers for money to buy sanitary napkins. Most of the girls are still using cloth during menstruation with limited knowledge on how to clean and reuse the cloth.



## School Health & Wellness Programme (under AB)

- School health and wellness ambassador program was implemented in Bihar and Haryana. Ayushman Bharat Health and Wellness Ambassadors were identified in schools, but they were not functional due to COVID lockdown in Fatehabad, Haryana. MOs were unaware of Health and Wellness School Ambassadors and there were no coordinated activities in collaboration with the schools.
- Bihar is implementing SHWP in a total of 14 districts with 91 State Resource Group members trained. State has merged the State level Coordination Committee for SHWP with the existing State Level Committee for Adolescent Health.

## National Tuberculosis Elimination Programme

- Bidirectional screening of COVID-19 and TB cases was not observed in the states. Due to COVID-19, many of the states reported decline in TB notification.
- Most of the facilities visited had adequate amount of IEC material regarding TB prevention, control, and diagnosis. TB treatment protocols, medicines boxes, treatment cards etc. were well displayed across facilities.
- In Haryana, TB preventive treatment was not given for 4–6 months due to non-availability of Isoniazid tablets. In Rajasthan, TB treatment cards were found to be incomplete at PHC level in various aspects such as status of HIV testing, family members eligible for preventive INH therapy, etc. In West Bengal, Community members with cured TB cases were hailed as TB champions. Religious leaders, gram sabha etc. are actively involved in the TB programme through FGD and village level meetings.
- Arunachal Pradesh has developed a “State Strategic Plan to eliminate TB by 2025” to reverse the losses due to COVID-19 pandemic

and further intensify the end-TB activities. Facilities are actively using Nikshay Aushadhi and indenting done through Nikshay Aushadhi. Time taken from specimen collection to test results, delivery to the patient and its turnaround time was approximately 24 hours.

## National Leprosy Eradication Programme

- Active Case Search for Leprosy Cases was not conducted in 2021 in many states. However, Sikkim completed Active case finding for Leprosy along with distribution of self-care kit by ASHAs. AB-HWC teams are yet to be trained for community-based activities for leprosy across states.

## National Vector Borne Disease Control Program (NVBDCP)

- State of West Bengal and Haryana are taking intensive efforts for prevention and control of vector borne diseases. West Bengal has engaged Entomologists since 2017 who are actively engaged in entomological surveillance activity in the field like house-to-house visit for vector collection, species identification, larva collection, culture etc. across rural and urban areas.
- Kit based rapid testing was observed at the primary care facilities. All the ASHAs are trained for the slides preparation and track the sources of larvae. Distribution of LLINs and source reduction activities were reported in the states.

## National Rabies Control Program

- Availability of Anti-Rabies vaccine was reported in cold chain points across states. However, the program activities were not distinctly observed at primary level.

## National Programme for Control of Blindness and Visual Impairment

- Only Arunachal Pradesh reported Community Based Eye health activities to address avoidable blindness. Other states have not reported any primary care level activities for eye care.

## National Tobacco Control Programme

- Health facilities had IEC material published regarding cessation of tobacco. No state except Assam reported primary care level activities. However, Assam has trained AB-HWC team for cessation of tobacco use.

## National Viral Hepatitis Control Programme

- In Tripura, few of the health workers at PHC-HWC reported to be vaccinated with 1st dose, however no documentation was found. IEC material for Hepatitis B testing was found in some facilities but was mostly inadequate. Hepatitis B test kits are not available till the PHC-HWC level in Rajasthan. Test kits for Hepatitis C are locally procured and patients are charged at higher rates compared to the cost of procurement in Tripura. All pregnant women are being tested across all the states except Tripura. Treatment for Hepatitis B is not available at PHC-HWC. NVHCP is not being implemented in Bihar.

## National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke

- Community based activities are continued for the NPCDCS program through filling of

CBAC and population-based screenings. West Bengal reported limited rollout of community-based screenings for NCDs.

- SHC-HWCs were seen to be screening individuals for hypertension, diabetes, and oral cancer. As far as Cancer screening was concerned, Cervical cancer screening was not reported at the SHC-HWC, and Breast cancer screenings were found to be limited. Common medicines for hypertension were reported to be available at the SHC-HWC. However, some of the beneficiaries who were on medication for other non-communicable diseases reported incurring out-of-pocket expenditure for purchase of medicines.
- On the 14th of February, 2019, Mamit District, Mizoram, NPCDCS officials along with the MO, went to visit Rulpuihlum Sub-Centre as a part of supportive supervision and awareness generation under NPCDCS. The Medical Officer demonstrated self-examination for Oral and Breast cancers.
- A 74-year Female found some growth after performing self-breast examination at her home. She visited the Sub Centre on 11th March '19, where she was suspected of having lump/cyst on her left breast. She was referred to the higher centre (Civil Hospital, Aizawl) where she was diagnosed with breast



**Image 6: Reaching out to Elderly for NCD Care**

cancer. She was operated on time for the cancer and is now leading a healthy life. ***This incident highlights the importance of self-examination and timely referral which helps in early identification and timely management of cancer.***

### Provision of Expanded Range of Services (Common Ophthalmic & ENT Problems, Oral Health, Elderly & Palliative Care, Emergency Medical Services & Mental Health Ailments)

- The implementation of expanded range of services at primary care is at a nascent stage and is yet to be initiated across the visited states.
- However, in Tripura, Home based palliative care visits were supported by the district program division team. For cancer patients, Regional Cancer Centre (RCC-Agartala) was following up of cancer patients for palliative care services regularly.

### Availability of Drugs and Diagnostics Tests as per the Norms

- **Diagnostics**
  - Availability of diagnostics at AB-HWCs as per the norm was not found in any of the State/UT. 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) (mostly around 7–8 diagnostic tests) were observed at most of the AB-HWCs.
  - At the level of PHCs, point of care diagnostic tests were available in most facilities. Shortage of Lab technicians was reported to be a challenge in providing expanded range of diagnostic services at PHCs in Bihar and Odisha. Posting of Lab

Technician at PHCs was through a PPP model (POCT) in Bihar.

#### ■ Drugs

- Many states such as Odisha, Rajasthan, Bihar have modified their EDLs beyond that issued by MoHFW. For e.g.- Bihar has notified 109 drugs in EDL against MOHFW's National EDL list of 105 and 172 drugs at SHC-HWC and PHC-HWC, respectively. Rajasthan has notified 49 drugs at SHC-level level and 411 drugs at PHC-HWC level. In Bihar, a list of 37 medicines was available at HWC-SHC which are essentially mandated as part of provision of teleconsultation services at SHCs. Around 58 drugs were available at PHC-HWC.
- In Haryana, Drug supply roster is present from warehouse to health facilities and found to be regular in supply to PHC. Definite dates had been allocated to the health establishment to collect drugs from the Central Drug Store. ODISCMS system was the application for procurement and supply of drugs. The Central Drugs Centre followed a transparent system for procurement of drugs.
- In Arunachal Pradesh, limited antihypertensive medications were found at the wellness centre while Mizoram and Sikkim reported unavailability of drugs. This was also reported by beneficiaries from these states where they reported Out of Pocket Expenditure for drugs.

### Bio Medical Waste Management

- Across all the primary health care facilities, BMW management was reported to be poor. There were some delays in picking up the biomedical waste and little compliance to the 2016 guidelines was observed. However, in few of the facilities date of last cleaning of the septic tank was mentioned.







## Community Processes: From the Perspective of Equity and Gender

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# Community Processes: From the Perspective of Equity and Gender

## National Overview

Over the past 15 years, with nearly 9.83 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 interventions of the National Health Mission. At the community level, ASHAs undertake new and complex tasks such as identification and long term follow up of patients with chronic illnesses and newer services, in addition to the ongoing tasks related to RCH and communicable diseases services. Under Ayushman Bharat, ASHAs are a key member of the primary health care team at Health and Wellness Centres and are expected to play a critical role in demand generation, community mobilisation and ensuring continuum of care.

Findings from all thirteen states highlight the instrumental role played by ASHAs at the community level. The field findings 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 are undertaking new tasks at field level, such as community-based risk assessments for NCDs, referrals for NCD screening etc.

However, reports from most states also highlighted gaps in critical programme components that affect functionality of ASHAs such as variable quality of training resulting in poor skill acquisition, inadequate supportive supervision, delays in payments and 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.

## Key Findings

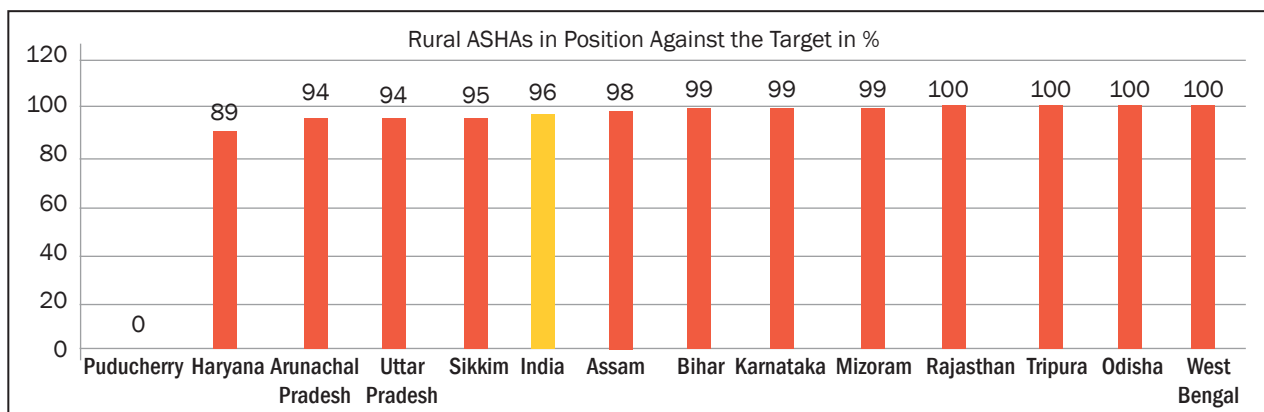
**Functionality of ASHA, VHSNC, MAS AND JAS for their focus on equity, gender, people with disability, sociocultural and environmental determinants of health**

### Selection of ASHAs

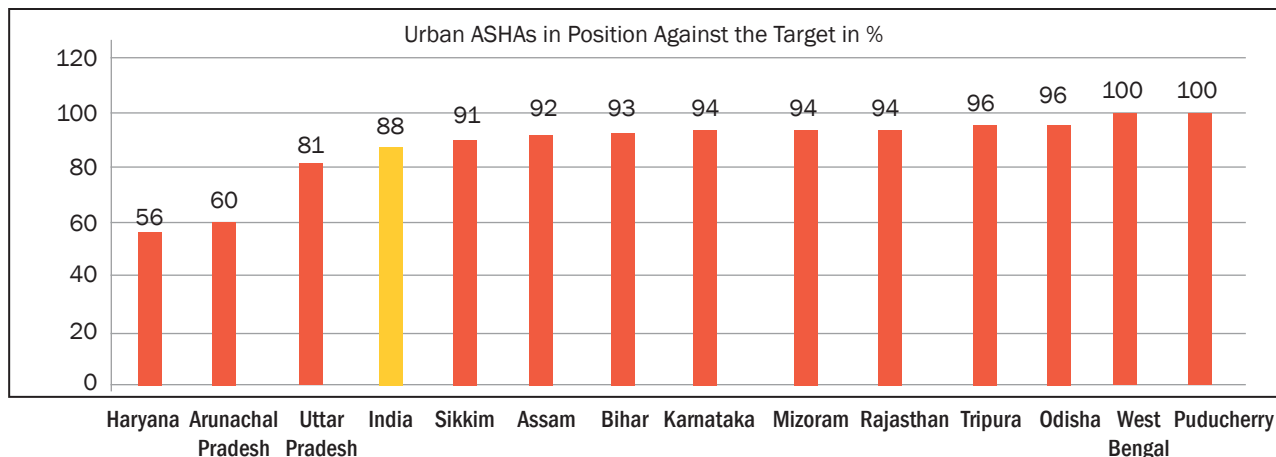
- Most of the states have selected ASHAs against the target requirements. In rural areas, only four States of Haryana, Arunachal Pradesh, Uttar Pradesh, and Sikkim reported less percentage of in-position ASHAs than the national average of 96% (Figure 1). Similarly, three states of Haryana, Arunachal Pradesh and Uttar Pradesh reported less percentage of in-position ASHAs in urban areas than the national achievement of 88% (Figure 2).
- Across all the states visited, ASHAs were found to be pro-active, knowledgeable about the health programs and actively mobilized

community members for seeking health services. The average population catered by ASHAs ranged from 330 in North Eastern states to around 1100 in West Bengal and Assam.

- In the states of Assam, Arunachal, Sikkim, Uttar Pradesh, Bihar & Haryana the selection process was consultative in the presence of VHSNC members, schoolteacher, ASHA facilitator, ANM, AWW in both urban and rural areas. In most states, it was observed that the selection of ASHAs was according to the recommended population norms.
- In Rajasthan, the recruitment process for ASHAs is carried out by the Women and Child Department (WCD) as the State has a different model wherein ASHAs (called ASHA Sahyogini) are posted at Anganwadi centres (AWC) under ICDS. In Haryana, Selection of ASHAs was carried out through Gram Sabha's after nominations from Gram Panchayat &



**Figure 2: Rural ASHAs in Position against the Target in Percentage**



**Figure 3: Urban ASHAs in Position against the Target in Percentage**



ANM and a screening test. In Uttar Pradesh, Triple A- Convergence meetings of ASHAs, ANMs and AWWs are well organized.

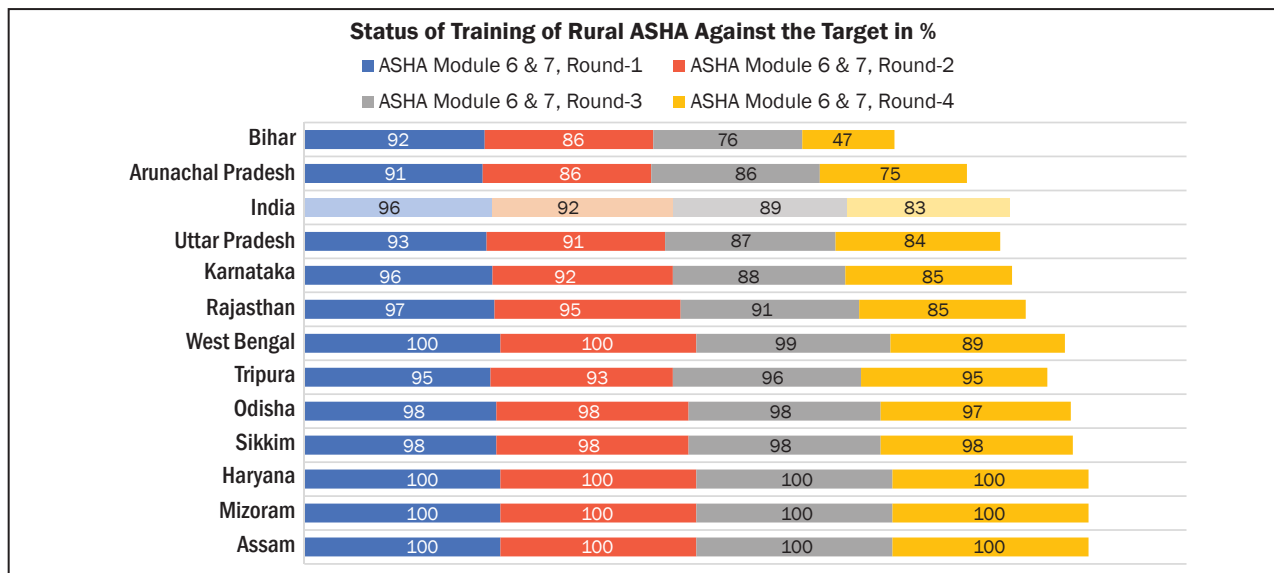
- Community consultation and Panchayat / ULB involvement was reported in ASHA selection in West Bengal (desired as per the fundamental premises of ASHA programme). The health department's control over the ASHA selection process was limited, which led to delays in new ASHA recruitments.

Arunachal Pradesh) out of thirteen visited states reported slower pace of Module 6 and 7 training compared to the National average.

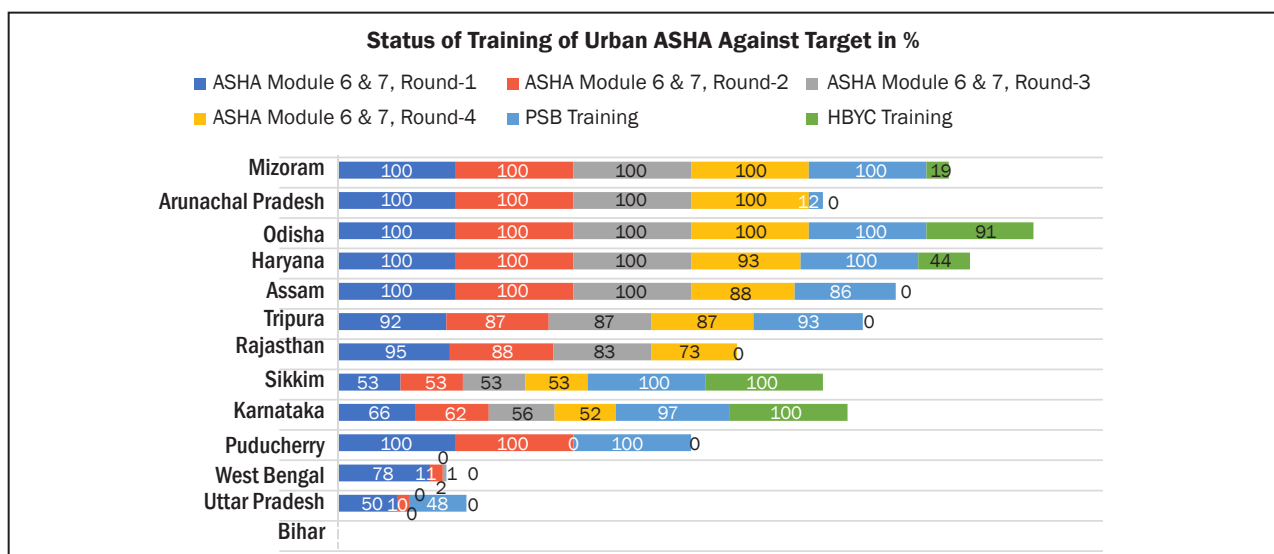
- Training on all modules of HBNC, HBYC, ASHA Modules & NCD have been completed for ASHAs recruited in the states of Assam, Mizoram, and Haryana. In Rajasthan & Haryana, ASHAs struggled to demonstrate the process of CBAC updation adequately. In Rajasthan, HBYC training has not been conducted due to long- pending tenders for provision of refreshment during the trainings.
- Most states have established training teams at state and district level to conduct training

## Training & Capacity Building of ASHA

- Most states have completed the training of ASHAs in Module 6 & 7. Two states (Bihar and



**Figure 4: Status of Training of Rural ASHAs in Module 6&7**



**Figure 5: Training of Urban ASHAs in Various Modules**

of ASHAs on a regular basis. In the state of Bihar, the pool of ASHA trainers has shrunk over last four years which is matter of concern as new trainings such as HBYC and new services under CPHC are already being instituted.

- In Arunachal Pradesh, Assam, Bihar, Haryana, and Uttar Pradesh, ASHAs have been trained in induction module for 8 days, module 6 and 7 in 4 rounds of 5 days each. ASHAs are also trained in HBYC and NCDs. However, training of ASHAs for expanded packages for the delivery of Comprehensive Primary Health Care is pending.

## Support Structure and Supportive Supervision

- Provision has been made for dedicated CP support systems comprising of state and district programme officers in all the States/UT visited. ASHA facilitators are the most important link in the support chain for ASHAs. A dedicated ASHA facilitator (AF) was available in most of the states. Three states and UTs of Sikkim, Puducherry and West Bengal reported a different arrangement. ASHAs in Sikkim and Puducherry were playing the dual role of ASHA and ASHA Facilitator while Health Supervisor at Gram Panchayat level was supporting ASHAs in their work in West Bengal.
- Mizoram, Sikkim, Puducherry, and Odisha do not have dedicated cadre at block level for ASHA program. The existing cadre of BPM is tasked with the responsibility to look after the program.
- Limited capacities of the support structures in providing mentoring support to ASHAs is reported from Assam, Arunachal Pradesh, Rajasthan, Bihar etc.
- In Arunachal Pradesh, most of the ASHA facilitators were selected from freshly graduated ASHAs without adequate experience who found it difficult to function effectively as supervisors.
- In Rajasthan, currently, there is only one PHC supervisor for one Primary Health Centre area, who looks after the work of ASHAs, in

addition to undertaking other data entry, administrative work responsibilities. On an average, one PHC supervisor looks after 40 ASHAs, which is way more than the Nationally recommended norm of 20 ASHAs per ASHA Facilitator, making supportive supervision of ASHAs challenging.

- In West Bengal 2-member team of Program Managers is working as state support team, along with 1 State Nodal Officer. District ASHA Facilitators are in place in all districts. Block ASHA Facilitators (BAF) are in place at block level – with 2 BAFs in each block. There are no ASHA Facilitators in position in the state. The ANMs, play the role of first level of support of ASHAs.
- In Assam, ASHA Supervisor, BCM and DCM were selected as per norms. However, there were few vacant positions of ASHA Supervisor and BCM. One review meeting/ month was held between ASHAs and its support structures. Adequate handholding was being provided to ASHAs by ANM, CHO, ASHA Supervisors/ Facilitators, MOs. Even some VHSNCs provided timely support to ASHAs.
- In Odisha, 717 ASHA Facilitators were functioning for 10 days in a month at sector level (CHC area). State does not have a 'Block Community Mobilisers' position to facilitate the rollout and implementation of Community Process activities, making it difficult to monitor the programme properly.

## ASHA Incentives

- **Monetary Incentives:** There were wide variations in the average ASHA incentives reported across States/UTs. The average monthly incentive earned by ASHAs ranged from Rs. 4500 in West Bengal and Odisha to Rs. 10,200 in Haryana. In addition to the incentives provided under NHM, a number of the states such as Arunachal Pradesh, Sikkim, Bihar, Haryana, Karnataka, Odisha, Rajasthan, Sikkim, Tripura, Uttar Pradesh and West Bengal provided incentives to ASHAs from state funds. Disbursement of Payments linked with PFMS via DBT have become a norm in all states except in few with limited banking services.

- Delays in release of performance-based incentives were noticed in Sikkim and Mizoram. ASHAs had not received the performance-based incentives for the last one year in Puducherry. In the state of West Bengal, disbursement of performance-based incentives was reportedly delayed by up to 4 months.
- Additionally, in Uttar Pradesh, ASHAs were not aware of their incentives other than the routine RCH ones. The incentive claim form and the incentive register list heads were not understood by ASHAs. NCDs sub-head was not noticed in the incentive forms for ASHA. For filling the CBAC forms, inconsistencies in understanding of incentive amount were noticed between rural and urban ASHAs.
- **Non-monetary Incentives: Social Security & Measures:** At present ASHAs and ASHA Facilitators are eligible for three social security schemes namely Pradhan Mantri Jeevan Jyoti Beema Yojna, Pradhan Mantri Suraksha Bima Yojna (PMSBY) and Pradhan Mantri Shram Yogi Maan Dhan Yojna (PMSYMY). Along with them, state specific social security schemes are also in place in many states/UT visited. The subscription to PMJJBY and PMSBY with a premium of Rs. 330/- and 12/- per month is funded through NHM.
- There was limited awareness amongst ASHAs, ASHA Facilitator (AF) and support structures about the three social security schemes in almost all states visited in the 14th CRM.
- The enrolment of ASHAs in these security schemes was unsatisfactory in the states of Sikkim, Assam, Bihar, and Puducherry. In Sikkim, only 4% ASHAs and 2.4% ASHAs were enrolled with Pradhan Mantri Jeevan Jyoti Beema Yojana and PM Suraksha Beema Yojna, respectively. In Puducherry, social security benefits were yet to be provided. ASHAs had been enrolled in only one insurance scheme.
- However, in Karnataka, Rajasthan, and Haryana it was observed that ASHAs were enrolled and covered under various benefit packages and social security schemes and were paid on time.

- Additionally, in the state of Assam, ASHAs were enrolled in Aarogya Nidhi Scheme of the state government.
- A concern was shared by ASHAs in Jalore and adjoining districts on wearing blue colour Sari as uniform as blue colour is considered a colour of mourning and is worn by widows. *This resulted in out casting of ASHAs by their communities as wearing that saree is considered a 'bad omen.'*

## IT Applications for Strengthening Payments

- Many states reported use of IT applications to streamline ASHA payments. Bihar state reported use of ASHWIN portal to streamline ASHA payments and post its implementation, the status of ASHA payments has reportedly improved. The average monthly ASHA payment in the state was Rs. 4300. Most of the ASHAs interacted with, reported having received payments till August 2021. There was a two-step authentication process and some delays were noticed which were to be iteratively addressed.
- In Haryana, simplified ASHA-Pay app was being used to streamline ASHAs payment on-time. The master data sheet with complete information of line listed ASHAs was available for program managers to monitor the progress.
- In Uttar Pradesh, ASHA Sangini App for assessing work of and providing support to ASHAs was found to be performing well in the rural areas in the following ways:
  - a. Decreased turnaround time for data availability for review and discussions at block/district level
  - b. Support in conducting MDR and CDR
  - c. Real time data for remote monitoring and follow up
  - d. Real time data on ASHA performance to help feedback and support
  - e. Enabling quick identity of areas with little or no HRP identification
  - f. Establishing paperless reporting

- Apart from ASHA Sangini application, the state has also introduced e-Kavach App for ASHAs in block Bahua, as a pilot. The App appeared promising. However, ASHAs needed more hand holding and regular support for usage of this App. All the activities done by ASHAs have not been covered under this App yet. The data entry can be done offline, and data syncs on availability of internet connection. The Apps have a mandatory GPS location feature. BCPM-MIS for ASHA payments were also reported in the state.
- **Smartphones:** Availability of Smart phones with ASHAs and ASHA Facilitators was reported in some states namely - Haryana and Arunachal Pradesh. ASHAs used smartphones for record maintenance and mobilization of beneficiaries. Availability of smartphones with ASHA can also be leveraged for digital training of ASHAs. In the state of Haryana, BCM and DCM were also reported to have been provided with smartphones.
- The availability of smartphones also enabled them to stay connected and receive information faster than before, as was reported in Arunachal Pradesh.
- In Tripura, due to lack of internet service providers, healthcare service providers were using mobile hotspot or using their personal mobile phones instead of tablets and totally depended on network connectivity.
- In Rajasthan, ASHAs were using their personal smartphones to enter CBAC data in the NCD app.
- In the state of Sikkim, ASHAs were neither provided with smartphones nor they were getting compensation claims for the use of their own smartphones.

## Safety Measures and Gender

- States like Uttar Pradesh, Haryana, Assam had a structured grievance redressal mechanism in place. A structured grievance redressal committee was not reported from Mizoram, Sikkim, Puducherry, Rajasthan, and West Bengal. ASHAs approached their seniors for grievances in Assam and Rajasthan.

- In Haryana, the grievance redressals at the state and district level were in place. During 2021-22, 13 grievances were received and resolved at the State level. 89% of all the grievances were resolved at the district level.
- In the state of Assam, though grievance redressal mechanism was not in place, most grievances were being resolved through AFs, ANMs and the CHOs from time to time. BCM, DCM, VHSNC members were also involved in facilitating resolution of ASHA's issues pertaining to local disturbances. Main grievances were regarding support required for addressing community issues.
- ASHA Ghars/ restrooms were not found in almost all the states/ UTs visited. Though in Bihar, 190 ASHA Ghars were reported across state, the utilization of ASHA Ghar was found to be limited in facilities due to lack of security and infrastructural issues. The remaining facilities specially in remote areas were devoid of ASHA Ghars.
- Regarding violence and safety measures, ASHAs of Uttar Pradesh complained of the bad behavior of staff when they stayed at facilities.

## Career Progression

- While some states (Karnataka, Rajasthan, and Odisha) had Career progression pathways for ASHAs, the others did not have a mechanism in place.
- In Rajasthan, ASHAs were encouraged to enroll in NIOS for enhancing their educational qualification. Furthermore, 10 percent reservation was earmarked for ASHAs in the ANM course. PHC ASHA supervisors, however, did not receive any social security measures or encouragement for career progression. They were independently selected and were not selected from amongst the ASHAs. Hence, their selection was not in accordance with the GoI norms.

## Performance Monitoring Mechanism

- The 10-indicator grading system for assessing the performance of ASHAs was found to be non-functional in most of the states visited. ASHA Facilitators were also unaware about



## ASHA Anecdotes from the Field from Bihar

Kiran, (not her real name), is part of the million-strong Accredited Social Health Activists better known as ASHAs throughout the country who are the backbone of country's public health system.

Dressed in a bright Pink sari with a blue border, Kiran works with a PHC in Ramgarh Chowk, Lakhisarai, Bihar. CRM team came across her while she accompanied a pregnant woman for delivery to the facility. On interaction, she narrated tales about her work in the community especially those on mobilizing people for COVID vaccination.

One such particular instance was when Kiran, while covering up COVID vaccination drive, came across a family belonging to vulnerable marginalized section of the society, who were hesitant on getting a vaccine, due to myths revolving around the vaccination drive in the village. The head of the household, an old woman in her seventies asked Kiran to leave her house premises, leaving her dejected.

On interaction with the family, she asked for a glass of water from the family members who were often ignored and ostracized by the community. Members of the family were shocked and overwhelmed on this request as caste system is still very prominent in these remote areas. Kiran's request for a glass of water gave confidence to the family that she is making efforts to reach out to them. Soon as Kiran got up to leave, the old woman who was head of the family said "Why are you leaving now? If you can drink a glass of water from my house, can't I take your vaccine now??" which was enough to put a smile on those around. Needless to say, the family members including the old lady accompanied Kiran to get themselves vaccinated. Needless to say, the incidents like these are a testimony to the embeddedness of the ASHAs in the community which empowers them to mobilise community members and link them with health services effectively.

their role in monitoring performance of ASHA on 10 key tasks.

- Currently, performance monitoring indicators to assess the monthly performance of ASHA Supervisor & BCM have not been prescribed by GOI and neither was this done by the states.
- However, in Haryana- State, district, and facility monitoring teams were seen to monitor the ASHAs performance, and transparency was ensured in the ASHAs incentives through the ASHA pay App.

## Village Health Sanitation and Nutrition Committee (VHSNC)

- Across India, approximately 5.5 Lakh VHSNCs have been constituted and 57% of them have been trained on the VHSNC handbook. In most of the states visited, the VHSNCs and RKS committees have been formed as per the guidelines issued by MOHFW.

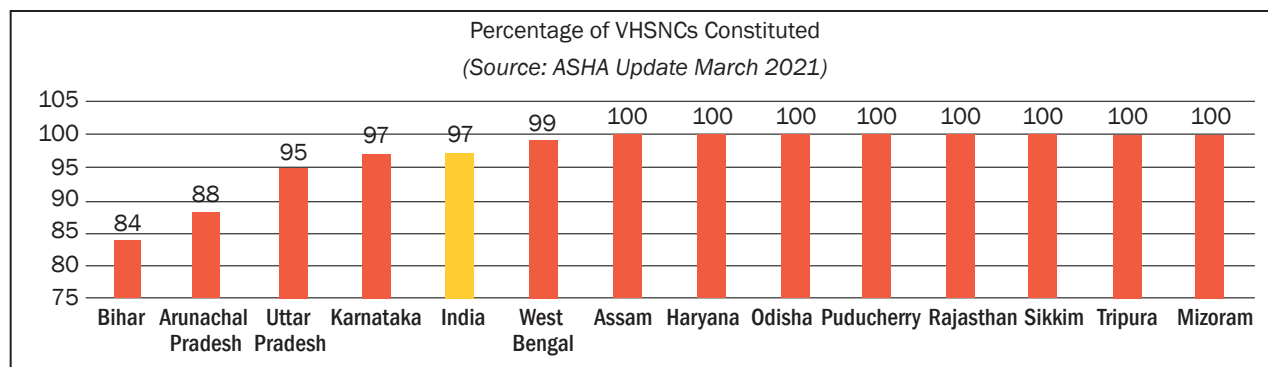


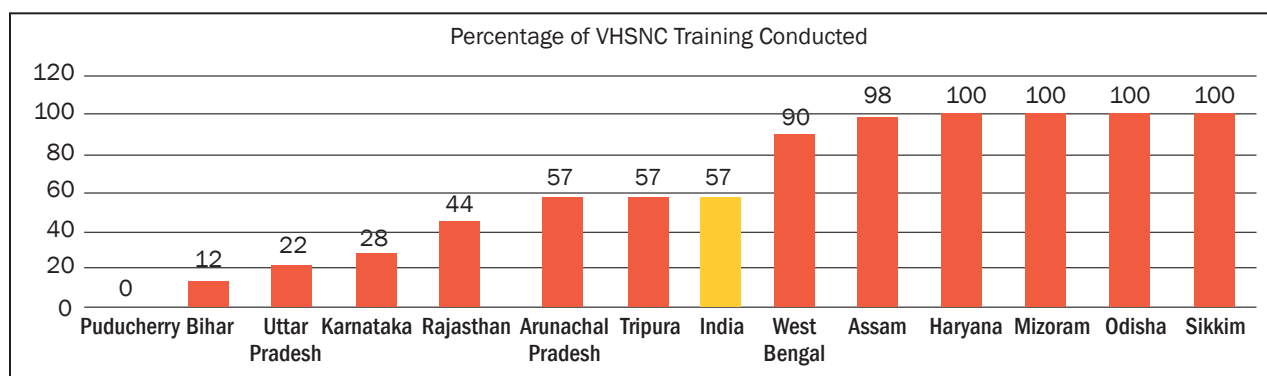
Figure 6: Percentage of VHSNCs Constituted

- Of the 13 states visited, eleven states have constituted VHSNCs at revenue village level except Bihar and West Bengal. Bihar has VHSNCs at Gram Panchayat level and West Bengal reported VHSNC formation at Gram Samsad, which is Booth/ Ward area of GP. Constitution of VHSNCs is near completion in all states except UP, Arunachal Pradesh and Bihar which reported lesser percentage constitution against the national average of 97%. Almost all constituted VHSNCs have bank accounts.
- In Bihar, 7890 VHSNCs still continue to be functional at Gram Panchayat level and 2161 were constituted on revenue village level in two districts of Nawada and Darbhanga for which budget was approved in RoP 2019–20.
- However, the meetings were found to be irregular and meeting minutes were unavailable in some states. This made it difficult to ascertain the output of the meetings and VHSNCs in general.
- In the state of Assam, the CRM team interacted with VHSNC members and learnt that they were aware of their roles and responsibilities and had maintained minutes of the meetings. However, clarity amongst the members regarding national health programs and utilization of untied funds was limited. This was also reflected in other states.
- In the two districts visited in Haryana, VHSNCs were functional in only one district (Fatehabad).



**Image 7: Community Platform Interaction in Odisha**

- **Training of VHSNC members** were completed in only few states like Odisha, Haryana, Mizoram, Assam, Rajasthan where the members were trained for 1-2 days on their role in health promotion, prevention activities and the use of untied funds. The pace of training was seen to be slow. Remaining 7 States/UTs reported much lower training percentage of VHSNC members compared to the National Average (Refer Figure below).
- Most states were in requirement of a refresher training of the VHSNCs. Such limited investment in training of VHSNCs, has translated in low levels of functionality of VHSNCs across almost all visited states. On



**Figure 7: Percentage of VHSNC Training Conducted**

the other hand, in West Bengal, the VHSNCs were well trained and active participation of PRI members was seen.

- Wherever VHSNCs were active, the main agenda topics of the meetings revolved around enhancing quality of care, access to care, and promotion of IEC activities for health, wellness, and improvement of SHC-HWCs catering to their village.
- Regular VHSNC meetings have been reported from states of Odisha, Assam, and Sikkim. Irregular meetings have been reported from states of Arunachal Pradesh, Haryana, Mizoram, Uttar Pradesh, and Bihar.
- **Use of untied funds** was found to be unsatisfactory. It was seen that the VHSNC members were unaware about the appropriate usage of the funds. In the state of Haryana, the untied fund was transferred to Swasthya Kalyan Samitis (SKS) for the current year and SKSs had submitted the utilization certificate (UC) for the previous year. The untied fund was not released to VHSNC since 2014 on account of unspent balance and a problem with submission of the UCs was noted. In the state of Rajasthan, an annual sum of Rs 5000/- was generally used for refreshments, banner preparation, and minor purchases by the VHSNC. The account was being jointly operated by the ASHA and a ward member. Beyond the nominal monthly meeting, participation of VHSNC in health promotion activities was minimal.
- **Village Health Action Plans (VHAP)** were not found in many VHSNCs visited across the states. However, the VHSNCs in Assam were seen to maintain VHAPs.
- **A good example of communitization** was seen in the state of Assam where the VHSNCs were seen to monitor the SHC-HWCs through a checklist. This also involved taking feedback of the community on the services they have availed from the SHC-HWC. Through this monitoring system, a sense of accountability

রোগী - ১	রোগী - ২	স্বাস্থ্যকর করা রোগীর হাতে প্রশংসা
স্বাস্থ্য এবং কল্যাণ কেন্দ্রে আসিত খরচ	১৪৮.৩০	৩০
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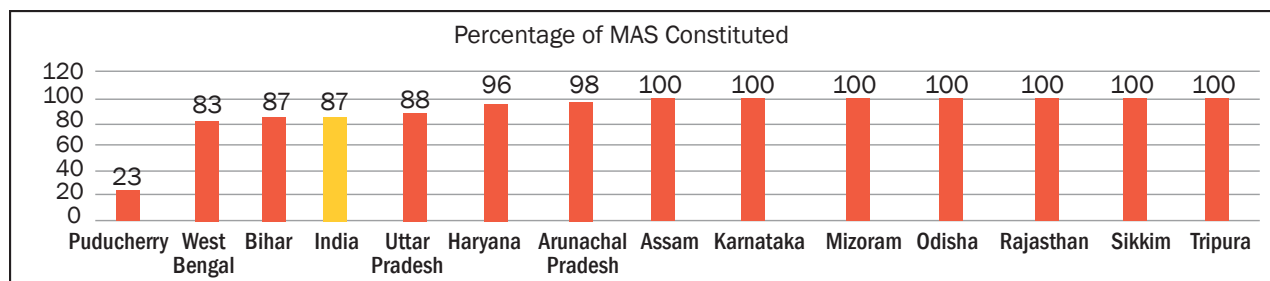
**Image 8: Active AB-HWC Monitoring by VHSNCs, Hailakandi, Assam**

has been instilled in the health functionaries and it also serves as a medium to identify and rectify gaps in service provision. In an instance, it was seen that a VHSNC in Assam had identified and hired a yoga instructor who worked as a tea garden labourer. The turnout for yoga sessions at the SHC-HWC had reportedly improved since the instructor was from the community itself.

## Mahila Arogya Samitis (MAS)

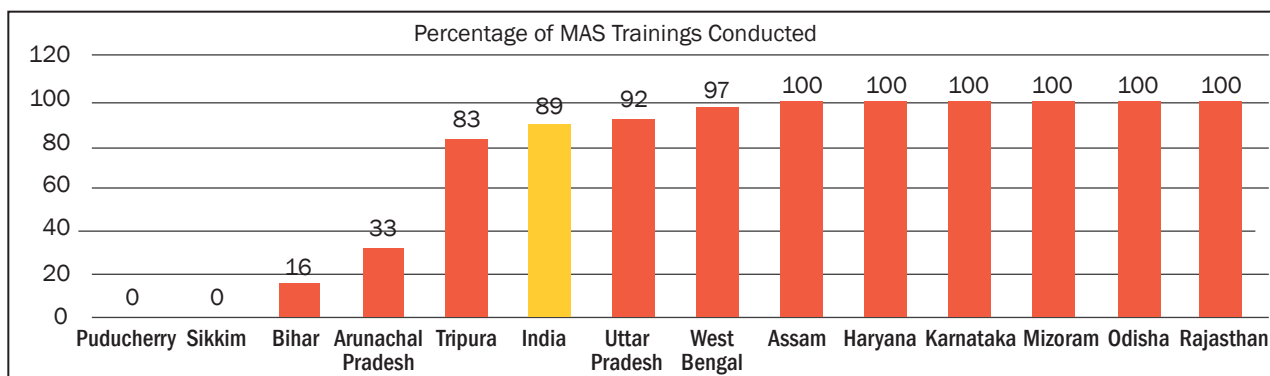
- Across India, 80,238 MAS have been constituted in the urban slum areas and 89% of them have been trained on MAS handbook. Out of 13 states visited, 3 States/UTs (Puducherry, West Bengal, and Bihar) reported less than National average MAS formation.
- In most states visited, absence of Mahila Arogya Samitis (MAS) in urban areas was seen to be a major concern. In the states where MAS has been formed, it was either irregular in their meetings or were inactive. MAS members were not oriented on their roles and responsibilities. However, in the state of Rajasthan, the MAS were seen to conduct meetings on a monthly basis in the Anganwadi Centre. More than 50% of the MAS members of these groups had received trainings.





**Figure 8: Percentage of MAS Constituted**

- **Training of MAS Members:** Around 5 States/UTs reported slower pace of MAS trainings against the National average. The status of MAS training for all 13 states is shown in the graph below:



**Figure 9: Percentage of MAS Trainings Conducted**



**Image 9: MAS with ANM and ASHA, Rajasthan**

- In the state of Rajasthan the members were involved in awareness generation on health issues such as cleanliness and sanitation, maternal and child health, government schemes and community mobilization on COVID-19 vaccination. The meeting records (including attendance and meeting minutes) were maintained for the MAS interactions observed. The NUHM Program Manager frequently attends and supervises the meetings. Themes such as Chiranjeevi

Yojana, COVID-19 vaccination, seasonal infections, NCDs, malnutrition, ANC, PMSMA etc. were discussed over the last three meetings. The meetings were suspended for three months from April to June 2020 due to the lockdown, however, they were resumed during the second COVID-19 wave while following COVID-19 appropriate behavior.

- Similarly, in the state of Uttar Pradesh, MAS members were also seen to support women in getting maternal services, COVID surveys

## MAS Members Interactions in West Bengal

Interaction with MAS members also showed that the members feel empowered because the information and knowledge they acquire from these meetings. Following are some of the excerpts from the interaction with a MAS member in West Bengal.

- *"I am very old, but I like being a part of this group. I think because of them, I am active in the community. Otherwise, I would just be sitting around idle and chewing paan like others..... During COVID-19 times so many people came to me to talk about their nervousness. I was told by ASHA that these are the tough times, so I talked with many of them. They felt better and kept in contact later as well. I am glad I could help them."*
- *"We tell pregnant women and women with children about the regular immunisation. At times when ASHA is doing some other work, she calls me and lets me know if someone needs to be reminded of their immunisation schedule date. Since they know that I am from MAS, they listen to what I say."*
- *"Yes, we do see some young pregnant women (referring to teenage pregnancy). I make sure that I talk to adolescent girls about their health. I ask them to continue their education, get jobs and delay their marriage a bit."*
- *"I am childless, but I understand the importance of immunisation. I have also seen ASHA mobilising others for their child's immunisation. So, I also do the same as a MAS member for people living around me."*

etc. Monthly meetings are fixed, and regular discussions were seen to be focused on topical issues and programmes. The minutes of meetings were maintained in a separately designated register by the ASHA and the utilization of untied funds was seen to be recorded in the same register.

- Across the states visited, the untied fund is generally, spent on logistical purchases such as *dari*, weighing machine, banner, water filter, glasses, chairs, cleanliness of the Anganwadi premises etc.
- The state of Odisha has developed an innovative system of grading of MAS on 10 measurable indicators, based on which they are marked Red, Yellow, and Green, and corrective action is undertaken accordingly.

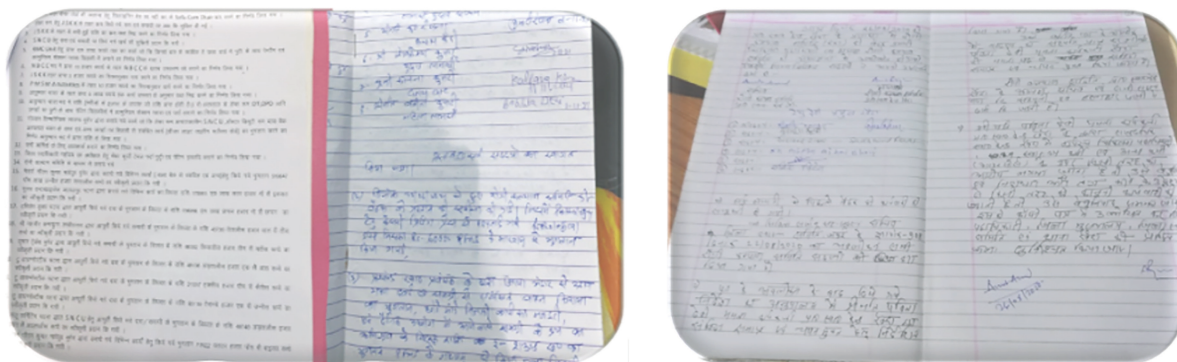
## Village Health Nutrition Days/ Urban Health Nutrition Days (VHND/UHND)

Across all states, VHNDs and UHNDs were being conducted in the outreach for delivering ANC and immunization services. In most states, the

involvement of PRIs in VHNDs was limited. However, minimal engagement or dialogue with the community for organizing these services at village level was seen.

## Rogi Kalyan Samiti/ Jan Arogya Samiti-PHC

- Rogi Kalyan Samities (RKS) were established under the National Health Mission (NHM) in health care facilities at the level of the PHC and above. The RKS were seen as a mechanism for promoting active public participation in health with the principle of decentralization and devolution of administrative and financial powers.
- With the launch of Ayushman Bharat, Primary Health Centres are also being upgraded as Health and Wellness Centres throughout the country. The scope of services and responsibilities at Primary health Centre have also increased. Considering upgradation and increase in scope, Rogi Kalyan Samiti at PHC has been reformed as Jan Arogya Samiti- PHC (JAS-PHC). However, it was observed that RKS at PHC still continue functioning as RKS.



**Image 10: Minutes of the RKS Meeting held on 26.08.2020 at CHC Khaira, Jamui, Bihar**

- In the 14th CRM, Rogi Kalyan Samitis/ Jan Arogya Samiti-PHC (JAS-PHC) were formed in all the visited States. However limited understanding about the objectives, significance of JAS, training and role of RKS/ JAS was observed which is evident from the low level of participation of RKS members.
- The minutes of the RKS meetings were maintained in Bihar, Haryana, Mizoram, UP, Karnataka, Sikkim, and Tripura. However, the frequency of the meetings was found to be irregular. In Puducherry, Jan Arogya Samiti (JAS) were either inactive or were not constituted specially in Karaikal District.
- In Karnataka, all PHC facilities and taluk hospitals had a Rogi Kalyan Samiti (RKS) or Arogya Raksha Samiti with adequate representation of CMO, assistant commissioner, and elected body as well as religious minorities. RKS meetings were held regularly at every 6 months and record keeping like agenda, minutes of meetings and other proceedings were properly maintained.
- RKS funds have been utilized mainly for extension of cold chain room, maintaining cleanliness of the PHC-HWC campus, rainwater harvesting system as well as providing support in outreach activities in the communities, for infrastructural strengthening, repairs, purchase of drugs, constructing toilets within the premise of PHC in Rajasthan for OPD patients along with rainwater harvesting pits, purchase of medicines and consumables although the criteria was different across states.
- Representation from females, PRI, and other departments (Education, ICDS, PHED etc.)

was poor in the RKS committees in Bihar. In Arunachal Pradesh, mobilization of funds by RKS was not reported in visited districts.

- In Odisha, good coordination with Panchayat, SHGs and ICDS dept including ASHAs, ANMs – was observed in Gaon Kalyan Samiti (GKS).
- In UP, unplanned RKS funds utilization was found at some visited facilities. RKS fund utilization at UPHC was done without an accountant, by the CMO office as per the decisions taken in RKS meetings. There were some governance issues with RKS such as renewals being done 4 years after expiry.

## Jan Arogya Samitis– SHC-HWC

- Since 2020, under Ayushman Bharat, the SHC level AB-HWCs, are provided Rs. 50,000 as untied fund, enhancing the amount from Rs. 20,000 that is provided to all SHCs. This untied fund is expected to be used primarily for supporting the essential requirements for AB-HWC. A new committee called Jan Arogya Samiti is to be formed at the SHC-HWC, PHC-HWC and UPHC-HWC.
- All the visited states JAS at SHC level were at a very nascent stage. In most of the states, the state specific guidelines and orders were in the process of being issued. Hence, JAS at SHC-HWC were not formed.
- JAS-SHCs has been constituted in all the visited facilities of Odisha. However, the JAS members had to be trained on objectives of JAS, their roles, and responsibilities.



- One day state level orientation on JAS has been completed for HWCs across the districts in Tripura

## Community Action for Health

- Intersectoral coordination with other departments was not observed in most of the visited States.
- In Rajasthan, Intersectoral coordination with other departments was not observed in both districts. Interactions with the Sarpanch of 'Gadhi ka Gaon' informed the Karauli Team on the pervasive gender inequality. The female Sarpanch was not taking part in any PRI activities except where her signatory powers were required. Instead, her husband would take part in the planning, execution, and monitoring activities. She also did not have any knowledge of the new XV-FC initiatives or in fact, any activities in the health sector.
- In Cachar district of Assam, DCM and BCM attended CAH district level training of trainers' program. Block level ToT was also organized at the district level. However, no order or instructions had followed these trainings resulting in unsatisfactory performance.
- ULBs in Tripura helped during COVID, however unaware of fifteenth finance commission grants and their role.

## Best Practices

- In Karnataka, Coordination with WCD was observed to implement 'Arogya Nandana

Abhiyaana' for screening of Anganwadi, in-school and out-school children for COVID-19.

- Good coordination and convergence with Panchayati Raj Institutions/Urban Local Bodies- The DM and CEO of Davanagere took lead in getting the COVID vaccine and visited various colonies and villages to mobilize people to get vaccinated leading to good awareness and coverage of COVID vaccination.

## Health Promotion and Wellness Initiatives

- In most of the states visited, wellness activities at AB-HWCs were not regularly conducted and facilities did not have adequate space for conducting wellness sessions (Arunachal Pradesh, Assam, Bihar, Karnataka, Mizoram, Tripura, and Rajasthan).
- There was limited focus on annual health calendar days in all the states. In some states such as Bihar, Odisha and Mizoram, a wellness calendar was displayed at the facility. In Assam and Puducherry, primary health care teams were found to be highly motivated to conduct wellness sessions on their own.
- Linkages with R.K Ashram in conducting wellness activities was observed in Cachar district of Assam. Facilities visited in district Puducherry had regular annual health calendar days with proper documentation. However same was not observed in Kariakal district of Puducherry. In Odisha, wellness calendar days were followed in all facilities visited. The SHC-HWC had eat right toolkit.



Image 11: Eat Right Toolkit and Wellness Calendar at SHC-HWC in Mizoram



## IT Applications in CP/CPHC - Status, Utilization, and Challenges

- IT equipment with internet facility and trained primary healthcare staff for data reporting on IT-Based applications was observed in all the states visited during CRM. But data updation and utilization by primary healthcare team members and program managers for regular monitoring and undertaking course corrections were lacking.
- Daily report and monthly service delivery was regularly reported in the AB-HWC portal in all the states visited during CRM.
- The data entry into the GOI Portals such as AB-HWC Portal, CPHC-NCD App, RCH/ ANMOL portal, e-Sanjeevani was irregular and inadequate in Bihar.
- The utilization of CPHC-NCD application was found to be very limited in all the states in terms of creating Health-IDs and data entry of NCD screened individuals.
- A great initiative by MO, Bungzong PHC (Mizoram) on managing facility data was observed. MO had designed customized data-sheets on MS excel for auto-computing and reporting OPD, high risk pregnancy and immunization numbers. The MO had trained the Staff Nurse in using the system-based OPD sheet, mitigating the need for maintaining physical registers for OPD.
- West Bengal has adopted state specific robust portal called MatriMaa for tracking of Eligible Couples, Pregnant Women and Children instead of RCH portal. Service providers upload their SC/UPHC data or due list through the designed SC's Tablet or from any Android Mobile Phone.
- Most SHC-HWCs visited had one functional tablet/desktop (with CHO and ANM in Bihar, ANMOL tablet with ANM in Arunachal Pradesh, with ANM in West Bengal).
- Internet connectivity was observed as the major issue in North Eastern states of Arunachal Pradesh, Mizoram, Assam, and Tripura.

## Continuum of Care: Teleconsultation Services and Upward and Downward Referral Mechanism

- Teleconsultation services were used optimally for upward referral. However, downward referral and follow-ups by primary healthcare team was found to be lacking in all the states. Erratic Internet connectivity was observed as the major issue in North East states of Arunachal Pradesh, Mizoram, Assam, and Tripura.
- Hub and spoke model were adopted in all states/UTs except Puducherry. In West Bengal, State specific teleconsultation portal "Swasthya Ingit" had been rolled out since August 2021 - 1st Phase included 113 spoke and 4 sub divisional hospitals as Hubs which were fully functional and provided tele-consultation services. In Odisha tele-consultation services were available at the level of AB-HWC-PHC and UPHCs. The State had adopted the e-Sanjeevani HWC model for Teleconsultation. In Arunachal Pradesh, CHOs at HWCs had e-Sanjeevani application but were unable to use it due to audio and video connectivity issues during teleconsultation.



**Image 12: Teleconsultation being Undertaken by CHO in West Bengal**

- Hub for teleconsultation had not been identified in Puducherry. Teleconsultation was not adopted due to lack of training though infrastructure in most of the facilities was set up.
- It was observed that telemedicine services were utilized primarily for routine illnesses and a potential challenge of overloading of the hubs was felt by the teams.
- Mechanism of Upward & Downward referral from AB-HWCs were displayed in all facilities of Assam for only NCD and basic obstetric complications.
- While in Bihar, the visited facilities did not have any mechanism for forward and backward referrals. Diabetic and hypertensive patients detected at district hospital were not intimated at respective SHC-HWCs.
- The north-eastern States like Arunachal Pradesh, Mizoram, Sikkim, and Tripura also reported using WhatsApp calls for teleconsultation. A good connect between the specialist at DH and the patient was seen in the Mamit district of Mizoram.

## UPHC-HWCs

- In all the states visited, the UPHCs are being converted into Health and Wellness Centres (UPHC-HWCs) in order to deliver comprehensive primary healthcare.
- Bihar had well-established and operational Urban Healthcare Facilities (104) in terms of infrastructure and made marked progress in completion of GIS and vulnerability mapping. It had also converted approx. 89% of its Urban Primary Health Centres into Health and Wellness Centres.
- In Assam, despite the presence of wellness rooms in UPHCs, no wellness sessions were conducted in the past year and no documentation was maintained
- In West Tripura, the urban areas were visited, and it was observed that the primary

healthcare infrastructure is further stratified to include an SHC-HWC under UPHC-HWC (in Dhaleswar), which is unique to Tripura. The Urban HWC (SHC) is the first port of call with a dedicated full-time CHO. A designated place for breast self-examination along with pictorial IEC for early screening of breast cancer was observed at the HWC. This place was in plan to upgrade the UPHC to UPHC-HWC.

## Performance Linked Payments

- Performance based incentives were being provided to CHOs in all the states. Softwares were being used in States like West Bengal (Susasthya Kendra Information Management System), Assam (Swasthya Seva Darpan) and Arunachal Pradesh for calculation of incentives. Team based incentives were also being given in Karnataka, West Bengal, Puducherry, Tripura, and Odisha.
- Backlog in payments related of Performance Linked Payment/Team Based Incentives was observed in Assam, Puducherry, West Bengal.

## Program Support and Monitoring – Adoption by Medical College, Developmental Partners

- Adoption by Medical College has been initiated in some states like Odisha and Bihar. In Tripura and Assam, Medical Colleges are in the process of adoption of AB-HWCs.
- Almost all the States rely on AB-HWC portal data for their regular Programmatic review. In Karnataka, program support and monitoring are done through multi stakeholder district level committee under CEO-ZP, Taluk level committee under THO in support with TILC-PHFI.
- Jhpiego through USAID-NISHTHA is providing technical support in operationalizing AB-HWCs in North-Eastern States, Uttar Pradesh, Odisha, and Bihar. Support for rolling out IT-NCD services is being provided by Tata Trust.

## Recommendations

### Overall Planning and Operationalization of AB-HWCs

- States which are lagging behind in their operationalization targets for FY 21–22, need to expedite timely operationalization of AB-HWCs by ensuring adequate availability of CHOs for SHC-HWCs, infrastructural strengthening supplemented by trained HR, robust drug, and diagnostic supply chains. Additional funds under Fifteenth Finance Commission and PMABHIM should be leveraged for strengthening primary healthcare.
- States which have achieved their targets for FY 21–22 should plan for upgradation of all public health facilities as per RHS 2019–20.
- Conforming to the overall principles of equity, states to prioritise upgradation of facilities in tribal and aspirational districts with block saturation approach for provision of primary health services.

### Strengthening Infrastructure

- Augmenting infrastructure of facilities using different funding sources.
- Adequate area for Wellness should be identified in all the AB-HWCs
- Provision of uninterrupted electricity supply to be made at all the facilities
- There should be provision of separate functional toilets for male and females at the facility
- The facilities should have disabled friendly infrastructure
- Privacy needs to be ensured in the OPD area for examination of patients

### Human Resources (Community Health Officer)

- Availability of CHO to be ensured through timely enrollment of candidates for CPCH course, regular monitoring, advertisement, and recruitment of CHOs at AB-HWCs.

- Moreover, states may adopt the shorter CPCH course through an accredited body adhering to the norms of CPCH Task Force and obtain due approvals.

### Primary Care Strengthening of Various Programs

#### RMNCAH+N

- Line listing, follow-up, and management of High-Risk Pregnancies has to be strengthened. Orientation of all the personnel concerned including MO, SN, ANM, MPW, ASHAs and Program Managers needs to be done.
- Basket of choice approach needs to be reinforced in the states supplemented with adequate availability of injectable and newer contraceptives till SHC-HWC level.
- Male sterilization can be focused with community awareness for NSV through adequate trainings of FLWs and sensitization of community.
- States need to plan for Refresher trainings for AB-HWC team for IUCD insertions.
- Extensive IEC campaign for JSSK and JSY should be planned through AB-HWCs to address lack of awareness on entitlements for the beneficiaries.
- RBSK MHT visits need to be initiated across the states with refresher trainings.
- Community based activities may be planned and chalked out for RKSK program to increase demand for AFHCs.
- Refresher training or revamping of peer educator initiative through AB-HWC can be planned.
- School Health and Wellness program to be strengthened by augmenting coordination among the different departments.

#### Communicable Diseases

- Revamping the NTEP and NLEP notifications through mission mode active case finding shall help overcome the effect of COVID-19 pandemic.
- States to ensure vaccination of all health workers against Hepatitis B.

## Non-Communicable Diseases

- Expanded service training need to be expedited for ensuring community-based activities and effective health promotion approach in the program.
- Chalking out community-based activities for all expanded package services through AB-HWC team at the local level to address local disease burden can be undertaken by the states.
- Refresher training on all National Health Programs for AB-HWC team needs to be undertaken.
- Availability of essential medicines should be prioritized in the states.
- Continuum of care and follow up of beneficiaries at community level to be ensured for NCDs.

## Recommendations for Community Processes

- Strengthening of ASHA training and support structures to be done.
- ASHA payments should be further strengthened through regular monitoring and IT application use. ASHAs should be made aware about the different activities against which they receive incentives.
- ASHA grievance redressal mechanisms and ASHA Ghars should be strengthened.
- States to focus on enrolment of ASHAs in social security schemes under ASHA benefit package and also on making ASHAs aware about these schemes.
- Expediting constitution and training of different community platforms such as VHSNC, MAS, JAS and RKS. A strong monitoring and supporting mechanism to be institutionalised across states.
- **Community stakeholder engagement needs to be strengthened** if the uptake of services delivered through the Government public health care delivery system is to be further improved. Community should be empowered through continuous dialogue and engagement in planning and delivery of the health services at the village and facility level.

- Provision and **optimal utilization of Untied Funds** and constitution of Jan Arogya Samitis (JAS at SC/PHC-HWC) with proper representation from PRI members needs to be ensured.
- Taking precedence of the Corona Core committees in some states, **intersectoral action should be catalysed** at the village level for other health related activities.

## Recommendations for Wellness and Health Promotion Activities

- Streamlining wellness activities at AB-HWC facilities by recruitment of Yoga instructors as per norms and training of CHOs and Staff nurses for wellness counselling.
- Monitoring and reporting of Wellness activities in AB-HWC portal.
- Focus on celebration of 39 Annual Health Calendar days with active community participation.
- Initiation of School Health and Wellness Ambassador initiative as per guideline.
- Define coordination mechanism between AB-HWC team and school health ambassadors in health promotion activities.
- Engagement of the Department of AYUSH, Youth Affairs and Sports for regularizing wellness activities.

## Recommendations for IT Application

- Strengthening use of IT applications like AB-HWC portal, CPHC-NCD app, RCH portal, etc. at local level to support service providers in decision making and facilitating continuum of care across levels.
- Most of the program applications such as AB-HWC portal, CPHC-NCD portal, RCH portal have dashboards for program managers to enable regular monitoring and data use for decision making. Therefore, regular review of data reported in IT applications should be done by program managers and during monthly meetings for programmatic improvements.



## Recommendations for Continuum of Care

- The coordinated and concerted care between community, primary and secondary healthcare must be strengthened. Recording and reporting mechanisms must be set and monitored regularly to reduce dropouts and loss to follow-ups, especially the downward referrals back to community. Currently, even HRP tracking showed variations across states. The tracking of chronic care patients for TB, Diabetes, hypertension, cancers must be strengthened as these contribute the most to the morbidity and mortality burden.
- The primary health care team needs to be oriented towards continuum of care for every service. Medical Officers especially needs to be trained to facilitate downward referral to the CHOs. This must be reinforced in regular meetings at each level.

## State Findings

### Arunachal Pradesh

- State has operationalised 204 AB-HWCs against the target of 234 for FY 2021–22. As part of 14th Common Review Mission, four SHCs (two in Namsai and two in Lower Subansiri) were visited, out of which three were HWCs and one was not converted to AB-HWC yet. Health and Wellness Officers (CHOs) are appointed at the HWCs.
- In terms of infrastructure, the centres were neat and well maintained. However, areas like Wellness Room, waiting room, separate toilets were not available.
- Services were mostly limited to RMNCHA in both districts. In Lower Subansiri services were being provided for NCD screening and NVBCDCP screening. Expanded set of services are yet to be operationalized in both the districts.
- Family Planning Service delivery is limited to Mala N, Condoms and Ezy Pills at most facilities. Some CHOs and ANMs are trained for IUCD insertion but not in PPIUCD and Injectable MPA.
- Essential supplements such as Calcium tablets, IFA and Folic acid were not available in most health facilities; beneficiaries were advised to purchase them from medical shops. HRP tracking was found to be weak.
- Few of the beneficiaries who were receiving incentives, were receiving it through Cash and not DBT due to non-availability of bank accounts. State has launched MAMTA Program for promoting Institutional Deliveries.
- Cold chain equipment was present and found to be functional in all PHCs and cold chain points visited. Temperature records were maintained for both ILR and Deep freezer in the facilities visited. However, power back-up was not available in most of the facilities. Majority of the facilities did not keep a record of AEFI and at many places AEFI register did not have minor AEFIs recorded. ASHAs were aware of incentives provided for full immunization but delay in disbursement of incentives since many months was reported.
- Lack of uniform reporting and recording of Immunization data was seen. Multiple records of Immunization were kept by the health workers (even 4–5 registers at some of the facilities- ASHA diary, EPI register, Integrated RCH register and RCH – Immunization register). Shortage of Vitamin A was observed at some facilities. Display of Immunisation IEC was found erratic at many facilities.
- Labor rooms at all the visited facilities were found to be clean and infection control practices were practised. Partographs were largely not used to monitor progress of labor. Maternal deaths have not been reported in the districts in the last one-year.
- Despite availability of functional radiant warmers, they weren't being used as the Staff nurses and ANMs were not trained in NSSK. Equipment for Neonatal resuscitation was available like Ambu bag and mucus extractor in most facilities.
- Most of the ASHAs and ANMs were aware about HBNC visits schedule and breastfeeding practices. Postnatal mothers were aware of the six months exclusive breastfeeding

period. IEC on breastfeeding and colostrum feeding were displayed at some of the health facilities.

- Under Rashtriya Bal Swasthya Karyakram (RBSK) - One team is available at the district level with two AYUSH doctors, one ophthalmic assistant, one pharmacist and one ANM. There is no system for follow-up of children except for some of the conditions requiring surgery. No equipment was available for ophthalmic assessments in some of the facilities, although one Ophthalmic Assistant is part of the team.
- Though Rashtriya Kishor Swasthya KaryaKram (RKSK) was launched two years ago but the implementation of Adolescent health program was largely missing in all facilities. The commodities like Sanitary napkins, Blue IFA tablets have not been supplied by the district. Selection of peer educators have been completed in all villages and they have been trained by district level educators but ASHAs were not aware about the training offered to peer educators resulting in poor convergence for implementing RKSK program. In Namsai district, ASHAs have not been trained under RKSK and are not engaged in the community processes under RKSK.
- There is currently a delay in the provision of DBT benefits to TB patients in the state. The state has developed a “State Strategic Plan to eliminate TB by 2025” to reverse the losses due to COVID-19 pandemic and further intensify the end-TB activities. Facilities are actively using Nikshay Aushadhi and indenting done through Nikshay Aushadhi. Time taken from specimen collection to test results, delivery to the patient and its turnaround time was approximately 24 hours.
- Despite the state achieving elimination of Leprosy in 2004–05, the grade II disability cases are seen among newly detected leprosy cases. Multi-drug is available at district facilities. Availability of SSS test besides availability of MDT drugs, steroids, clofazimine, MCR footwear and self-care kits was seen. Backlog of cases requiring reconstructive surgery and ulcer management was observed.
- Long-lasting insecticidal nets (LLINs) are being distributed regularly and usage of bed-nets have increased over the years. This is complemented by IEC for vector control and source reduction.
- Out of all Non-Communicable Diseases (NCD) programmes, NPCDCS, NTCP and NOHP are implemented effectively in the State. NCD screening for oral and cervical cancers, diabetes mellitus & hypertension is being done and records are maintained. Limited antihypertensive medications were found at the wellness centre. Community Based Eye health activities are undertaken to reduce avoidable blindness.
- Community awareness on assured services (such as free ante-natal and intra-natal services), and knowledge of anemia, newborn danger signs, management of low birth weight babies etc. was limited.
- Though MCP cards were available, growth monitoring details of children were missing. Also, the lack of growth monitoring can be attributed to the fact that none of the ASHAs had weighing machine, MUAC tape, measuring tape etc. for monitoring.
- State has all ASHAs in position (4040) against the target. Induction training for 206 ASHAs, which was a state target for year 2021–22 has been achieved. The work of ASHAs in visited districts were seen to be limited to RMNCH related tasks. There were issues during the initial selection of some of the ASHA as observed during field interaction. Some of the ASHAs selected earlier did not have any formal schooling, some others had less than 8 years of schooling. In Namsai, a replacement strategy was developed for those who were not performing well and over the last 2–3 years, 10 ASHAs have been replaced by new ASHAs.
- The state has achieved more than 90% selection and training of ASHAs up to three rounds of Module 6 and 7. It was found that due to low incentives received by the ASHAs (around 1–1500 per month) drop-out rates are very high (around 20%). ASHA and ASHA facilitators have not received incentives/



honorarium for the last 5–8 months including that for COVID related activities.

- Additional incentives were given to ASHAs from State fund in ASHA TOP UP scheme, under which performance linked incentive is provided to ASHAs in addition to honorarium of Rs. 2000. Ten parameters are defined to decide eligibility for the incentive based on monthly performance monitoring.
- ASHAs (in East Siang) were not provided the basic ASHA kit. ASHA support structures at the block level and below were found to be weak.
- The VHSNCs and RKS committees have been formed as per the guidelines issued by the Govt. of India. However, minutes of meetings were not available in visited areas. Due to this, output of the meetings could not be ascertained. Based on interaction with ASHA it was known that the VHSNCs were engaged by health functionaries for improving coverage with COVID vaccination in most of the villages. However, their participation in other health promotion and wellness initiatives is limited.
- There is an urgent need for refresher training of ASHA in technical, communication as well as community mobilization skills.

## Assam

- State has operationalised 2285 AB-HWCs against the target of 3477 for FY 2021–22 (Source - AB-HWC portal; 30th November 2021)
- At the PHC-HWC level, well-built rainwater harvesting systems were in place. At all the SHC-HWC and some PHC-HWC, herbal gardens with name boards were maintained. Branding of the HWCs had been done.
- Good sanitation practices were observed at the PHC-HWC with a deep burial pit in place and the date of last cleaning of the septic tank was also mentioned.
- Well displayed IEC materials in vernacular language and organogram were observed across the SHC-HWCs visited. Facilities lacked running water, electricity backup/emergency lights and separate toilets. Limited

mobile network connection was hampering communication as well as teleconsultation. Poor road connectivity was noted to some of the SHC-HWC. Inadequate human resource was observed almost in both SHC-HWC and PHC-HWC level.

- Out of the 12 CPHC packages, 7 of them have been effectively rolled out. On an average, the SHC-HWCs visited conducted 15–20 OPDs/day and about 8–10 normal deliveries are being conducted (L1 facility). The SHC-HWCs were complying to the IPHS 2012 population norms. There was no separate wellness room in most of the facilities. Limited focus and awareness on wellness activities like yoga and annual health calendars.
- The SHC-HWCs have been offering 7 diagnostic tests instead of 14 and PHCs 27 tests instead of 63 tests. SHC-HWCs had all 31 drugs mentioned in the state EDL whereas the PHC-HWC had 24–45 out of the expected 172. There are minimal instances of stock out and if so, there is a minimal lead time for replenishment of drugs.
- SHC-HWCs are not a cold chain point though they are delivery points resulting in missing zero dose of routine immunization. A person is hired to deliver vaccine from cold chain point to SHC-HWC.
- Backlog in payments related of PLP/TBI was observed.
- Continuum of care linkages were well formed for only NCD and basic obstetric complications with CHOs referring cases to the linked MO I/C who in turn would diagnose and have the patient followed up at the community level.
- In Cachar district the process needs to be strengthened as it was observed that SHC-HWCs are linked with PHC-HWC of different health block which is bringing in administrative challenges.
- Teleconsultation was not happening at Cachar district and two of the SHC-HWCs in Lala Block due to limited availability of internet services in the area. SHC-HWC Burnie Brease conducted 25 tele-consultations in October month through smartphone –consultations were pertaining to skin infections, pain

abdomen, limp pain etc. Documentation and tracking mechanism of patients requires improvement. Limited focus on quality certification was observed at the AB-HWCs especially in Cachar district.

- **Community Process:** Assam has engaged about 32546 ASHAs for rural and Urban areas. ASHAs are trained and supported to function in their own villages / slums with a goal to provide primary health care, advice on sanitation, hygiene, ante-natal and post-natal care, and when necessary, escorting expectant mothers to hospital for safe delivery. The functionality and performance of ASHAs was found to be good at both the individual and community level.
- It was observed that the selection of ASHAs was according to the recommended population norms. The VHSNC and community members are selecting the ASHAs. However, it was noticed that in some areas, ASHAs were catering to a population more than the existing norms. The number of drop outs in both Hailakandi and Cachar districts were minimal. Few positions of ASHAs were vacant. The ASHAs have been trained till Round 4 of module 6 and 7, HBYC and NCDs. However, training of ASHAs for expanded packages for the delivery of Comprehensive Primary Health Care is pending. There is no plan at the district level for upcoming training of ASHAs either for expanded package of services or refresher training.
- There were few vacant positions of ASHA Supervisor and BCM. One review meeting/month was held between ASHAs and its support structures. Adequate handholding was being provided to ASHAs by ANM, CHO, ASHA Supervisors/Facilitators, MOs. Even some VHSNCs have provided timely support to ASHAs.
- ASHAs and the ASHA Supervisors were seen to share a good rapport with the community and were well aware of the issues of the community. However, lack of connectivity in terms of roads, mobile network, increased population coverage, pending trainings of ASHAs and erratic network connectivity hindered effective service delivery. This was seen to be affecting ASHA's work satisfaction as they were not able to help the individuals reach health facility on time. ASHAs were trained to draft birth plans for every expecting mother. However, only a few expectant mothers were aware about their birth plans.
- Most grievances were regarding support required for addressing community issues. This was being resolved through AFs, ANMs and the CHOs from time to time. BCM and the DCM were also involved if needed. Sometimes, the VHSNC members were also involved in facilitating resolution of ASHA's issues locally.
- Awareness level related to social security schemes like Pradhan Mantri Jeevan Bima Yojna, Pradhan Mantri Suraksha Bima Yojna, Pradhan Mantri Shram Yogi Maan Dhan Yojna was not satisfactory and many ASHAs were yet to enrol in these schemes. ASHAs had enrolled in Assam Aarogya Nidhi Scheme.
- The VHSNCs were formed and functional as per the guidelines with adequate women and minority groups, migrants, and tea garden labourers. Though MAS was formed, the members were less oriented towards their roles and responsibilities. Presently the State has a total of 27,673 VHSNCs constituted. Each committee has around 12- 15 members and is headed by the PRI member and ASHA being the member secretary and convener conducts the monthly meeting. However, during COVID-19 surge, it was observed that the participation of members in the VHSNC meetings got reduced. All VHSNCs had Bank Accounts and had received annual untied fund, which was put to good use, for the betterment of the community. The VHSNC members have also been trained as per MOHFW's "Hand book of VHSNC members", maintenance of the cash book and vouchers.
- The chairperson of the VHSNC was unclear on the norms for utilization of untied funds. Funds were being used for purchasing assets like carpets for the SHC-HWC, portable water camper, table, mugs etc. However, during COVID pandemic, villagers who could not afford, were provided sanitizers, masks etc.

- **Community Action for Health (CAH):** In Cachar district, DCM and BCM attended CAH district level training of trainers program. Block level ToT was also organized at the district level. However, no order or instructions had followed these trainings resulting in unsatisfactory performance. A few good practices were observed under CAH in Hailakandi which are as follows:

- **HWC Monitoring by VHSNC:** VHSNC members were trained on a feedback form to monitor HWCs resources and functionality. The functionality and challenges of the SHC-HWC are identified through a locally appropriate checklist. In the monitoring of a SHC-HWC in Hailakandi in Sep 2021, the committee identified non-availability of Urine Pregnancy Strips, RDT Kits for Malaria etc. They were subsequently made available by the efforts of the CHO, who had been responsive to the feedback.

- **Action for mobilizing for social issues:** Another good practice noticed was collective action taken by the VHSNC to address COVID-19 vaccine hesitancy and social issues like child marriage, exploitation of tea garden labourers etc which have shown positive results with 95% vaccination completed and significant reduction in child marriages and exploitation in the village.

- **Rogi Kalyan Samiti:** The RKS has been formed at the PHC-HWC level. The block panchayat head is the chairperson of the 36 membered RKS. The meetings are held once in two months. Under the RKS, funds have

been utilized for extension of cold chain room, maintaining cleanliness of the PHC-HWC campus, rain water harvesting system as well as providing support in outreach activities in the communities.

## Bihar

- Bihar's target for operationalising AB-HWCs for FY 21-22 is 7346 (SHC-5857; PHC-1379 and UPHC-110). So far, 2323 AB-HWCs have been operationalized (As on 26th November, 2021; Source- AB-HWC Portal).
- The pace of operationalisation of AB-HWCs is very slow in the state. In the visited districts of Jamui and Lakhisarai, only 32 AB-HWCs against the target of 206 AB-HWCs and 18 AB-HWCs against the target of 87 AB-HWCs respectively have been operationalised till date.
- In all the AB-HWCs facilities visited, boundary wall was not present at two of the visited AB-HWCs in Jamui district.
- All the HWCs had sufficient space for OPD, patient examination with privacy, room for ILR, laboratory, pharmacy/medicine dispensation, limited space for conducting Yoga sessions, Toilet facilities and waiting areas with chairs/benches. CCTV cameras were installed at visited AB-HWC in Jamui district.
- The average daily OPD at HWC-SHC Tetarhat was 10-11 while it was 30-40 at the visited HWC-PHC (APHC).
- All the facilities visited had initiated prevention, screening and management of Diabetes and Hypertension but ASHAs in both districts were filling the old CBAC forms

### Good Practices of VHSNC

- Arrangement of boat by VHSNC members for transportation of pregnant women.
- VHSNCs campaign to close the liquor shops in their area.
- Hiring of a local tea garden worker skilled in Yoga, as Yoga instructor at Burnie Brease SHC-HWC, Hailakandi. This helped the yoga trainer to earn extra money by utilizing his skills. This has helped in increasing number of community members attending yoga sessions as the trainer is familiar and from local community.
- HWC monitoring by VHSNCs

- The first 7 service packages of CPHC have been rolled out at HWCs but largely focused on Maternal and New-born healthcare services.
- **Inadequate HR at HWC-APHC, UPHCs and HSCs-** State has deployed MBBS Medical Officers and CHOs through a rotational roster of postings to operationalize HWCs.
- 662 CHOs are currently present at HSC-HWCs on rotational posting. Recruitment of CHOs (against 4050 approval) from integrated BSc Nursing is also under process.
- The state has notified 109 drugs in EDL against MOHFW's National EDL list of 105 and 172 drugs at SHC-HWC and PHC-HWC, respectively. A list of 37 medicines were available at HWC-SHC which are essentially mandated as part of provision of teleconsultation services at SHCs. Around 58 drugs were available at PHC-HWC.
- The State has adopted the e-Sanjeevani OPD model for teleconsultation. There were 5 hubs and 13 spokes at Lakhisarai and 2 hubs and 85 spokes in Jamui district. An average daily teleconsultation OPD of 50 cases was reported from DH Lakhisarai.
- Adoption of 10 AB-HWCs by Medical Colleges has been operationalized in the State: 15 Medical Colleges have adopted AB-HWCs till date.
- PARIWAR NIYOJAN DIWAS is being celebrated at all facilities up to PHC/UPHC level on every 21st day of the month.
- Identification of high-risk pregnancy (HRP) is low and there is no SOP in place for the referral and management of HRP's identified. The knowledge among the doctors & nurses on the management of HRP's also needs improvement. Community awareness on outreach ANC services is limited and was found to be further disrupted due to COVID-19,
- SEHAT KENDRA - A peer led, non-clinical desk to promote awareness among youths, set up at 26 university/ college/ educational institution
- 208 Adolescent Friendly Health Clinics (AFHCs) called Yuva Clinics are functional in the State (147 in Peer Educator districts and 61 in Non-Peer Educator districts), established up to Block PHC level. Total 21,247 adolescents have availed services from the Yuva Clinics till 2nd quarter of FY 2021-22.
- In National Tuberculosis Elimination Programme, cases considerably decreased since last year as well as active case finding and IPT has gone down.
- Training status of human resources in health section in respect of leprosy needs improvement in the State.
- The State is reporting all Six Vector Borne Diseases (VBDs) under NVBDCP namely Malaria, Dengue, Chikungunya, Japanese Encephalitis (JE), Kala-Azar and Lymphatic Filariasis.
- Most of the facilities visited were providing screening services for Diabetes and Hypertension (HTN) at the facility level. Cancer screenings were limited, Mechanism for provision of identification and referral of stroke is low.
- **Community Process:** The overall selection of ASHAs is about 93% against the target in both Lakhisarai and Jamui districts. However, the pace of training of ASHAs on Modules 6 & 7 is quite slow. While around 49% of in-position ASHAs have been trained in Round 4 in Lakhisarai, only 4.9% of those in position have been trained in Jamui. There was a long-term gap in trainings (new and refresher trainings) which restricted the functionality of ASHA on tasks related to NCD and mobilization of suspected TB cases for screening etc.
- Pool of ASHA trainers have shrunk from 803 to 719 over last four - years which is matter of concern as new trainings such as HBYC and new services under CPHC has already been instituted.
- ASHAs are well supported and guided by ASHA Facilitator and Community Mobilizers at Block level. Around 4266 ASHA Facilitators (91%) are in position to mentor ASHAs across the state. While around 43 (96%) of ASHA Facilitators are in position in Lakhisarai, 79 (95%) ASHA Facilitators were working in Jamui. However, there is more than 70% vacancy of District Community Mobilizer across the State.



- The knowledge and skills of ASHAs were found to be limited on RCH, communicable diseases and NCDs. Less than 1% newborn were identified with danger signs in HBNC visits. The enrolment of ASHAs under the three social security schemes namely Pradhan Mantri Shram Yogi Maandhan (32%), Pradhan Mantri Jeevan Jyoti Bima Yojana (17%), Pradhan Mantri Suraksha Bima Yojana (16%) was found to be extremely low. Correspondingly, the awareness about these schemes amongst ASHAs, AF and the support structure was also low.
- **Online Incentive Payment System for ASHA and ASHA Facilitator:** Bihar State has started Incentives payment to ASHA & ASHA Facilitators by State Level Centralized System through DBT (Direct Beneficiary Transfer) in their bank accounts from December 2020.
- ASHAs were found to be motivated and well accepted & respected by the community. They have significantly contributed to the COVID awareness, house to house campaigns and vaccination drives.
- There are 22 district ASHA Grievance redressal committees and 190 ASHA *Ghars* in the state. However, the utilisation of ASHA *Ghar* was found to be limited in facilities where it was available due to lack of security and infrastructural issues.
- VHSNC - Around 84% VHSNCs have been formed against the target of 10,051 across the state. Traditionally, VHSNCs have been formed at the Gram Panchayat Level in the state, so ASHAs were not made Member Secretary. 7890 VHSNC still continue to be functional at Gram Panchayat level and 2161 on revenue village level in two districts of Nawada and Darbhanga for which budget was approved in RoP 2019-20.
- The pace of training of VHSNC is very slow in the state. Only 1173 (14%) VHSNCs have been trained against a target of 8406. VHSNCs have been trained in 107 batches (Araria-218, Darbhanga-330, Nawada-187, Gaya-64, Samastipur-281, Begusarai-79, Sheikhpura-14).
- State needs to immediately ramp up the pace of VHSNC member trainings.
- VHND: The activities under Village, Health and Nutrition Day have been recently resumed at the outreach sites after the lockdown and were being managed by the ANM, ASHA and Aanganwadi worker (AAA). The essential equipment was available at the site, however it was observed that the due list of beneficiary was not updated and new MCP cards were not available at one of the sites. The key activities like weighing of pregnant mothers and growth monitoring of the children were not found to be in practice.
- **RKS or Hospital Management Society** were formed at all facilities visited. However, the constitution of separate General body and Executive committee of RKS were not found to be as per the guidelines. The representation from females, PRI, and other departments (Education, ICDS, PHED etc) was poor.
- The Untied funds provided to the facilities was reported of being used for infrastructural strengthening, repairs, purchase of drugs and consumables.
- **Mahila Arogya Samitis-** The State has 87% MAS in position against the target of 843.
- Interaction with ASHAs and MAS member at UPHC revealed poor understanding of MAS, its role, and responsibilities. To facilitate optimal functioning of MAS and strengthen service delivery in urban areas, the state should invest in capacity building and regular mentoring of MAS members.
- The state has implemented several innovative practices in urban areas such as Tika Express, Model Immunization Corners, Eye care Services, Lab Service Strengthening etc.
- Roles & responsibilities of various stakeholders under NUHM (CP, CPHC, NUHM officers) needs to be clearly identified and communicated.

## Haryana

- State had operationalised 1115 AB-HWCs against the target of 1990 for FY 2021-22 (Source - AB-HWC portal; 30th November 2021)



- State has prioritised PHC upgradation to PHC-HWC and has gradually rolled out SHC upgradation to SHC-HWCs. None of the SC in the visited districts is converted into AB-HWCs yet.
- Infrastructure setup of the visited AB-HWCs had adequate space, construction, branding, electricity, potable water supply, toilet, privacy for examination of patients etc. Branding of all AB-HWCs is completed.
- State is focused in implementing all RMNCHA+N services. Immunisation programme was also planned and implemented well, however, the outcome of fully immunisation coverage varied across the state.
- Community and field level activities of RMNCHA+N and NCD services are regular. AB-HWCs have rolled out maternal, neonatal & infant care, childhood health care, family planning, communicable disease and OPD services well. High-Risk Pregnancies are tracked and referred to District Hospital.
- NCD services have been initiated. Screening of NCDs and dispensation of drugs are carried out through AB-HWCs. Also, At SHC-HWC, lack of team coordination between the CHOs and ANMs. This reflected in poor completion of CBAC and Family folders at the community level and irregular screening of NCDs.
- Visited AB-HWCs had a Yoga room and wellness activities have been initiated. The state has identified and empanelled Yoga experts. However, Wellness activities are limited and irregular.
- HWCs lacked a planned system for follow-up of chronic diseases like NCDs, HIV, Mental health disorders and thereby affecting continuum of care. There was lack of documentation.
- The adolescent services being provided at the facilities were counselling, screening for obesity and anaemia, IFA supplementation and management of reproductive tract infections. No Ayushman Ambassadors have been identified so far. The MOs were not aware of Health and Wellness School Ambassadors and there were no coordinated activities reported in collaboration with the schools.
- ASHA/ANM have been trained to look for patch /skin lesions of leprosy. Identified suspected case is referred to the DH directly for dermatology or district leprosy officer's opinion.
- There is a clear channel of referral services established. The staff are aware of the referral chain. Because of the lack of specialist services, the referral services were carried out directly to District Hospital or Medical College. This had posed accessibility challenges for people being referred from facilities far from the district hospital or medical college.
- Continuum of care in regard to referral to higher centres and record of follow up of the beneficiaries was lacking (Keeping in proxy the implementation of NCD services in AB-HWC)
- Drug supply roster is present from warehouse to health facilities and found to be regular in supply to PHC. Definite dates had been allocated to the health establishment to collect drugs from the Central Drug Store.
- Drugs are available for treatment of TB, malaria, diabetes, hypertension at health and wellness centres. ODISCMS system was the application for procurement and supply of drugs. The Central Drugs Centre followed a transparent system for procurement of drugs.
- Despite having a centralized drugs management system, all the HWCs are maintaining multiple manual inventories.
- RCH portal, HWC-app, Nikushth portal, Nikshay, online drug inventory and supply chain management system, HMIS, e-Sanjeevani, NCD portal, FP-LMIS were functional. ASHA Workers were using IT Apps like ASHA PAY and ASHA Sarvekshan.
- State also had functional e-Sanjeevani Services (both e-Sanjeevani OPDs and e-Sanjeevani HWC), although the implementation level varies across districts.
- **Community Process:** ASHA has good presence in the community. ASHAs predominantly focussed on RMNCHA+ programme

components with limited engagement in other programmes, particularly in NCD care.

- State, district, and facility monitoring teams were monitoring the ASHAs performance, and transparency was ensured in the ASHAs incentives through the ASHA pay App.
- HBYC & HBNC kits were available with the ASHAs. The incentive disbursal of ASHAs was done through ASHA-PAY android application. There were delays in payment of incentives at a Sub-Centre at the time of the visit in Fatehabad
- The state has put in place a mechanism to encourage ASHAs to be enrolled for ANM Course and ANM Post. ASHAs were enrolled under PMJJBY, PMSBY, and PMSYMY insurance schemes but there was lack of awareness about the scheme amongst them.
- Smart phones were distributed to ASHAs, AFs, BACs, and DACs.
- The grievance redressals at the state and district level were in place. During 2021-22, 13 grievances were received and resolved at the State level. 89% of all the grievances were resolved at the district level.
- Involvement of ASHAs in COVID vaccination through “Har Ghar Dastak” was commendable.
- The grievance redressal at the state and district level were in place. Enrolment of ASHAs in urban areas, was not happening as of now.
- **VHSNC:** Only a total of 246 VHSNCs were functional in the Fatehabad district. Limited functionality of VHSNCs with irregular and unstructured meetings in Nuh (Mewat) was noticed. The state and district level programme coordinators of Community Processes should also give emphasis to strengthening of VHSNC/MAS and Swasthya Kalyan Samitis. The training of VHSNCs should focus on strengthening skills of VHSNCs in the village health planning and action system in the community.
- Village Health and Nutrition Days were celebrated in both urban and rural areas. Absence of Mahila Arogya Samitis in urban areas was a concern.

## Karnataka

- State had operationalised 5833 AB-HWCs against the target of 7257 for FY 2021-22 (Source - AB-HWC portal; 30th November 2021).
- Branding of HWC-SHC and PHC are done as per CPHC guidelines. NHM and Ayushman Bharat logos are displayed on the walls. CHOs recruitment is under process in the State and Davanagere but completed in Yadgir district.
- The wellness activities are yet to be initiated in most of the facilities. No wellness calendar was available at HWCs visited.
- Services as per the 12 packages of services under CPHC is yet to be rolled in Davanagere districts. E.g.: NCD screening- opportunistic screening being conducted in both the districts and population-based screening in Yadgir district only.
- The training on various programs like palliative care, elderly care, etc. are not yet complete.
- Screening for Tuberculosis and Leprosy is being done separately in both districts. However, TB notification in both districts significantly decreased in 2020 when compared to 2019.
- Software like HMIS, RCH, Anmol, S-form (IHIP), e-Samiksha, NIKSHAY, Nikushth, are available but its functionality and real time data entry is limited due to 3G enable tablets. Tele consultations being done and monitored using e-Sanjeevani app.
- In all the visited facilities, ASHA were proactive, well trained and knowledge about all the health programs implemented in Karnataka State.
- All ASHAs receive a minimum monthly wage of more than Rs. 6000 out of which the state grants a fixed sum of Rs. 4000/month.
- All ASHAs are covered under various benefit packages and social security schemes and are paid on time.
- Good coordination and convergence with Panchayati Raj Institutions/Urban Local Bodies were observed.

## Mizoram

- State had operationalised 202 AB-HWCs against the target of 280 for FY 2021–22 (Source - AB-HWC portal; 30th November 2021)
- Most of the Primary Health care facilities visited had branding of AYUSHMAN BHARAT-Health and Wellness Centre, however. All the primary health facilities had adequately covered and well-ventilated waiting area. None of the centres had areas demarcated for wellness activities.
- The electricity supply was interrupted at all the primary care facilities visited without Power backup. Most of the facilities had drinking water facilities. All of the facilities visited had functional toilet. There was no separate toilet for male and female at most of the facilities, except PHC West Phaileng.
- The Community Health Officer (CHO) is known as Health and Wellness Officers (HWO) in Mizoram. Most of the HWOs had been recently posted as the earlier ones either got transferred or resigned. The HWOs were not getting paid regularly. The AB-HWC team was not getting either Performance linked payment or team-based incentives.
- Bio Medical Waste Management - Bins are placed; however, colour protocol not being followed, and the waste is not segregated as per the norms. Burial pits were found at the PHC-HWC. Open burning of bio medical waste was seen at all the facilities.
- The availability of drugs is grossly inadequate. DVDMS is implemented up to PHC level but is widely used only for updating stock and not for indenting purpose. It was observed that patients bore the Out of Pocket Expenditure for drugs.
- Diagnostic list is displayed at all the facilities. Only In house diagnostic facility was available. Few of the diagnostic test provided at the facility are chargeable and vary across facilities. At PHC-HWC about 16–20 tests were available while SHC-HWC performed only 6 tests.
- None of wellness activities in form of Yoga or other was being performed. The SHC-HWC had wellness calendar displayed, however it was not updated. Few of the SHC-HWCs visited had Eat Right toolkit available in local language.
- All the primary health care facilities visited had very less footfall (e.g., PHC-HWC had an average footfall of 10 per day). The reasons mentioned were due to COVID-19, people refrained from using the facilities. State has planned to train all the cadres by end of this financial year.
- Insertion of IUCD is done by MPW (F) at very few SHCs. Provision of Injectable contraceptive has been made available at the PHC and above facilities since 2019. As reported by the health workers, male engagement in birth spacing is minimal in the community. There was a lack of IEC campaigns being held for male sterilisation.
- Adequate IEC material for key maternal health programmes like PMSMA, SUMAN, JSSK, JSY was not displayed at the Primary level facilities.
- ASHAs were not seen to be maintaining line listing of pregnant women. Pregnant Women are incurring high OOPE on drugs, diagnostics & referral transportation. Referral linkages between facilities was seen to be poor. This led to increased number of Home deliveries.
- Quarterly micro planning is being done for Routine Immunization at facilities. SHCs and SHC Clinics are fixed vaccination sites for Routine Immunization. Immunization session is conducted once in a month based on the availability of vaccines at the health facility.
- Infant Milk Formula was being procured and widely practiced in health facilities and Community. Bottle feeding practices were seen to be largely prevalent in communities. No follow up for Newborns discharged from SNCU was being done. Rashtriya Bal Swasthya Karyakram (RBSK) program is on hold due to ongoing COVID-19 pandemic. Insufficient supply of medicines to RBSK teams is a challenge. Children referred by RBSK team find it difficult to reach District Hospital due to high OOPE following loss of daily wages of parents.

- Under National Tuberculosis Elimination Programme, very few IEC materials displayed at the SHC or PHC related to National Tuberculosis Elimination Program (NTEP). Community is unaware of incentives given under NTEP.
- Sputum examinations are done for very few patients, only those coming to PHC are examined for TB sputum. All the suspected TB patients required to visit TSU for confirmatory TB test and DBT formalities. Only patients with MDR TB are paid transportation charges.
- The National Leprosy Eradication Programme does not seem to run well in the State. Active Case Finding and Community Surveys have not been conducted since the COVID-19 Pandemic has begun.
- Rashtriya Kishore Swasthya Karyakram (RKSK) - District RKSK Coordinator is in place. The strength of Peer Educators for AFHS has increased. District level training and Block level training for Anaemia Mukta Bharat has been conducted virtually for the health workers. Iron and folic acid distribution has been maintained through Subcentres and ASHAs in spite of the closure of the schools.
- The facilities did not have designated space for Adolescent Friendly Health Clinics (AFHC). Despite functioning of RKSK in the State, with trained staff, tobacco addiction, early marriage, teenage pregnancy, and unwanted pregnancy are still prevalent. These may be attributed to lack of awareness for available health services.
- Though the number of peer educators has increased, the adolescent health days were not observed due to closure of educational institutions due to ongoing COVID-19 pandemic. Average client load per clinic per month is having a decreasing trend.
- School Health and Wellness Program (under AB-HWCs) has not been started in Mizoram. In coordination with education department, 4 days of district level training is in which schoolteachers and Principals are being trained.
- National Rabies Control Programme - Supply of Anti Rabies Vaccine (ARV) was found to be irregular. There were instances in which the facility had stock but as per the regular practice, the patient was asked to buy the ARV on his own incurring OOPe.
- Under National Programme of Control of Blindness and Visual Impairment, Screening was being conducted in OPD and through outreach (school and home visits). Cataract surgery camps and distribution of eyeglasses was being done, however there was backlog of Cataract detected cases in the community who need surgical intervention.
- National Tobacco Control program- There was lack of awareness amongst the community members. Tobacco addiction was common among adults as well as teenagers. The facilities had "No smoking" chart displayed.
- Test kits for Hepatitis B and Hepatitis C are available. All ANCs are being tested, record for the same was found. Treatment is not available at the PHC-HWC.
- Under NPCDCS, Population enumeration is being done, ASHA is filling the Community Based Assessment Checklist (CBAC), few places have not been supplied with revised CBAC. All screening including common cancers (breast and oral) except cervical is being done however not on regular basis.
- Data on HMIS portal was found to be accurate, reliable, and credible for analysis at district/ state/ centre level for Mizoram.
- No reporting of data on NCD portal across PHC-HWC or SHC-HWC by healthcare staff at facility.
- The HWC application was widely accessible to all Medical officers and HWOs. Adoption of IHIP is low among visited districts. Mera Aspataal is only integrated in district hospitals and to some UPHC in the State. Records for Tuberculosis patients are regularly updated on NIKSHAY portal and found to be reliable. Very low uptake of teleconsultations via e-Sanjeevani across districts in Mizoram was seen. Largely reasons cited for not using e-Sanjeevani is low network bandwidth to conduct teleconsultations. Alternate model of teleconsultation is used by Medical Officers (WhatsApp video call) but no records were found in terms of prescription or logs).



- **Community Process:** The ASHAs in the state were seen to have been posted without following the population norms resulting in some areas having no ASHAs.
- Irregular and untimely disbursement of incentives for ASHAs and ASHA Mobilizers. Furthermore, staggered disbursal of funds from DH to PHC, SHC and VHSNC was seen.
- Grievance Redressal Mechanisms was not seen to be in place across the districts visited.
- Though JAS had been formed at AB-HWCs but meetings were yet to be conducted.
- It is recommended that the funds to VHSNCs must be sent directly from the state to VHSNC instead of through DPMU and BPMU and then to VHSNC.
- Directives should be sent to hold VHSNC meeting regularly and the JAS/RKS members should be oriented in their roles and the meetings should be organized regularly.

## Odisha

- Odisha's target for operationalising AB-HWCs for FY 21-22 is 3760 (SHC-2437; PHC-1233 and UPHC-90). 1661 AB-HWCs (SHC-374; PHC-1229 and UPHC-90) had been operationalized (As on 26th November, 2021; Source- AB-HWC Portal).
- Operationalization of AB-HWC is strategically planned to prioritize PHCs for operationalization and focus now has shifted in training regular Nurses as CHOs who will be posted at Sub-Health Centres.
- 7 out of 12 service packages have been rolled out so far, while it was observed that NCD screening limited to Hypertension and Diabetes Mellitus only.
- Gaps in infrastructure (electricity, water supply, boundary wall) observed at the HWCs.
- Telemedicine services were utilized primarily for routine illnesses and a potential challenge of overloading of the hubs was felt by the team.
- Standardized branding was observed to be completed in all HWCs.
- Basic services for RMNCAH, NCD (HT & DM), TB, Leprosy and Malaria were provided. UPHCs are providing comprehensive services.
- COVID Pandemic preparedness was found to be adequate at primary care levels, although COVID Vaccination coverage and implementation of Har Ghar Dastak Campaign were observed to be better managed in urban areas than in rural areas.
- Among the available IT Applications under the NHM, Nikshay and IHIP were not fully operational at AB-HWC in PHC / SHC levels. NCD-HWC app, AB-HWC portal & ANMOL were found to be functional at SHC-HWC. MO-NCD portal is being used in PHC & UPHC-HWCs.
- In District Sundargarh, Antenatal Care Services are being facilitated under a specially designed "Matrujyoti" scheme. It aims to provide 4 free ultrasound and other basic investigations like Haemoglobin, BP, Blood Sugar, Urine, etc. to all women during pregnancy. This helps in ensuring safe motherhood while immediate attention and treatment is given to High-Risk Cases.
- NCD screening is limited to Hypertension and DM in most of the facilities.
- The NPCDCS programme is being implemented across the State at facility level through the NCD clinics and community level through CBAC and HWCs.
- All new PHC-HWCs had basic physiotherapy equipment in the Wellness Room.
- The expansion of NPCDCS program is till the level of SHC-HWC. However, in absence of CHOs, the upward and downward referral is not being implemented completely.
- There was no awareness about the availability of the palliative care services among the community. Staff were not trained in palliative care.
- State has initiated the activities on mental health screening and awareness from 2019. A one-day Training which included capacity building of ASHAs on identification of common signs of mental illness has been given. The district has been conducting screening camps (4 per year) which are preceded by rigorous awareness campaign supported by ASHAs and block health educators.
- The State has performed exceptionally well in the control of malaria; reducing the API and death rate significantly over the last 5 years.



- The State has conducted several active case finding campaigns which has increased the Presumptive TB Examination Rate to 1725/lakh in public sector against target 2173/lakh. State achieved 128% of notification in Private Sector (till September 2021).
- Tele-radiology services were restricted to CT scan.
- Referrals for Continuum of Care directly to DH/SDH level. Limited post treatment follow-up for downward referrals of CBAC.
- **Community Process:** Odisha has successfully completed around 98% of ASHAs training on Module 6 and 7, NCD, HBYC in both the visited districts. Additional Trainings like sensitisation in Malaria, Leprosy, Dengue, Diarrhoea, Tuberculosis, first-aid, immunisation, Paediatric COVID care, etc. have also been imparted.
- More than 95% of ASHA were enrolled in social security schemes like PMJJBY, PMSYM and PMSBY.
- ASHA rest shed was in place in both the districts. They had good knowledge of care of mother and home-based care of new-born, CBAC forms with risk assessment and NCD screening and were maintaining 13 to 15 registers which needs to be replaced with simple recording system.
- ASHAs were receiving incentives without any delay. ASHAs are receiving an average monthly incentive ranging from Rs. 4500 to Rs. 6000 (inclusive of Rs. 1000/month fixed incentive by the State and additional COVID-19 incentive).
- MAS was constituted in all facilities in both the visited districts. Untied fund of Rs. 5000/MAS/year was received regularly and it's observed that it was and spent on activities such as rallies, cleanliness drives, purchasing bleaching powder, travel cost during emergencies, etc.
- JAS was constituted in all the visited facilities and initial meeting was conducted. However, JAS members didn't receive any training.
- State has developed an innovative system of grading of MAS on 10 measurable indicators, based on which they are marked Red,

Yellow, and Green, and corrective action is undertaken accordingly.

- Good coordination with Panchayat, SHGs and ICDS dept including ASHAs, ANMs – Gaon Kalyan Samiti (GKS), MAS & JAS was observed. Untied funds of GKS is utilised for cleanliness activities, sanitation activities, weighing scale for AWC, wall paintings, refreshments in meetings, drinking water, emergency transport, labour charges, etc.

## Puducherry

- The provision of Comprehensive Primary Health Care services under Ayushman Bharat Health & Wellness Centre (AB-HWC) was limited to Puducherry district only, and not universally implemented in other districts of the UT. Immense inter-district variations in terms of rollout of Comprehensive Primary Health Care services was observed in the UT.
- In Puducherry district, out of the 12 CPHC packages, 6 have been effectively rolled out and remaining 6 are to be incrementally rolled out. Branding of the HWCs were completed in most of the facilities. All the facilities visited had herbal gardens. On an average, the SHC-HWCs visited conducted 30–35 OPDs/day.
- Services at SC-HWC were limited to maternal & child health specially in Karaikal District, expanded ranges of services under Comprehensive Primary Health Care (CPHC) were yet to be implemented.
- Deployment of MBBS doctors on ad-hoc basis as CHOs at SC-HWCs led to high attrition rate and vacant positions at SC-HWCs. 12 (Twelve) Medical Officers in Karaikal region resigned out of total 17 (Seventeen) recruited on ad – hoc basis in Karaikal region.
- The SC-HWCs and PHC-HWCs did not have all the expanded range of diagnostic services and the patients were referred to district hospitals for availing such services. It was informed that revised diagnostic services list has not been circulated in the district.
- SHC-HWCs did not have all 31 drugs mentioned in the UT Essential Drugs List (EDL) and PHC-HWCs also did not have all 174 essential drug list in the facility. It was informed that revised EDL have not been circulated in the district.

- The Wellness activities in functional HWCs have not yet started due to poor orientation of staff in Karaikal district and unavailability of dedicated yoga room and instructor.
- Limited awareness regarding wellness activities among community members was found during group discussions however the community were eager to participate in such session. Lack of awareness was cited as the main reason.
- Inadequate training and mentoring of Primary Health Care team in both the region/districts was observed.
- Hub for teleconsultation is yet to be identified by UT. The teleconsultation services have not adopted due to lack of training though infrastructure in most of the facilities were set up.
- Celebration of annual health calendars were being observed in all facilities visited in Puducherry district only and there was proper documentation maintained for the same.
- IT infrastructure and tablets are available at most of the HWC and daily reporting through IT portals at PHC-HWCs & SHC-HWCs.
- **Community Process:** Community recognized the efforts of ASHA and ANM which was evident by the way the community participated. ASHA were energetic and pro-active. Field functionaries (ANMs) are having commendable rapport with the ASHAs, AWWs and community members. However, community forums like Village Health Sanitation and Nutrition Committee (VHSNC), Mahila Arogya Samiti (MAS) and Jan Arogya Samiti (JAS) are either inactive or have not been constituted specially in Karaikal District.
- It was observed that ASHA had initiated enumeration by entry of Community Based Assessment Checklist (CBAC) through NCD app.
- All the PHC Management Committees have been renamed as 'Rogi Kalyan Samiti' and registered under Society Registration Act and Certificate of Registration have been obtained under Single Nodal Accounts initiatives.
- A structured mechanism to monitor ASHA's monthly performance and address their

grievances were lacking. This has resulted in irregular distribution of performance-based incentives for past one year.

- UT has not devised regular training for ASHA. There was no appropriate structure for ASHA Career Progression.
- ASHAs were enrolled in only one social security schemes. However, the UT had received approval for enrolment of ASHA in PMSBY & PMJJY.

## Rajasthan

- State had operationalised 2447 AB-HWCs against the target of 10,841 for FY 2021-22 (Source- AB-HWC portal; 30th November 2021).
- Rajasthan has more than 90% of the PHCs and Urban-PHCs (U-PHCs) sanctioned for upgradation have been converted into HWCs (1970 of 2092 approved PHCs and 290 of 300 approved U-PHCs), however, only 5.5% of the approved SC have been upgraded to HWC-SC.
- As per State records, the number of functional PHC-HWC, U-PHC- HWC and SC-HWC in District Karauli are 34, 4 and 2, while in District Jalore are 68, 2 and 5, respectively.
- The first batch of Community Health Officers' (CHO) training has been completed and the second batch of training is ongoing.
- HWC premises in district Karauli did not have an intact boundary wall. In rural areas, some of the visited HWCs were pre-fabricated units with limited availability of patient waiting area.
- OPD footfall was 10-15 per day in HWC (Karauli), and 15-20 in HWC (Jalore).
- Regular routine immunization sessions are being held in the field; Supplementary immunization activities have been carried out to cover the missed out and left out children.
- Minimal uptake of FP services, either IUDs/ PPIUCDs/ Antara or others was noted. The Saas and *Bahu Sammelans* were being held regularly in the districts. The incentives for the same are also being disbursed regularly.
- In adolescent's health, no counselling or promotional services were made available to them.

- Population-based screening has been initiated in both districts for NPCDS; however, it was not found to be universal across facilities. ASHAs and ANMs have undergone training (5 and 3 days, respectively) to undertake CBAC assessments and are maintaining the CBAC forms and the family folders at the HWCs.
- Programme-specific services such as community-based screening or interventions for oral health, mental health, visual and aural impairment, geriatric, and palliative care were not being delivered at the primary care level.
- Tobacco control activities were also not observed below the district level. High level of tobacco consumption was observed among women and men in the districts.
- Adequate amount of IEC material was found at the facilities regarding TB prevention, control, and diagnosis. TB treatment protocols, medicines boxes, treatment cards etc. were well kept and displayed.
- Long Lasting Insecticide Treated Bed Nets (LLINs) were being distributed in the community. Regular fogging activities and anti-larval measures were taken by the Panchayats. The community was aware of vector breeding and source reduction, however were not actively taking measures to check vector breeding in their premises, despite the ongoing Dengue outbreak in Jalore.
- It was reported by the Counsellors that PLHIV striving to avail educational benefits for their children (Paalan Haar scheme) lose their confidentiality and face stigma in process of obtaining due signatures. A Single-window clearance resulting in simplification of this process, or acceptance of the green ART treatment book as valid proof may result in reducing stigma. IEC and counselling services however need to be strengthened and special efforts need to be made given the low health literacy levels of the community.
- The Essential Drug List (EDL) was displayed in each health facility except at HWC level.
- There were gaps in the medicine availability as per State EML, as approximately 70 to 80% drugs as per the state's EDL were available in every facility in both districts.
- There is system of e-Aushadhi at each level facility except sub-centre. At the PHC and UPHC levels, there is a mechanism for indenting and consumption of drugs through e- Aushadhi portal software.
- The State of Rajasthan is providing diagnostic facilities free of cost to all patients visiting the govt centres under the flagship scheme, '*Mukhya Mantri Nishulk Janch Yojana*' since 2013.
- The State is conducting 5 Tests at SC and 15 at PHC level in all the districts.
- **Community Process:** The recruitment process for ASHAs is carried out by the Women and Child Department (WCD) as the State has a specific initiative wherein ASHAs (ASHA Sahyogini) are posted at Anganwadi centres (AWC) under ICDS. Presently, around 121 vacancies exist in Karauli district, while there are 384 vacancies against the sanctioned number of AWC in Jalore. A major bottleneck to the optimal functioning of the ASHAs is the **duplication of leadership and reporting channels**, and overburdening of the ASHAs consequent to NHM and ICDS workload. Recruitment via ICDS also results in underserved pockets, as wherever an AWC does not exist, ASHAs are not deputed.
- **Induction training is provided** by the Department of Health; however, such training was last conducted in 2017 in Karauli. There is also no set training plan for the ASHAs. 915 ASHAs in Jalore district have received training up till the 7th Module, 80% have also received CBAC training, however **HBYC training has not been conducted** due to long- pending tenders for provision of refreshment during the trainings.
- Although the ASHAs were trained in CBAC, they were unable to demonstrate the process of CBAC form-filling adequately. They lacked clarity on how to ask the questions or mark the responses including assigning the scores to responses recorded.
- The ASHAs are paid a base salary of Rs. 2750 by the WCD with supplementary incentives

provided by the Health Department. Social Security is ensured through subscription to PMJJBY and PMSBY with a premium of Rs. 330/- and 12/- per month.

- **Career progression is facilitated** by encouraging the ASHAs to enrol in NIOS for enhancing their educational qualification. Furthermore, 10 percent reservation is earmarked for ASHAs in the ANM course.
- **ASHA supervisors/PHS, however, do not receive any social security measures or encouragement for career progression.** ASHA supervisors are independently recruited, not adhering to Gol norms, and are not selected from amongst the ASHAs, resulting in sub-optimal supervision. Currently, there is only one ASHA supervisor for one Primary Health Centre area, which makes it a ratio of around 1:40, making supportive supervision practically impossible for the field programs.
- There is no specific mechanism of grievance redressal of ASHAs in place.
- Many of them were observed to not have smart phones. Those with smart phones in Jalore were using their personal devices to enter CBAC data in the NCD app.
- There were minimal supervisory visits of block and/or district officials in Karauli. However, the District ASHA coordinator at Jalore would conduct regular supervisory field visits and on-the job trainings, along with motivating them for enrolling for the social security schemes.
- A major cultural barrier is experienced by ASHAs in Jalore and adjoining districts where the blue colour of the Sari as uniform of ASHAs is considered as a color of mourning and is worn by widows. *This results in many ASHAs being outcast by their communities or considered as a 'bad omen' whenever they perform their duties wearing their Saris.*
- Constitution of VHSNCs is as per Gol guidelines. One-day trainings are offered to the VHSNC members. Main agenda topics of the VHSNC meetings revolve around enhancing quality of care, access to care, and promotion of IEC activities for health and wellness. The annual sum of Rs. 5000/- is generally used

for refreshments, banner preparation, and minor purchases by the VHSNC. The account is jointly operated by the ASHA and a ward member. Participation of VHSNC in health promotion activities was minimal.

- The MAS meetings are conducted on a monthly basis in the Anganwadi Centre, however, did not have a fixed day approach. More than 50% of the MAS members of these groups had received trainings at the MCH Hospital in 2013 and 2018. The members are dedicated to raising awareness about various health issues such as cleanliness and sanitation, maternal and child health, various government schemes and motivate the community for COVID-19 vaccination. The NUHM Program Manager frequently attends and supervises the meetings.
- The MAS receives a fund of Rs. 5000/- annually, which has been utilised to procure tables and chairs, and install fans in the Anganwadi Centre.
- Intersectoral coordination with other departments was not observed in both districts. Interactions with the Sarpanch of Gadhika Gaon informed the Karauli Team on the pervasive gender inequality. The female Sarpanch was not taking part in any PRI activities except where her signatory powers were required. Instead, her husband would take part in the planning, execution, and monitoring activities. She also did not have any knowledge of the new XV-FC initiatives or in fact, any activities in the health sector.

## Sikkim

- State had operationalised 109 AB-HWCs against the target of 113 for FY 2021-22 (Source- AB-HWC portal; 30th November 2021)
- At the community level, universal screening of NCD's has commenced, and ASHAs are administering CBAC forms for risk identification and stratification for early screening and referrals.
- Considerable out-of-pocket expenditure was borne by beneficiaries due to unavailability of essential medicines and diagnostic services. Limited diagnostic tests (Hb, Sugar, sputum



collection) were being conducted at all the SC-HWCs.

- Dispensing of medicines for Chronic illness (Diabetes mellitus, Hypertension) for one month at HWCs (wherever available) was observed throughout the state.
- Ophthalmic OPD, NCD Clinic, MCH clinic, General OPD services were provided at UPHC.
- Telemedicine was not implemented in visited health facilities.
- Identification and management of High-Risk Pregnant women, including severely anaemic women for providing special attention and care at the referred centre, needs focus.
- Active case finding for Tuberculosis and Leprosy along with distribution of self-care kit by ASHAs.
- No regular system of programme reviews meetings, either at PHC/CHC and District levels or at the state level.
- No systematic Grievance redressal system and career progression for ASHAs.
- Less enrolment of ASHAs in 3 insurance schemes (PM Jivan Jyoti Bima Yojana, PM Suraksha Bima Yojana, PM Shramyogi Mandhan Yojan).
- State to emphasise the implementation of all strategies under NTCP. TCCs to be made operational at facilities.

## Tripura

- State had operationalised 324 AB-HWCs against the target of 760 for FY 2021-22 (Source - AB-HWC portal; 30th November 2021).
- The status of operationalizing AB-HWCs varied across the state. Branding of AB-HWC is variable across the state. Complete branding is done through PWD. State has Urban HWC (SHC) under the UPHC-HWC, which is unique to Tripura. The UHWCs (SHC) are functional with a HWC team led by CHO.
- The state is yet to roll out the expanded range of services. The NCD care services pertaining to NCDs screening and management was partially implemented and limited to

Hypertension and Diabetes. The linkages for continuum of care are yet to be established at HWC level. Though the referral records are being maintained, the facilitation is an area of concern.

- State has its own Drug Procurement Software for management, indenting drugs and vaccines up to PHC level, which is linked with DVDMS software through APIs. The medicines and diagnostics at the HWCs were available as per the old list of medicines/diagnostics under NHM. Revised list of Medicines/Diagnostics under CPHC is yet to be implemented.
- CHOs were receiving salaries on time but the performance linked payments (PLP) were yet to be implemented in Khowai district. However, in urban HWCs in West Tripura, the PLPs are being disbursed on timely basis. The average incentive received by CHOs ranged between Rs. 8,000 and Rs. 13,000/-.
- The MOs at HWC-PHC/PHC were not yet oriented on CPHC as HWC team lead at PHC level. The follow up mechanism is yet to be institutionalized. However, It was observed that MOs at PHC-HWC were having regular interactions with the CHOs; however, the interactions were limited to certain programme monitoring and COVID vaccination reporting.
- RBSK activities is one of the best practices of the state; and are found to be well organised.
- Home based palliative care visits are supported by the district program division team. For cancer patients, Regional Cancer Centre (RCC- Agartala) was reported following up of cancer patients for palliative care services regularly.
- National Oral Health Program camps were reported to be organised either in isolation or along with general health/ COVID vaccination camps.
- While the Health Promotion activities are yet to be streamlined, the wellness activities were not yet fully implemented at HWCs.
- The internet connectivity across the facilities was poor, and currently mobile hotspot were being used for internet. The IT based systems were functioning depending totally on network



connectivity, and were not available for most of the times.

- The ‘**Mukhya Mantri Sustho Shaishab, Sustho Kaishore Abhiyan**’ (MSSSKA) implemented by the Government of Tripura were successfully organizing special drives all over the state to implement four programmes including de-worming and diarrhoea control, for target children and adolescents (1–19 years).
- The Mayer Ghar initiative have been facilitating optimal intrapartum and post-partum care for pregnant women and mothers and addresses issues of accessibility, acceptability, affordability, and related socio-cultural factors.
- The ASHA Varosha Diwas as a practice was seen in the state where monthly meetings with the ASHAs and ASHA facilitators were held to accelerate motivation, capacity building and skill development and knowledge updates. It also acted as a platform for grievance redressal mechanism, performance monitoring as well as tracking of performance-based incentives.
- The notification for formation of Jan Arogya Samities (JAS) at the AB-HWC level have been completed, although the committees are yet to be constituted. One day state level orientation on JAS has been completed for HWCs across the districts.
- While the Health Promotion activities are yet to be streamlined, the wellness activities were not yet fully implemented at HWCs.
- In addition to VHND/UHND, the outreach activities across facilities were mostly related to COVID, malaria screening and MSSSKA. In Khowai district, it was observed that AGMC students organize annual Health camps for tribal pockets to undertake social activities in addition to mass screening for malaria and hypertension and general examination.
- At the community level, committees to be constituted with representation from health and relevant non-health departments.
- Intersectoral coordination at state and district level although seen, but needs to be institutionalized to optimize health outcomes.
- During the pandemic, state conducted mass COVID Vaccination drives for hard-

to-reach areas with active engagement of local influencers, community mobilizers and religious leaders to address the issues like vaccine hesitancy, etc. The State has achieved 95.43% for 1st dose and 61.68% for second dose coverage of COVID-19 vaccination.

- The community clubs constituted in Tripura in the urban areas played a significant role in the management of COVID-19 by facilitating and mobilising funds and transportation for the patient during the pandemic.

## Uttar Pradesh

- State had operationalised 10,170 AB-HWCs against the target of 15,624 for FY 2021–22 (Source - AB-HWC portal; 30th November 2021)
- District Fatehpur had operationalised 93% of the target AB-HWCs and the remaining 19 were still pending due to unavailability of building. District Mahoba had operationalized 61% of the target HWCs and the remaining 42 were pending to be operationalized as CHO recruitment is in progress.
- Issues of electricity supply and internet availability have adversely affected the primary care services. BMWM, infection control protocols were not followed.
- All the enlisted drugs in the EDL were not available in HWCs. Additionally, the intended 14 diagnostic tests were also not available in all HWC-SCs. This contributes to high out of pocket expenditure (OOPE), as reported by few beneficiaries.
- Follow-up of patients released from higher centres was inadequate to maintain continuum of care for NCDs.
- Utilisation of e-Sanjeevani was not observed at Urban Primary care centres.
- The tablets for CHOs were to be replaced/upgraded. The poor internet connectivity at facilities resulted in reporting delays and errors.
- Health promotion and wellness initiatives: Yoga and wellness activities were irregular and slowly initiated.

- Special COVID campaigns are planned by the PHC MO I/C, using the ANMs, Staff Nurses under the HWCs with the CHOs as verifiers and administration of COVID vaccines. The ASHAs have worked relentlessly throughout the pandemic to create awareness, distribute commodities to prevent COVID spread and now are actively involved in improving COVID vaccination in all ages especially the 18–45 years. Oxygen concentrators have been supplied by the PM Care Fund as well as the State budget. Many have been supplied to the HWCs as well. However, the vaccination of pregnant and lactating mothers in both districts is not taking off as the ASHAs themselves are not convinced about its safety. 'Har Ghar Dastak' campaign targeting those who have not taken the first or second dose of the vaccine will be planned for both the districts.
- ASHA Sangini App for assessing work of and support to ASHAs is performing well in the rural areas; e-Kavach App for ASHAs has recently been introduced in block Bahua as a pilot.
- RCH portal (ANMOL app) – (Auxiliary Nurse Midwife online)-Those ANMs who have tablets could enter the data, but this app is not much in use these days. The data is often entered through the help of the RCH portal at the block level, the entries were facilitated by the block level data entry operator.
- AB- HWC app and Portal- for daily and monthly reporting of programmatic data. Reporting of infrastructure is done initially and regularly updated.
- Different Apps and portals were being used - HMIS+UPHMIS; Family Planning - Logistics Management Information System (FP-LMIS) for recording information on Family Planning; Drug & Vaccine Distribution and Management System-; Nikshay Portal; Integrated Health Information Platform under Integrated Disease Surveillance Programme; e-Sanjeevani and telemedicine; BCPM-MIS for ASHA payments.
- **Community Process:** In Fatehpur, of the target 2311 ASHAs, there are 2210 in position. Out of the 116 ASHA Sangini to be selected, 93 have been selected and trained. The average incentive earned by ASHA is Rs. 4382/- per month. While in Mahoba, of the target 697 ASHAs, there are 667 in position. Out of 35 ASHA Sangini, 30 are in position. The average incentive earned by ASHAs is Rs. 4401/- per month.
- Triple A: Convergence meetings of ASHAs, ANMs and AWWs are well organised and owned by the involved persons in both the districts. In the session all the commodities such as pregnancy test kit, IFA, calcium albendazole, MCP cards were available and ASHA also have these commodities in her kit as well. The session was held with joint efforts of Anganwadi worker, ANM, ASHA and Gram Pradhan. The community participation was evident.
- During VHND session, site adherence of COVID protocol was a challenge as all the beneficiaries were not wearing masks and social distance was not seen anywhere, though ANM and ASHAs along with AWW were wearing masks.
- ASHAs are not aware of their incentives other than the routine RCH ones. The incentive claim form and the register list heads of incentive are not in an easily comprehensible language for the ASHAs. NCDs sub-head was not noticed in the incentive forms for ASHA
- There were no rest room for ASHAs in District Hospital Mahoba. ASHAs complained of the bad behaviour of staff towards them when they have to stay in the hospital to ensure institutional delivery.
- ASHAs have good community connect and women listen to their advice on health issues. FGD with Adolescents in Salarpur, Mahoba revealed that they often reach out to ASHA to discuss anything that troubles them. The ASHAs were aware of the sick and old people who are unable to get proper treatment.
- Of the target 1071 VHSNC in Fatehpur, 1052 have been registered and 50% of the funds have been transferred for their use. In Mahoba, 340 VHSNC have been registered in all villages where the population is above

500. The designated villages where VHSNC is functional receive annual untied funds of Rs. 10000/-.

- VHSNCs are not active and irregular meetings are a challenge. VHSNC members are not even well aware of their roles and duties.
- All Rogi Kalyan Samitis are registered under Society Registration Act, as per guidelines in both districts. Committee meetings for RKS are irregular. Agenda of the meeting is often not provided to members with the invitation letter and meeting documentation is not as per requirement. The meetings of RKS were found to be under or not reported on the HMIS portal.
- Unplanned RKS funds utilisation was found at some visited facilities. Management of RKS fund (for UPHC with no accountant), is done by the CMO office as per the decisions taken in RKS meetings. There are some governance issues with RKS like renewals being done 4 years after expiry. RKS audits also need to be done diligently.
- Regular use of 'rain basera' at the DWH by the patient attendants and locals was noticed, however, the toilet required frequent cleaning and the running water for the comfort of the attendants.
- MAS had been formed with a bank account. MAS members support women in getting maternal services, COVID surveys etc. Monthly meetings are fixed and regular-discussions focus around topical topics, and programmes; minutes of meetings are maintained in a separately designated register by the ASHA. There is no separate record for fund utilisation, it is being written within the minutes of the meeting. Untied fund is generally spent on dari, weighing machine, banner, water filter, glass etc. The MAS-Khushi untied funds were withdrawn in cash and spent.
- There was good cooperation and support of the ward member (also a RKS member) under UPHC Bagriya in the health activities undertaken by the MAS and UPHC in the area.
- **Community Action for Health** has not been implemented in any of the districts.

## West Bengal

- State had operationalised 5260 AB-HWCs against the target of 8004 for FY 2021–22 (Source - AB-HWC portal; 30th November 2021)
- SHC-HWC have a well utilized two storey structure - as per state norm, across the facilities visited. The structure also divides service delivery, where ground floor is usually dedicated for ANC and other RCH related services and first floor has provision of OPD with CHO's cabin.
- Some facilities with additional space, have Bangla Sahayata Kendra (BSK) to provide online government service closer to the community.
- Regular & uninterrupted supply of electricity with power backup, clean water supply was available at the facilities visited. Separate functional toilets were present for both genders for both staff and beneficiaries.
- Uniform state specific branding was observed across all operational AB-HWCs.
- All the SHC-HWC are linked to BPHCs, CHC and RH. This leads to congestion of higher-level facilities and underutilisation of PHCs.
- Many of the SHC-HWCs are co-located with PHC or BPHC. CHO is also posted in those SHC-HWCs which is not recommended. However, relocation of such CHOs is being undertaken by the state in a phased manner.
- The state is yet to roll out the expanded range of services. AB-HWC team is less oriented on health promotion activities and observance of health calendar days. There is a limited focus on health promotion and wellness activities in service delivery.
- PHC-Medical Officer lacked orientation to AB-HWC and concept of Comprehensive Primary Health Care.
- Remarkable decline in the out-of-pocket expenditure per delivery in public health facility was observed. Community interactions reveal minimal to zero OOPe during childbirth in public health facilities reflecting good implementation of JSSK.

- Pregnancy testing Kits were available in the facilities. All newer methods of contraception are available in all the primary care facilities.
- The line listing of pregnant women and children is well maintained with front line workers. ASHAs are well versed with HBNC practices and are able to undertake the relevant activities.
- Due list, MCP cards and updated micro plan were found to be available. VVM on the vaccine vials revealed that they were at usable stage. Adrenaline kit was available in all the vaccination sites except at one PHC. Open vial policy is followed properly.
- Community members, cured TB cases as champions, religious leader, gram sabha etc. are actively involved in the TB programme through FGD and village level meetings.
- Panchayat and rural development department is actively supporting and contributing to the environment and vector management part through vector control team and village level executor. Guppy fish is distributed to all villages.
- An online platform vector borne disease monitoring system (VBDMS) has been created by West Bengal state. This portal is used to record the daily activities of house-to-house teams (that search and identify mosquito breeding sites and breeding) and vector control teams (that eliminate breeding from sites identified by house-to-house teams). It is used to monitor the activities carried out for environment and vector management, particularly for Dengue.
- Screening of Hepatitis B and HCV being done for Pregnant women and high-risk groups.
- Revised CBAC is rolled out across the facilities visited. ASHAs are mobilising the community based on their risk assessment, as reported by CHOs. Community based screening is rolled out partially across the state. Opportunistic screening for Hypertension and Diabetes is being undertaken in all the facilities. Screening for oral and breast cancer being carried in many facilities. VIA for screening for cervical cancer only in few facilities. Limited health promotion activities are being undertaken.
- Referral linkages between SHC-HWC and linked BPHC/CHC/RH was seen. CHOs inform regarding referrals proactively to the BPHC/CHC/RH. After the treatment at higher facility, CHOs were following up individuals through ASHAs. This was corroborated through beneficiary interaction.
- State specific teleconsultation portal “Swasthya Ingit” is well adapted across SHC-HWCs. The hubs and spokes are well connected through the user friendly interface.
- Store Management Information System (SMIS) is being regularly used for indenting drugs. It is facilitating timely procurement and assured availability of drugs.
- Daily reports and service delivery reporting in AB-HWC portal is being regularly filled at all AB-HWCs.
- **Community Process:** The State has 54706 ASHAs in position as against the State’s present target of 63164 (for the FY 2021–22). The state has sanctioned and additional 13297 ASHAs, based on rural population, as per the SECC 2011 data, to be recruited over 5 years. ASHAs have clarity on their roles and skills and are well rooted in community with good rapport.
- The state has completed training of all ASHAs in rural areas in four rounds of module 6&7. Subsequently, ASHAs have been given refresher training as well. NCD training for ASHAs have also been conducted, and more than 70% ASHAs have been trained. Training of ASHAs has not been rolled out in other expanded service packages under HWC.
- All ASHAs have been given HBNC equipment, and all training modules.
- A good drug replenishment system is in place. ASHAs fill a stock update on their 7 drugs every month. Replenishment is done from SHC by ANM.
- Robust infrastructure for ASHA training is available wherein NGO partners are engaged @ Rs. 623 / ASHA day.
- The on-field mentoring support to ASHAs needs strengthening. Village visits done by ANMs do not have a definite pattern and assured frequency. The supportive



supervision visits by Block ASHA Facilitator are very limited.

- There is no Grievance redressal system for ASHAs. State has not implemented the GOI direction, to give benefit of 3 insurance schemes to ASHAs. ASHA restrooms are not found in most facilities

## ASHA Support Structure

- **State:** 2-member team of Program Managers is working as state support team, along with 1 State Nodal Officer.
- **District:** District ASHA Facilitators are in place in all districts.
- **Block:** Block ASHA Facilitators (BAF) are in place at block level – with 2 BAFs in each block. There are no ASHA Facilitators in position in the state. The ANMs, play the role of first level of support.
- **Village Health Sanitation and Nutrition Committee (VHSNC)** - The state has 48472 VHSNCs in position, against the target of 49051. Of these, total 45261 VHSNCs have bank account. VHSNCs have been formed at the Gram Samad level, which is Booth/Ward area of Gram Panchayat.
- Total 44234 VHSNCs have been trained in the VHSNC handbook, and 575781 VHSNC members have been trained. The last training of the VHSNCs was conducted in Nov. 2020. State has 791 trainers trained as VHSNC trainers. They have also been given online training on different issues of Public Health, Observation of Suswasthya Dibas & Control of Vector Borne Diseases in Rural Areas in September 2020. Subsequently, they have also been given online training on different issues of control of VBD and COVID-19 (with 3 members from each VHSNC trained), in March 2021.
- The state also has a strong convergence mechanisms, through Jan Swasthya Sabha-which is a monthly meeting on health and convergent action, conducted by Gram Panchayat, with ASHAs and AWCs of the area. VHSNCs are also involved. The state also has a cadre of GP level Health Supervisor (who are regular cadre senior ANMs). They play

role of a good link between GP and health and provide strong support to ASHA.

- Ownership and engagement of ASHA support cadre over VHSNC is very low, despite active engagement of ASHAs with VHSNCs on the ground. Limited ownership of district over RKS, and their capacity building/mentoring.
- **Rogi Kalyan Samiti (RKS):** The state has RKS constituted and functional in all of its facilities at DH, CHC, and PHC level. The Untied funds of the RKS at the CHC / Block PHC level, is being kept in the bank account of the Block Health Society.
- **Mahila Aarogya Samiti:** The state has 9758 MAS in position against the target of 11792 MAS. Against the target of 9698 about 98% (9483) MAS are trained. 102772 MAS members are trained. Many of the MAS members are also members of self-help groups. The ASHAs may or may not be the members of these groups. ASHA facilitated the formation of Mahila Arogya Samiti by linking the self-help group working in that community.

## State-specific Innovations

- **Community Delivery Centre (CDC)** in North 24 Parganas: To promote institutional delivery and ensure timely referral of cases with obstetric complications for the women living in the inaccessible island of Sundarbans areas of Basirhat district, 4 CDCs were established under public private partnership (PPP).
- **Boat Clinics (Mobile Medical Units) for Riverine Areas and Islands in North 24 Parganas:** Four MMUs are functional in 24 North Parganas with the objective to provide primary RCH services and general OPD services, in the identified area for the people residing on the islands who are not able to access government health services on mainland.
- **ANMs Use Mobiles/Tablets for Online Entry on the Matrima Portal (State's RCH Portal):** It is a mobile App /Tablet based application which is designed to capture the data from the field on real time by the ANMs directly. It also includes user friendly FAQ and teaching learning materials developed in Bengali for ANMs.







## **TOR 2:** **Secondary Care**

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# TOR 2: Secondary Care

## Objective to See

**a. Availability of critical care services and operational status of critical care areas: Emergency, SNCU, ICU, OT, LDR, etc at FRUs-CHC/SDH/DH**

- i. Assessment of adequacy and accessibility to critical care services with reference to population and time to care approach.

Emergency Services, OT, HDU/ICU, LDR, SNCU, PICU/NICU, etc, and other support services- Mechanized Laundry and CSSD, Dietary and Kitchen services.

- ii. To understand the gap in implementation of NUHM, RMNCH+A, RBSK, RKSK, SUMAN, NVBDCP, NLEP, NRCP, NTEP, IDSP, NVHCP, NACP, NPCDCS, NPPCD, NPHCE, NPPC, Trauma & Burn Injuries, NPCBVI, NPPCF, NTCP, NIDDCP, NOHP, NMHP, PMNDP, BMMP.

**b. Medicines**

- i. To understand supply chain management for EML and its availability at the site of dispensation.
- ii. Linkage with DVDMS or any state specific IT app. for procurement management, stock monitoring till HWC level, and quality control.

**c. Referral Transport System (Ambulances)**

- i. To assess the adequacy of referral mechanism from primary to secondary care health facilities in rural/urban areas.
- ii. To review observable components mainly in terms of availability, access, and service delivery in the following areas:

§ Vehicle- As per norms, operational aspects (based on type & services).

§ Equipment- Availability as per norms, functional status.

§ Human Resource- EMTs, Training (Knowledge and skills).

**d. PM-JAY – uptake in public institutions and challenges**

**e. A review of all relevant IT applications**

## Availability of Critical Care Services and Operational Status of Critical Care Areas

Critical Care Services comprise of emergency, surgical and intensive care services. As per NSSO/ NHA, most of the critical care services are confined to tertiary level with limited access to secondary care and referral transport systems. National Health Accounts, report an out-of-pocket expenditure of Rs. 2097 per capita. This amounts to 48.8% of the Total Health Expenditure (NHA 2017–18). COVID-19 further highlighted the need for strengthening health systems response and availability of adequate infrastructure. The top 5 causes of mortality are Ischemic Heart disease, COPD, Stroke, Diarrheal Diseases, Neonatal disorders (Global Burden of Disease Study, 2019). If these are managed timely at the level of district hospital itself, it will not only reduce the burden on tertiary care facilities but will also reduce the OOPE tremendously.

The secondary care health services are expected to have functional units for critical care including emergency area and ICU, isolation wards, OT, Labor-Delivery-Recovery rooms (LDRs) with Newborn Care Corner etc. These service areas should be supported with Medical Gas Pipeline Systems, Oxygen generation plants/ Oxygen supply, Air Handling Units (AHUs) etc., and mechanism for Infection Prevention control. Emergency medical services is a key area of critical care which includes Pre hospital care, transportation of patients and also care at hospital has been looked extensively.

### Key Observations

- It was heartening to note that well-functioning SNCUs and Newborn Care Corner with functional radiant warmer and other critical equipment were available in almost all states during the CRM visit except Arunachal Pradesh where these were not optimally operationalised due to lack of HRH and supporting infrastructure.
- New-born Care Corners in Puducherry were found to be unhygienic with shortage of essential commodities i.e., masks, shoulder role, mucus extractor etc.
- Most of the states visited were not aware of fixed criteria/process available for the referral of sick new-borns to other facilities.
- No follow up of the new-borns discharged from the SNCU/NBSU facility being done except for the state of Assam.
- NICU, PICU were hardly seen functional in the states visited particularly at/below district level.
- ICUs created for managing and mitigating COVID cases were also functional in all the states however, availability of same for non-COVID cases were diluted in most of the states.
- In the visited states, most of the health care facilities were providing emergency care but further monitoring of patients requiring either ventilatory or non-ventilatory support were observed to be uneven among the states.
- In all the states OTs were operational at DHs level. Maternity services were also being provided in all the district level facilities however, other surgeries were not equally uniform.
- C-section and other EmONC services were being rendered at almost all the DHs visited.
- The functional number of OTs varied widely between the states leading to at times less than optimal utilization of available surgical specialist particularly orthopaedics, eye, ENT and in some places even general surgery. OT in Sikkim & Tripura were non functional due to shortage of specialists.
- In Davanagere district of Karnataka and Puducherry, OTs were found fully operational and well maintained with clearly demarcated clean, buffer, and sterile zones.
- There was lack of anaesthetists and at places gynaecologists leading to less-than-optimal number of surgeries being conducted in many states.
- Deliveries are being conducted in all the facilities visited however, deliveries envisaged as per LaQshya guideline were observed to be missing in most of the states.
- The factors which require attention and improvement are largely non availability of labour beds, privacy, adequate number of nurses and other trained HR.



- Overall comprehensive critical care planning is lacking in almost all the states visited.

## Recommendations

- All the secondary care facilities should have assured critical care services including (emergency and triage services, modern OT, Labour Room/LDR, High Dependency unit for general and obstetric care, General and Obstetric ICUs, NICUs, SNCUs and PICUs) along with support services like Mechanized laundry and CSSD, modern kitchen, affluent treatment plant, trained HR, and diagnostic facilities as per the Indian Public Health Standards 2012. The IPHS has now been revised in 2022 and the States now have to be IPHS 2022 compliant.
- All the states should make comprehensive prospective plan to ensure availability of critical care services at district level, apart from that there is a dire need to build the capacity of architects, hospital planners, engineers, and relevant program officers for preparing a prospective plan based on scientific needs of the population for critical care services.
- ICUs created for managing and mitigating COVID cases should also be utilized for managing and treating other critical cases.
- Triage services at emergency and zoning at all the critical care areas need to be strengthened.
- The linkages of National Ambulance services with critical care areas to be ensured in all the states.
- State should plan for comprehensive OT complex rather than creating standalone OT at District hospitals. And if the facility is having availability of various specialists, should be optimally utilized for surgical services as well.
- Hiring/ recruitment of sanctioned critical human resources shall be done as per the state's protocol.
- The concept of LDR and respectful maternity care to be followed by the states, labour tables need to be replaced by labour beds.
- Essential documentation at labour room such as partograph monitoring, record of high-risk pregnancies need to be maintained by the health professionals.
- The states to have fixed criteria/process available for the referral of sick new-borns to other facilities. Also, follow up mechanism of the new-borns got discharged from the SNCU/NBSU facility need to be ensured by the facilities.
- Infection prevention protocol and standard operating procedures to be followed in every critical area.
- In-service education and capacity building of staff at all levels (Emergency, ICU/HDU/ SNCU, OT and LDR) should be done on the defined intervals, also as and when required.

## State-wise Observations

### Arunachal Pradesh

**ICU/HDU:** In terms of infrastructure, the district hospitals at Lower Subhansiri were having critical care components like Operation Theatres, Intensive Care Units, High Dependency Units with support services like CSSD, laundry and kitchen/ dietary services. In Lower Subhansiri fully equipped ICU and HDU was available with HR in place awaiting COVID patients as DH is presently functioning as DCHC.

**OT:** District Hospital in Lower Subhansiri has two operation theatres with facility of C-Sections (one general surgery and one eye OT). In Namsai one OT for management of mainly obstetrics & gynecology cases with a small proportion of general surgery cases like hernia, appendectomy, cholecystectomy, laparotomy was functional

Zoning (protected, clean, sterile & disposal) was not practiced in the OTs in both the districts hospitals. Inadequate triaging and no HVAC system for air quality maintenance found during the visits. As observed, normal window and split air conditioners were used compromising the air quality requirements inside the OT. The standard operating procedures were not present not only for the OT but for other critical care areas too.

**LDR:** Don't have the LDR facility in the secondary care facilities.

## Assam

**ICU/HDU:** The health care infrastructure including intensive care units were not found as per Government of India norms to cater the critical care needs of the population.

**OT:** DH Hailakandi has two functional OTs i.e., eye OT and Obstetrics OT. All staff nurses at the labour room and the MOs were well versed with all quality protocol and treatment procedures. The facility lack infrastructure in terms of zoning of OT and unidirectional flow of services to ensure sterile environment.

No dedicated dirty utility area: unidirectional flow of people and materials not maintained - at one of the CHC visited.

**LDR:** don't have the LDR facility in the secondary care facilities.

**SNCU:** The SNCUs at both the Hailakandi and Cachar DH were functional having decent infrastructure. However, SNCU at Hailakandi was staffed with only 2 full time paediatricians and 10 SNs. SNCU bed occupancy was found to be more than 100 percent in DH of both districts. Out born admission in SNCU Hailakandi and Cachar due to community referral was 13.6% and 2.7% respectively.

**NBCC:** Almost all the visited L2 & L3 health facilities were found to have dedicated area for new-born care corners (NBCC) inside the labour room and operation theatre with functional new-born care equipment. Most of the ANMs & SNs of the visited health facilities were not trained on essential NSSK, although trained in SBA & IYCF. Kangaroo Mother Care (KMC) was observed as an inherent component of care of LBWs in health facilities in both districts. Although a proper reclining chair was lacking in the KMC room.

**NBSU:** The visited CHCs had well equipped NBSU with the requisite HR. However, the visited CHC in Hailakandi district was underutilized due to lack of training to the staff nurses and doctors. - Only few of the staff nurses posted in NBSU had received F-IMNCI or FBNC training. Most of the stable babies were referred from NBSU to SNCU at district.

## Bihar

**ICU/HDU:** The visited facilities do not have HDU and ICU facilities.

**LDR:** None of the visited LRs were LaQshya certified. Only 11 health facilities are LaQshya certified in the entire State.

**SNCU:** The visited SNCUs were well equipped and had provision of centralized oxygen for few beds.

- The number of staff nurses needs to be rationalized to ensure presence of at-least two nurses per duty shift. Not all SNCU staff was FBNC trained.
- A system has been developed in all the SNCUs for facility and community follow up of SNCU discharged babies via WhatsApp group and was functioning well before COVID-19. Since last year, due to the deployment of the data entry operators for COVID-19 duty, the system got disturbed and is yet to be streamlined.
- None of the two visited districts, had a functional NBSU. There is no dedicated nursing staff approved for NBSUs. None of the staff at CHCs and PHCs has received F-IMNCI training in the last 3 years. All the peripheral new-born referrals are directed to district facility, delaying not only management but also diminishing chances of survival.
- New-born care corners with well-functioning radiant warmer were established at all delivery points visited.

## Haryana

**ICU:** At DH Mandikhera, ICU is under construction for 3-4 months. A dedicated space has been identified. In DH Fatehabad, construction is ongoing to build a separate ICU unit having 5 HDU beds and 5 ICU beds and all necessary equipment like defibrillators, monitors and ventilators are in place. Laundry services are available in the facility with an in-house washing area.

**LDR:** Don't have the LDR facility in the secondary care facilities.

**SNCU:** Facilities have functional SNCU. However, equipment at SNCU were sub optimally functional.

## Karnataka

**ICU/HDU:** Well-equipped HDU/ICU were found at the DH, Taluka Hospital and Women and Child Hospital in Davanagere District and at DH Yadgir.

In Yadgir, PICU and NICU services were not established, and HDU/ICU are not available at any level except at Taluka hospital however, not being used despite availability of intensivist for last 4 months. So, all the patients requiring critical care services are being referred to other districts.

**OT:** Well maintained OT with clearly demarcated clean, buffer, and sterile zones in all facilities of Davanagere and modular OT observed at Taluka Hospital, Shahpur (Yadgir).

In both the districts, HVAC system not available at DH where most of the surgeries are being performed whereas one Taluka hospital has two modular OTs with HVAC, but no surgeries are being performed due to lack of specialists in Yadgir.

Specialists like ENT & Ophthalmologists (only 1-2 surgeries in a month) were not optimally utilised in comparison to young Orthopaedic Surgeon who is performing 4-5 surgeries per day. One of the major reasons for less number of surgeries were lack of some equipment mention name of place.

**LDR:** Health Care facilities in Karnataka have all the critical equipment available and functional in Labour room. However, the concept of LDR is not yet implemented in the district visited. Also, the HVAC system was not available in critical areas of DHs.

Deliveries were being conducted on labour tables however, no labour beds were available and alternate birthing positions are not being practised.

### SNCU:

- Both the districts have SNCU with adequate bed occupancy, 30-bedded SNCU at DH Davanagere had more than 80% BOR.
- Considering the BOR, the number of beds in SNCU needs to be increased from 12 to 30 in the new MCH wing layout at CGH, Davanagere to accommodate high case load of sick new-borns.
- All Taluka hospitals equipped with 4-bedded NBSUs, rest all facilities visited had functional

NBCCs with radiant warmers and Ambu bag (0,1 size) at all levels.

- Posted staff nurses were trained and aware of the essential new-born care skills, use of Ambu bag for Neonatal resuscitation and its disinfection protocol in Davanagere but not in Yadgir.
- There is no fixed criteria/process available for the referral of sick new-borns to other facilities.
- No follow up being done of the new-borns discharged from the SNCU/NBSU facility.
- High mortality rates (almost 15%) observed in SNCU of Davanagere District however, no report of Child Death Review found in the hospital.
- In Yadgir, PICU and NICU services were not established, and HDU/ICU are not available at any level except at Taluka hospital however, these are not being used despite availability of intensivist for last 4 months. So, all the patients requiring critical care services are being referred to other districts.

## Mizoram

There was no High Dependency Unit established at DH Mamit, while on the other hand, DH Champhai had established HDU, which had a single entry/exit point, continuous oxygen supply, critical equipment, and drugs.

**LDR:** don't have the LDR facility in the secondary care facilities.

**SNCU:** Facilities have functional SNCU. However, equipment at SNCU were sub optimally functional.

## Odisha

**ICU/HDU:** There is also an urgent need to operationalize facility for Obstetric HDU and Obstetrics ICUs in both DHH and RGH to improve maternal survival.

Operationalizing functional FRUs to reduce delivery load and late referrals to higher centres.

Establishing Obstetric HDU in both hospitals to improve emergency care.

**LDR:** The 100 bedded hospital (RGH-MCH Centre) is unable to cater to the patient load coming and there is an urgent need to create more space for ensuring respectful care for labouring mothers at hospital.

Lack of beds for labouring mothers is creating unfavourable environment for postpartum women and consequently a very high rate of early discharge was observed from RGH Rourkela.

**SNCU:** Facilities have functional SNCU. However, equipment at SNCU were sub optimally functional.

## Puducherry

**OT:** Zoning was observed in all Operation Theatres at IGM, IGGMC, RGM and DH Karaikal. All OTs were well equipped. Obstetric HDU was available with adherence to technical protocols at Rajiv Gandhi Medical College.

**LDR:** In Puducherry Maternity ward of the district hospital is well structured and adequate beds are available at ANC Ward, LR, OT, Post-operative ward, post-natal ward, Special ward and Gynae ward (Karaikal GH).

Reporting and documentation at LR found satisfactory. Partograph for monitoring of labor is being done by the Labour room staff.

Infrastructure of Maternal and Child health services area of delivery points of Puducherry are disorganized and not found to be as per GoI recommendations.

**SNCU:** SNCU bed occupancy rate is more than 80% in both the districts. All protocols including death audits are being conducted at SNCU in Rajiv Gandhi Medical College and gap identification and action plans were accordingly prepared. Screening of newborns at birth are being done by the SNCU staff.

## Sikkim

**ICU/HDU:** 10 bedded ICU in female ward is currently functioning as a general ward with direct entry and lack of equipment (like Multipara monitors and ventilators).

**LDR:** District hospital Gyalshing in Sikkim has a MCH facility with Triaging attached to LDR complex, four bedded NBSU and female ward.

Proper zoning was maintained in the LDR and changing protocols were being followed by the staff and patients.

Two LDRs were available in the MCH complex. But only one of them was equipped with Labour bed while other has Labour table.

**SNCU:** No SNCU at facilities visited in Sikkim.

## Rajasthan

**ICU/HDU:** Intensive Care facilities were available at both the DH. At the DH Karauli, the ICU had 10 beds, 14 ventilators, 1 defibrillator, 4 multi-para monitors and connectivity with centralized Oxygen delivery system.

The DH Jalore had 14 ICU beds with 17 ventilators and 10 BiPAP machines. The In-Charge (I/C) at CHC Bhinmal being an anaesthesiologist, had also established a 3 bed ICU in the facility with the help of donations from the community.

An independent HDU facility with ventilators was available at DH Karauli, that was primarily put in place for managing critical COVID-19 patients. However currently it was in locked state as no COVID-19 patients were admitted. The HDU had a single entry/ exit point to the HDU with availability of centralized continuous oxygen supply.

Critical equipment and drugs were available. The doctors would take rounds of the facilities on an on-call basis.

**OT:** There were 2 OTs at the DH Karauli, both having one table each. Three General Surgeons were attached to the Surgery Department and were conducting 40–45 operations per month. Patients rarely incurred OOPE, and there was no significant waiting time for 33 surgeries, however, records for OT Cancellation rate were not available. Zoning of OT to ensure unidirectional flow of materials and functional HVAC system was not observed.

The OT at DH Jalore was underutilised due to unavailability of Surgeons. Occasionally, handful cataract surgeries would take place.

**LDR:** Gaps found in the provision of critical care services and linkage between these service areas. Referral protocol also was not found to be streamlined.

The Mother and Child secondary services are provided in separate MCH hospitals, which are located 10 kms from the DH in Karauli, and about 5 kms away from the DH in Jalore. The Labour room is LaQshya certified.



**SNCU:** The SNCU in both districts had good equipment, optimal bed utilisation and were well functional. The SNCU at CHC Bhinmal has previously been commended for being the best SNCU in the State of Rajasthan. Critical equipment and drugs were available.

SNCU had a single entry/exit point. Demarcated facility for triaging could not be observed. No dedicated MO for SNCU was available and Paediatricians are doing on call duty for emergency hours. All the babies are in the care of SN only after the OPD hours.

The Paediatric ICU at Karauli was well equipped with availability of critical equipment and drugs. It is a 10 bedded facility, with a provision of 7 additional beds as preparedness for any potential third COVID-19 wave.

In CHC, Ahore, Jalore, the 4 bedded NBSU seems non-functional and lacked maintenance, however the records were found to be maintained.

## Tripura

Emergency services managed in open areas, lack of manpower, emergency drugs, equipment, multipara monitors and infection control measures also coexisted in Labour room. Critical care service areas (emergency department, Labour delivery room) lacked distinct spaces for triaging and zoning.

**HDU/ ICU:** District hospitals in the state lacked HDU/ ICU and ventilators. Under ECRP 1 and 2 packages, twelve (12) beds – eight for ICU and 4 for HDU were allocated as a part of a 42-bedded pediatric COVID unit.

**OT:** Operation theatres were either unavailable or not operational at the CHC/ SDH level, hence patients were being referred to the district hospitals. OTs in DH did not perform major surgeries due to shortage of specialists. Pre-operative, Post-operative, PAC rooms, and separate pre/post maternity wards are unavailable in DH Khowai.

**LDR:** Labour rooms of the visited facilities were operating in conventional mode. There was no provision of LDR, birth companion, and alternate birthing position etc. Under LaQshya program, only 3 labour rooms and 1 M-OT are nationally and state LaQshya certified in the State.

Facility records revealed an increasing trend of C- section rates in DHs (14.4% in 18–19 to 29.3% current). The labour rooms have dedicated area for newborn care corners (NBCC) in every facility, however, they lack distinct spaces for triaging and zoning, and not practiced.

The labour rooms' arrangement and operations need attention. For instance, seven trays though available, were not maintained well; bed head tickets are being used instead of case sheets; partographs are not being filled as required; no BEMMP services were observed in labour rooms; and departmental SOPs were not available. However, instructions like hand washing, segregation of Biomedical waste, management of the third stage of labour, management of PPH, storing of the vaccine in ILR, etc are displayed in the visited facilities. Respectful maternity care needs attention too and the space allocated for ANC and PNC rooms needs to be improved to ensure adequate privacy. Providers demonstrated poor knowledge on technical aspects. Shortage of specialists and inadequate capacity building of the existing manpower affected service delivery.

**SNCU:** The district hospital at Khowai has functional SNCU/ NBCC with Paediatrician. Though hygienic and well maintained, admission was comparably less. Whereas in Dharmanagar, SNCU and Paediatric ICU are non-functional in DH. NBSU services need to be strengthened. However, the Neonatal Intensive Care units (NICU) at the district level present as one of the best practices. They worked efficiently, and are fully equipped with trained human resources.

## Uttar Pradesh

**OT:** Lack of Triage area and dedicated space for surge capacity was observed in both the districts. The CHC designated FRU but OT services was not functional. Zoning of OT was not seen at DWH level. There is one OT in the facility which is used for LSCS along with tubal ligation. The caesarean section rate of the facility varies between 12–13% and operation cancellation rate is 3% (October 2021) with only one DGO in position (on an average 22 surgeries / week).

**LDR:** LDRs were not found to be functional as per GoI norms even in the MCH wings.

**SNCU:** The labour room was equipped with NBCC with functional radiant warmer. Four fans were mounted

in labour room, which compromised the asepsis and draft free areas for the NBCC and Kangaroo Mother Care lounge was actively used by low birth babies for KMC, in both DWH and CHC. This lounge has all the IEC related to KMC and women are oriented along with their family members on KMC.

## West Bengal

**ICU/HDU:** Critical services such as SNCU, CCU, OT available at all FRUs visited. Staff is highly motivated and technically proficient in all the service areas visited.

**OT:** Critical services such as SNCU, CCU, OT available at all FRUs visited. Zoning not observed in any of the Operation Theatres visited in Nadia, however it was satisfactory in North 24 Parganas. HVAC not in place in both the districts.

**LDR:** Provision of respectful maternity care was observed in most of the Labour Rooms visited in West Bengal.

**SNCU:** New-born care corner is established as per norms at all visited delivery points. Essential new-born care is being provided by staff nurses. All high case load facilities have provision of Kangaroo mother care with reclining chairs. All district hospitals have SNCU facility. At SDH Barrackpore in North 24 Parganas, SNCU staff had conducted appreciable gap assessment and action planning along with child death reviews. State is in a process of augmenting SNCU beds in existing facilities and also creating new SNCUs with installation of required equipment.

Inadequate number of SNCU beds with required infrastructure leading to doubling on each bed or pre-mature discharge at DH/SDH.

## TOR 2 Category 1: Availability of Critical Care Services and Operational Status of Critical Care Areas

### Emergency Services

Medical emergencies including Road Traffic Injuries are one of the major leading causes of deaths in India. RTIs alone contribute to 1.5 Lakh deaths annually. Approximately 2 persons died owing to

heart attack every hour in 2015–16. Currently, Non Communicable Diseases alone account for ~62% of deaths in India and communicable infections, Maternal, New born account for ~27% of deaths. Most of these deaths present as emergency conditions. In fact, as per one estimate more than 50% of deaths and 40% of total burden of disease in Low Middle Income Countries could be averted with pre-hospital and emergency care. The global total addressable deaths and DALYs that can be averted amount to 24.3 million and 1023 million lives, respectively. In fact, in South-East Asia alone, 90% of deaths and 84% of disability-adjusted life years (DALYs) are due to emergency and trauma conditions.

As the primary portal of access into the health system, emergency care is critical to universal health coverage. Emergency care system in our country has seen uneven progress. It suffers from fragmentation of services in both the public and private sectors, ranging from pre-hospital to facility-based treatment. Some states such as Tamil Nadu and Kerela have done well, while others are still in the budding stages. Most of the emergency services are only available at the tertiary level, with limited access to secondary care and assured advanced referral transport systems. The lack of organized emergency care at the primary and secondary levels of health care has a substantial negative impact on health outcomes & also leads to out of pocket expenditure. District hospitals often lack skilled personnel, adequate infrastructure, and consumable supplies. Triage is rarely practiced.

It is therefore, important that Assured & Comprehensive emergency care should be made available at the primary, secondary, and tertiary levels, with a robust referral and transportation network, to ensure timely intervention and better survival.

### Key Observations

- In almost of the states public health care facilities were providing emergency services, however, range of services and quality needs to be strengthened.
- Prehospital assured transportation of the patients needing emergency care was available in almost all the states through ALS & BLS ambulances being supported under NHM.

- In most of the states one outstanding observation was the readiness of the emergency services & infrastructure, to cater the requirements to mitigate the COVID-19.
- Emergency drugs and oxygen was available in most of the facilities visited but most of the critical care equipment found to be partially/non-functional in the emergency care units.
- In most of the health care facilities visited disaster preparedness was lacking.
- State like Karnataka and Sikkim has District hospitals with emergency care unit having proper triaging, and division of beds under red and yellow categories with multipara monitors and oxygen support.

## Recommendations

- States must assess facilities in accordance with IPHS and develop a time-bound action plan to create adequate space for emergency care systems at existing health facilities, resulting in standardised emergency departments with recommended bed, infrastructure, equipment, drugs, and human resource ratios.
- The emergency set up although available in the facilities need thorough attention for better planning & implementation of EMS in the hospital as per GoI guidelines.
- Availability of emergency case management algorithms/charts, and capacity of health care providers to handle the various types of emergency conditions need augmentation.
- Emergency care services need to be further strengthened at all levels of care in order to ensure that services are available at the primary level as well.
- All hospitals need to a documented & organized system for efficiently handling of any disaster. States must ensure that emergency care services are provided with adequate human resources and competent staff, as well as hasten the capacity-building process.
- Referral linkages should be strengthened to guarantee assured & appropriate facilities based management of all emergency conditions.

- While planning for hospital based assured emergency services besides the core requirements of drugs, equipment, trained manpower, intra and inter facility transfer etc, the inhouse assured linkages with supportive services like diagnostics, radiology services and Blood Bank related services needs to be established.
- Quality assurance and its implementation through a robust governance framework is also required for effective emergency service provision.
- Handing over & taking over of critical equipment, Oxygen sources, suction apparatuses, multipara monitors, ventilators, emergency drug tray etc. need to be done by the Nursing in charge with change of every shift to ensure round the clock availability of functional equipment.
- The MS/ Hospital in-charge & manger need to take regular & daily review of the emergency department & monitor the cases treated/referred ,so that, any gaps if found can be filled.
- Infection prevention protocols through an assured & strict system of decontamination of equipment/instruments, change of linens, and adherence to infection prevention practices & segregation need to be strengthened.
- The Matrons/ Hospital In charge & Hospital managers need to monitor the IMEP & BMW protocols.

## State-specific Findings

### Arunachal Pradesh

- In both the districts, emergency is operating from single room with limited amenities, no demarcated triage of red, yellow & green zones.
- The location of emergency room is also not very accessible from main road and linkages with other service areas is also limited.
- In Lower Subansiri, all major accident cases and other emergencies are referred to TRIHMS, Itanagar, located about 65 kms and is accessible in about 5 hours with very

difficult roads. In TRIHMS also, no protocol or SOP is in place for management of emergency cases. The staff is not aware of the protocols.

- Likewise, in Namsai for all major emergencies, beneficiaries prefer directly going to either Assam Medical College/ Hospital, Dibrugarh, or Zonal Hospital, Tezu due to limited-service provision and lack of awareness about available services at DH.

## Assam

- Standard Operating Protocols of common emergency conditions were in place.
- A separate accessible entry for the emergency area exists. However, the main entry was not large enough to move two emergency cases in and out at DH Hailakandi.
- Triage is not being practiced. No dedicated staff nurse for the emergency unit is available.
- No intercom facility to communicate within department was available.

## Bihar

- Service Provisions for Emergency were uniformly available across the facilities visited.
- However, emergency departments at district hospitals need to be strengthened to provide advanced life support.

## Karnataka

- Availability of critical equipment available and functional in emergency.
- Emergency medicines were mostly available including anti-snake venom, anti-rabies vaccine in both the districts.

## Mizoram

- Emergency Care Services were being delivered at the District Hospitals.
- In the emergency ward, a separate space for triaging was indicated at the District Hospital

Mamit, but it was largely used for COVID patients.

- Tagging of beds into red and yellow zone was being practiced at DH Champhai but was not observed in DH Mamit.
- Continuous oxygen supply was operationalized at DH Champhai and on the other hand the required infrastructure for piped oxygen supply was being installed at DH Mamit. Oxygen was being supplied through oxygen cylinders at DH Mamit.
- The LAMA rate was found to be nil for DH Champhai and 0.8% for DH Mamit in the present year suggestive of good quality of secondary care being provided at both the facilities.
- The patients that were referred from the District Hospitals to higher tertiary care centres stood at approximately 4% since April 2021 for DH Mamit and it was 7.7% for the month of November '21 in DH Champhai.
- People from few of the blocks bordering Tripura State preferred to seek healthcare in the health facilities of Tripura due to better connectivity.

## Odisha

- District hospital emergency ward in Sundargarh district was only providing emergency OPDs due to lack of structured, organized, and assured emergency medical, surgical, and accidental services.
- Emergency services and critical care services were largely available at DH level due to lack of specialists at CHC/SDC level facilities.

## Puducherry

- IEC Posters, protocols were well displayed and emergency supplies were adequate in the emergency department of the facilities visited.



## Rajasthan

- The facilities had adequate road connectivity for accessibility; however, the Emergency / casualty did not have a separate entrance in DH, Jalore.
- In most of the facilities, either stretchers and wheelchairs were not available besides the entry gate or were found to be rusted and broken.
- Triaging and zoning were not observed in the facilities visited in Jalore.
- In Jalore, patient stabilization equipment in casualty wards were inadequate, and the staff was not trained well enough to handle critical cases.

## Sikkim

- 24\*7 Emergency care services with assured specialist services like Obstetrics and Gynaecology, Medicine, Paediatrics, Orthopaedics, ENT, Ophthalmology were available in DH Gyalshing, West Sikkim.
- DH had a separate entry for emergency patients near to the main entry of the hospital.
- Emergency department had triaging facility in place with the capacity of three beds. Staff nurses were responsible for the initial triaging process before shifting the patients to the monitoring room. Also, a minor OT was present in emergency for minor procedures like fracture reduction, incision & drainage etc.
- The knowledge of the emergency staff regarding triaging protocols, GCS scale, and COVID management were adequate but they were not found to be trained on recent Biomedical waste management protocols.
- SOPs for triaging, burns management, COVID care management, overall emergency, monitoring, MLC, shifting, hand washing, recording & reporting were displayed in the emergency department.

- Nursing staff was maintaining daily shift wise patient's reports and census including previous patients, new cases, discharge, LAMA cases, referred cases, patients shifted to other areas like OT, ICU, Ward, and Deaths etc.
- In the last month there were zero LAMA cases in the emergency department.

## Tripura

- Emergency and other critical care services were suboptimal in all secondary facilities in Khowai. Sub-divisional level facilities in Khowai refer more than 50% of emergency cases, especially RTA and CVA cases to the district hospital or tertiary hospital (AGMC) due to the lack of capacity and manpower to manage emergencies.
- In addition to the emergency services managed in open areas, lack of manpower, emergency drugs, equipment, multipara monitors and infection control measures also coexisted.
- Critical care service areas (emergency department, labour delivery room) lacked distinct spaces for triaging and zoning.

## Uttar Pradesh

- 8 bedded emergency ward available at District Hospital and 10 bedded Trauma Centre available with X ray, USG, CT facility at DH Fatehpur.
- Lack of Triage area and dedicated space for surge capacity was observed in both the districts.
- Emergency response plan was also found to be unavailable.

## West Bengal

- Gross space crunch and inadequate triaging observed across most of the Emergency departments visited.

# Medicines: Free Drug Service Initiative (FDSI)

The Government of India had launched Free Essential Drugs Initiative aiming at expanding the availability of free drug provision in all public health facilities. The initiative not only support states for the purchase of drugs, but enable states to put in place transparent systems of procurement and quality assurance IT backed supply chain management systems like Drugs and Vaccines Distribution Management Systems (DVDMS) and logistics that would ensure the highest possible levels of safety and quality of drugs. strengthening/setting up robust systems of procurement, quality assurance, warehousing, prescription audit, grievance redressal, Information, Education and Communication (IEC), training, dissemination of Standard Treatment Guidelines, etc.

According to the National Health Accounts report for 2017–18, OPE accounts for 48.8% of overall health expenditure and 19.5% of prescribed drugs. The implementation of a free drugs service initiative in public health facilities, on the other hand, would provide immense relief to people if vital drugs were made available to all patients attending public health facilities for free.

The National Health Mission (NHM) conducts Common Review Mission (CRM) every year to assess the implementation status of national health program including but not limited to “free drug service initiative,” key strategies, priority areas for improvement, and analyse strengths and challenges.

Drugs procurement and distribution has been streamlined through IT enabled Drugs Distribution Management Systems in 30 States/UTs.

It identifies trends in progress of key indicators, particularly relating to coverage, equity, and affordability of medicines.

Key observations and recommendations in r/o thirteen visited states are given below.

## Key Observations

- Arunachal Pradesh, Assam, Bihar, Haryana, Karnataka, Mizoram, Odisha, Puducherry, Rajasthan, Sikkim, Tripura, Uttar Pradesh, and West Bengal have all implemented the Free Drug Service Initiative (FDSI).
- With the exception of Karnataka and Mizoram, most states have a Centralized Procurement Agency.

- In most states, the Essential Medicine List (EML) was available. Except in Karnataka and Mizoram, most health institutions had displayed the EM. The availability of medicines at health care facilities was a problem in the majority states.
- Drugs and Vaccine Distribution Management System (DVDMS) — With the exception of Sikkim, most states have an IT-enabled inventory system.
- High Out of Pocket Expenditure (OOPE) on medicines was observed in Arunachal Pradesh, Bihar, Mizoram, Sikkim, and Uttar Pradesh. Increased Local purchase of drugs have been observed in most of the visited states.
- Prescription Audits is practiced in Assam, Odisha, and Uttar Pradesh while this practice not yet been adopted in other states.
- With the exception of Mizoram, Puducherry, Rajasthan, and Sikkim, most states have a proper grievance redressal system. In several states, ASHA grievance redressal is indeed a matter of concern.
- STGs are available in most states, with the exception of Assam, Haryana, Mizoram, and West Bengal, where adherence is a serious challenge.

## Best Practices

- One of the best practises identified was the use of an alert system to notify personnel of medications that “look alike and sound alike.” (at RGW & CH).
- It was observed that some states have their own medication procurement software, known as Supply Chain Management Software (SCMS), which is used for managing, indenting, and ordering drugs and vaccines up to the PHC level.
- Some healthcare facilities offer well-kept infrastructure, pharmacies, and laboratories. At other sites, bin cards were displayed in a systematic manner.

## Recommendations

- Centralized procurement body should be constituted to ensure transparent and uniform mechanism for the procurement of drugs in all States/UTs.
- District Drug warehouses must be strategically located to save logistical costs and lead times for stock replenishment. The infrastructure for drug storage in drug warehouses and health facilities should be adequate.
- Essential Medicine List (EML) to be displayed at each health facility wise and should be revised annually. Awareness about EML and their availability should be created among doctors and staff. State should ensure availability of EML drugs at Warehouse and health facilities to increase accessibility by timely procuring and minimize Out of pocket expenditure (OOPE) incurred on medicines.
- IT enabled supply chain management system should be implemented at each health facility. Real time data management system should be developed to get actual data of stock and their availability. There should be one central dashboard for all states to get centralized data for supply chain management and to avoid parallel integration of software.
- Efforts should be made to expedite the drug indenting process and provide timely and appropriate medicine supply at facilities, including Urban Healthcare Facilities. Pharmacists need to be trained on how to calculate drug stock outs because they are uninformed of the process.
- Prescription audit practice mechanism should be established for rational use of drugs and minimize misuse of drugs. State should encourage for adherence to Standard Treatment Guideline (STGs) and establishment of system for the handling near expiry drugs (such as First Expiry First Out – FEFO).
- At the end of State findings there is a summary report.

## State Findings

### Arunachal Pradesh

- The state has notified Essential Medicines List with 554 medicines at DH, 455 at CHC, 172 in PHC and 105 in SC respectively. EML however, lack of clarity among staff regarding same was found along with high out of pocket expenditure at all the facilities visited.
- It was also observed that the Health & Wellness Centre had a limited supply of hypertension drugs. In Namsai, there was also a scarcity of Vitamin K, stock outs of drugs, and BCG vaccine, as well as quality testing and storage concerns.
- IT inventory was functional and drug was dispensed in generic name under Standard Treatment Guidelines, Programme Guidelines and EML. However, High Risk and LASA medicine were not labelled separately.

### Assam

- The state notified “Free Drugs Service Initiative” scheme at public health facilities. The EML is revised once every 2 years for each facility level (Last update done in 2019). The visited SHC-HWCs had all 31 drugs mentioned in the state EML whereas the PHC-HWC had 24–45 out of the expected 172.
- Essential medicines list is available and displayed in the OPD area but free drug entitlements have not been displayed at the facility in the local language.
- Bin cards are maintained at drug stores/dispensaries.
- High risk and LASA medicines are labelled and stacked separately.
- Medicines are forecasted and procured by scientific inventory tools (ABC/VED/ABC-VED, etc.).

### Bihar

- The Essential Medicines List was displayed and updated at all the health facilities.

- Community members at APHC Gerua Parsanda complained of lack of availability of drugs at the facility.
- EML was displayed and updated at all facilities.
- Essential drug list are not displayed in the dialysis unit.
- DVDMS (Drug and Vaccine Distribution Management System) has been implemented in government hospitals across the state.
- Drugs for management of both diabetes and HTN like Metformin, Glimepiride, Atenolol, Telmisartan, Propanolol, etc. were available at secondary care facilities (CHC & above).

### Haryana

- The Central Drugs Centre followed a transparent system for procurement of drugs.
- ODISCMS did not have any provision which would alert online in case the stock of drugs goes below 25%.
- Despite having a centralized drugs management system, all the HWCs are maintaining multiple manual inventories and also applications have been used by ASHA workers and for procurement of drugs.
- The State Government has another software named “e-Upchar” which maintains in-house drugs inventory and monitors use of drugs at various facilities including the pharmacy.
- The visited facilities lacked the cold storage maintenance for the drug storage.

### Karnataka

- The lack of necessary drugs resulted in significant out-of-pocket expenses. At all levels of facilities, the average number of drugs available against the State EML is less than 50%. At the health facilities visited, there were drug shortages. However, emergency medicines, such as anti-snake venom and anti-rabies vaccine, are widely available in both districts.



- All of the healthcare facilities have well-kept infrastructure, pharmacies.
- The state headquarters has an IT-enabled inventory management system (DVDMS), which has been implemented up to the PHC level.

## Mizoram

- Patients are incurring high costs on drugs at DH, CHC, and PHC, resulting in significant OOPEx and inconsistent supply of programme drugs were also observed.
- Drug and reagent stocks are in short supply due to supply difficulties.
- Incorrect use of DVDMS – only used for stock updates, not indenting.
- There are no grievance redress mechanisms in place for ASHAs.

## Odisha

- Prescription audits were conducted in all the visited facilities.
- Odisha State Medical Services Corporation has demonstrated excellent work in procurement & supply chain management. However, stockouts and expired drugs were observed in a few facilities. Untied funds given to facilities for local purchase as required.
- No stock outs observed for essential drugs in Labour Room of visited facilities.

## Puducherry

- SHC-HWCs did not have all 31 drugs mentioned in the UT Essential Medicine List (EML) and PHC-HWCs also did not have all 174 essential drug list in the facility. It was informed that revised EML have not been circulated in the district.
- In the PHF that was visited, there were well-kept drug storage facilities.
- Most facilities keep a calendar of close drugs that are about to expire.
- Effective data management through the use of IT applications (Drugs Vaccines Distribution Management System (DVDMS)).

- Drugs such as erythropoietin are provided free of charge to all patients under the PMNDP.

## Rajasthan

- The Essential Medicine List (EML) was displayed in each health facility except at HWC level & there is system of e-Aushadhi at each level facility except sub- centre. FIFO principle was followed for the movement of drugs out of the district drug warehouse.
- Near expiry drugs were found in both district's facilities and the staff were not aware about expired drugs policy.
- There was a shortage of necessary drugs in ALS in DH Jalore; expired drugs and consumables were discovered in one labour room of Karauli district; and ASHA lacked a drug kit.

## Sikkim

- Profound out-of-pocket expenditure for beneficiaries due to unavailability of essential medicines. However, anti-Hypertensive & Diabetic drugs were available at all levels as per treatment protocol.
- ASHAs provide standard medicine kits to COVID patients at home, under the supervision of healthcare professionals.
- Centralised Procurement Agency in place in State but DVDMS, e-Sanjeevani was not functional at secondary care.
- There is a system in place to check the quality of medications.

## Tripura

- State has its own Drug Procurement Software for management, indenting drugs and vaccines up to PHC level, and it's linked with DVDMS.
- The supply of medicines was facilitated through the SCMS portal across all facilities, if not supplied by the state, were locally purchased through untied funds.
- The majority of the public facilities visited were unaware of the free drug initiative,

and the scheme's requirements have yet to be implemented. NCD medicines for hypertension and diabetes were also found to be insufficient at all levels of care.

## Uttar Pradesh

- All of the drugs specified in the EML, including those used in Urban Healthcare Facilities, are unavailable. For a long time, a substantial number of drugs were out of stock.
- There is no designated drug storage facility at DWH Mahoba.
- In the event that EML drugs are not available from the Drug Warehouse, local procurement of medicines is done at the district level (Mahoba).
- Schedule H narcotics were not found in secondary care institutions. The OOPE was found to be high.
- DVDMS was extended to all operational PHC-HWCs, and a process for DVDMS-based medicine indenting and dispensing at SC-HWCs was started.
- There is no system of bin cards. Expired medicines are not properly disposed of since there is no mechanism in place.

## West Bengal

- Store Management Information System (SMIS) is being regularly used for indenting drugs. It is facilitating timely procurement and assured availability of drugs.
- State has notified its Essential D List (EML) which was issued on 10 January 2018.
- Drug procurement system appeared streamlined up to district and larger facilities (such as DH and SDHs) level, with online options for intending drugs.
- The drugs in the state are procured through a Central Medical Store (CMS) and the State has District Reserve Store (DRS) in all districts for storage of drugs.
- The facility was not maintaining any reserve stock of the drugs.
- At North 24 Parganas and Basirhat health district, the drugs are not prescribed with generic names at the facility.
- All the drugs are not available as per the state EML in the facilities.
- There is a need to conduct regular prescription audits in all critical care areas.

# Summary Report

## Referral Transport/National Ambulance Services

Assured Emergency Medical Service is a critical component of any health system to ensure faster access to care, pre-hospital medical care, and medical transportation to the beneficiaries. This needs to be followed by ensuring facility-based care for provision of critical care which can be lifesaving on many occasions.

Name of the State/UTs	Free Drug Policy Notified	Facility wise EML	Quality Control (QC)	IT Enabled Inventory Management System	Grievance Redressal Helpline	Centralized Procurement Agency (CPA)	Standard Treatment Guidelines Present (STGs)	Prescription Audit Mechanism	Remarks
Arunachal Pradesh	Yes	Yes	No	Yes	Yes	No	Yes	No	State procurement agency is present.
Assam	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Need to adhere to standard treatment guideline
Bihar	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	
Haryana	Yes	Yes	Yes	Yes	Yes	Yes	No	No	the state follows SOPs/ Guidelines under various programmes, acts e.g. NACO, POSH
Karnataka	Yes	No	No	Yes	Yes	No	Not Mention in report	Not mention in report	
Mizoram	Yes	No	Not mention in report	Yes	No	No	No	Not mention in report	Low utilisation of IT initiative e.g., e-Sanjeevani

Name of the State/UTs	Free Drug Policy Notified	Facility wise EML	Quality Control (QC)	IT Enabled Inventory Management System	Grievance Redressal Helpline	Centralized Procurement Agency (CPA)	Standard Treatment Guidelines Present (STGs)	Prescription Audit Mechanism	Remarks
Odisha	Yes	Yes	Yes	Yes	Not Mention in report	Yes	Yes	Yes	
Puducherry	Yes	Yes	Yes	Yes	No	Not mention in report	Not mention in report	Not mention in report	
Rajasthan	Yes	Yes	Yes	Yes	No	Yes	Yes	No	No specific mechanism of grievance redressal of ASHAs in place. The usual process of approaching superior authorities is in practice.
Sikkim	Yes	Yes	Yes	No	No	Yes	Yes	No	
Tripura	Yes	Yes	Yes	Yes	Yes	Not Mention in report	Yes	Not Mention in report	
Uttar Pradesh	Yes	Yes	Yes	Yes	Yes	Not mention in report	Yes	Yes	
West Bengal	Yes	Yes	Yes	Yes	Yes	Yes	No	No	There is no grievance redressal system for ASHAs

Under National Health Mission one of the key achievements is the patient transport ambulances operating under Dial 102/108 ambulance services. People can dial 102 or 108 telephone number (which is centralized and toll-free) to avail ambulance services. 108 is predominantly an emergency response system, primarily designed to attend to patients of critical care, trauma, and accident victims etc. 102 services essentially consist of (but not limited to) basic patient transport which are aimed to cater to the needs of pregnant women and children. At present 11879 ambulances are being supported under 108 emergency transport system and 10716 ambulances are operating as 102 patient transport (NHM MIS June, 2021).

## Key Observations

- All the states visited had referral transport services rolled out, in some states they were being done through PPP mode and in some states directly through NHM.
- Some states had initiated state supported services and also innovated and tailored the services to meet the local demand e.g., boat ambulances and dedicated vehicles for tea estates in Assam.
- States like *Haryana, Odisha* are performing comparatively well; however, it is noteworthy that *all north-eastern states* visited had challenges in implementation of ambulance



services including deployment, performance, EMT training, quality of services etc., which calls for terrain/area specific solutions.

- A common issue across states was that of training of EMTs. Most of the observations suggest lack of skill and knowledge among EMTs. Refresher trainings were also not being conducted for EMTs.
- The ambulances equipped with Advanced and Basic life support were also being used as patient transport vehicle and thus the purpose of pre-hospital stabilization during transport is not met with.
- Most of the states visited, had not saturated the ambulance services as per the population norms and gaps persist in meeting the requirement of community for referral transport.
- Provision of services in remote, tribal, and hilly areas found inadequate and the response time in these areas was much more when compared to other regions.
- General population was aware of centralized toll-free number for ambulances (wherever available) however community interaction in most of the states revealed a general sense of dissatisfaction in the communities regarding the service availability.
- Issues were observed in maintaining records/ log-books of stocks, distance travelled etc.
- Some states reported a wide range for response time which does not help in evaluating their performance.

## Recommendations

- The training curriculum for EMTs needs to be designed with more focus on practical training and skill development. A set of minimum criteria may be developed by states to recruit EMTs to provide assured cared during transport.
- Refresher trainings for EMTs on regular basis have to be ensured.
- States should adhere to norms given in National Ambulance Code / AIS 125 for operationalizing ambulances.

- Regular and periodic quality checks and audits for patient safety, infection control protocol, equipment and medicines need to be undertaken.
- All functional ambulances should be GPS enabled for monitoring purpose. The data reported through log-books and obtained through GPS may be synchronized for reliable reporting.
- An identified referral pathway should be in place along with facility preparedness for managing high risk cases.
- Strategic placement and rational deployment of ambulances is suggested to reduce response time and ensure access to services for all beneficiaries in remote/difficult to reach areas.
- Referral chains need to be defined for each facility, considering the terrain, distance between health facilities, and availability of services.

## State-specific Observations

### Arunachal Pradesh

59 BLS ambulances were deployed across various districts in the state. Lower Subansiri and Namsai districts had 3 BLS ambulances each. It was newly initiated and being operationalized through PPP mode with GVK EMRI. As per current population norms, the ambulances are already saturated in the state. The training provided to EMTs was inadequate and there was a lack of a well- defined supply chain management. The average response time was 1.5–2 hours in Lower Subansiri. Average monthly trips per month were very less. From community interactions it was understood that utilization of ambulance services is very low.

### Assam

Apart from ALS/BLS ambulances and PTV, dedicated vehicles for Tea Garden Estates were observed. The ambulance services were running in a PPP mode (GVK EMRI). On an average about 2–3 trips per day per ambulance reported. The ambulances maintained COVID-19 protocols. The drug and equipment list were regularly updated. The average

waiting time for urban areas was 17 minutes and 25 minutes in rural areas. However, as reported by community, 108 services were not up to the mark and often people from remote areas incur OOP expenditure (about INR 1000–2000/- per trip) as they resort to private transport.

## Bihar

Functional ALS & BLS with critical equipment and essential emergency medicines monitored centrally available in the districts. Essential protocols displayed inside the ambulance with trained EMT and licensed drivers were available. There were 16 functional Ambulances 102 (2 ALS, 13 BLS and one for Mortuary) and 3 non-functional total 19 Vehicles available. Average response time of ambulance was more than 35 minutes. Transportation was free of cost available to all patients. People also aware about free transportation facility (102) to reach at the health care facility for delivery under JSSK and awareness of the beneficiaries about JSY entitlements is good. Although essential drugs and equipment were available in the ambulances; proper maintenance of equipment and timely entry of information in the log book were areas of concern.

## Haryana

Availability of a Centralized toll-free number was well known to the community. Ambulances well equipped with essential equipment and medicines. Reported average response time was approximately 15 minutes. Community members were satisfied with ambulance services. EMTs were not well trained. Service & maintenance of ambulance was an issue as service centres were not located within the districts. Biomedical waste disposal was another issue.

## Karnataka

Total 156 Advance Life Support (ALS) (95 are under NHM) and 556 Basic Life Support (BLS) (376 are under NHM) with the population saturation of 1 ALS per 5 Lakh population and 1 BLS per 1.1 Lakh population were available in Karnataka. There was a gap of 20% BLS as per the current population. The ambulance services connected with a Centralized toll-free number. All the available ambulances

were fully equipped and functional with an average response time of 30 minutes in rural areas. However, delays in patient reaching the functional facilities, lack of referral audits, limited knowledge, and skill of EMTs remain areas of concern.

## Mizoram

The ambulance under the NAS program at District Hospital Mamit was not functional and ambulances received through CSR support were being used largely to transport patients. Since the COVID-19 Pandemic hit, these ambulances were diverted to the COVID response efforts and used exclusively to transport COVID patients. In absence of any public transport in the district, the patients rely on private taxis to reach the District Hospital to seek secondary care. Mobile Medical Units were also non-functional in both the districts.

## Odisha

Majority members in the community were aware of the ambulance centralized toll-free number. Sundargarh district had leveraged District Mineral Fund to operationalize additional ambulances, it also had operationalized bike ambulances to ensure accessibility for hard-to-reach areas.

## Puducherry

108/ PTV/ALS were available as per the population norms. 24\*7 Call Centre was functional (three shifts-one operator per shift) and records were well-maintained.

## Rajasthan

104 Janani Express and 108 Medical Ambulances were functional in the state. In both the districts, the response time was reported to be ranging from 30–60 minutes. Availability of oxygen, drugs, consumables, and Emergency Medical Technician (EMT) was adequate in 108 BLS Ambulance, along with proper maintenance of logbook. However, lack of availability of essential drugs in ALS, utilization of ambulances for non-patient activities and limited utilization of 108/104 ambulance services by the community (not more than 20-30%) were some key issues.

## Sikkim

There was no assured referral transport mechanism in Sikkim except West Sikkim.

## Tripura

102 and in-house ambulances were functional. These were limited to transportation only as critical equipment were not available. The in-house ambulances were BLS. EMTs of 102 services were not confident to handle emergencies. No refresher trainings were organized.

## Uttar Pradesh

State reported average response time of about 15 minutes, but from log book of the ambulances, it was found that just about half of the patients were transported to the hospital within the golden hour. The 108 BLS ambulances were not fully functional.

The equipment was non-functional and EMTs were unable to use them.

## West Bengal

Total 931 '102 dial-in' ambulances and 2500 Nishchay Van (which are Patient Transport Vehicles) were available. Both these services were utilised for JSSK beneficiaries only. Dial 102 ambulance being run in PPP mode with GVKI-EMRI. The ambulances were equipped with oxygen support facility, enabled with GPS and are available round the clock. The Nishchay Van service are not linked to a uniform call centre. The response time of ambulance was found 25 to 30 minutes in urban areas; however, in rural areas, it was 20 to 25 minutes; it was around 30 to 40 minutes for some areas in North 24 Parganas. There were 13 ALS ambulances and 944 BLS ambulances. The ambulances are not saturated as per population norms.

# A Review of all IT Applications

## Introduction

The National Health Mission is focused on developing a fully functional, community-owned, decentralised health-care delivery system. The Mission oversees a vast number of health programmes, as well as a pool of IT applications that are part of the digital health ecosystem. Emerging technologies such as artificial intelligence (AI), internet of things (IoT), and others open up new possibilities for facilitating a more holistic digital health ecosystem that can enhance access to health services, improve health outcomes, and lower costs. The integrated ecosystem will also enable better continuum of care. Policymakers and programme managers will have easier access to data, allowing the government to make more informed decisions. It will also allow for geographic and demographic-based monitoring and appropriate decision-making to inform the design and implementation of health policies and programmes.

## Key Findings

- **RCH portal** had been implemented and was well-functional in most of the States visited. It was being used for planning and improving the Reproductive & Child Health service delivery. West Bengal has adopted a state-specific portal- MatriMaa for tracking of eligible couples, pregnant women, and children in which real-time data entry is done at all levels of facilities. However, in Arunachal Pradesh, Tripura, Mizoram and Odisha, the utilization was inadequate due to poor internet connectivity. There was another observation regarding registers being maintained in spite of portals being functional leading to extra workload for the ANMs.
- In Assam, **ANMOL** application was rolled out only in aspirational districts whereas in Uttar Pradesh, it was not being implemented.
- **Drugs and Vaccine Distribution & Management System** was running smoothly in most of the states. However, the software was not reporting department-wise consumption at the patient level in the hospital. As a result, indent based on consumption remains an issue. Real-time indenting was also not being done. The software was not being used for monitoring the store-level supply of near-expiry drugs as well as for the quality check of the drugs (slow and fast moving, critical and emergency



stocks, stocks that require cold chain, etc). In few States like Karnataka and Assam, the software platform was functional only till Taluka and district level respectively and not down below due to internet connectivity issues and unavailability of requisite hardware. In States like Haryana, Odisha, Tripura and West Bengal, State-specific portals like ODISCMS, OSMSC, SCMS, SMIS respectively, were being utilized to manage the supply chain for drugs and vaccines. However, in Haryana, E-Upchar was not found to be linked with the ODISCMS causing duplicity of efforts of stock management. At the time of visit, DVDMS was not rolled out in Puducherry and Sikkim. In Uttar Pradesh, it was implemented till district level only and indenting was being done manually at SC, PHC and CHC level.

- Among the States visited, most of them have implemented **Family Planning- Logistics Management Information System (FPLMIS)** however it was not rolled out appropriately in Arunachal Pradesh and Mizoram due to lack of training, network issues and hesitancy on the part of concerned staff towards the usage of application.
- In most of the States visited, **e-Sanjeevani** was properly functioning, teleconsultations were taken up by CHOs with proper linkages to higher centres. In Assam, a 24\*7 Command and Control Centre was established at the NHM Office with active 'e-Sampark', Sarathi' and 'Consult a Doctor' options. In West Bengal, a State-specific portal- Swasthyaingit had been recently rolled out for providing tele-consultation services. Whereas e-Sanjeevani was not being implemented in Arunachal Pradesh and Sikkim.
- Data entry on **Health Management Information System** was up-to-date and wide utilization for planning, review and monitoring was in place in most of the States visited. The Integrated Health Management Information System was integrated with Mera Aspataal to receive patients' feedback in Rajasthan. However, in Sikkim, there was no mechanism to review to quality of HMIS data.

## State-specific Findings

### Arunachal Pradesh

- **RCH Portal:** The use of RCH portal has been initiated in both the visited districts of the State but regular data updation and RCH Id generation were not complete.
- **ANMOL Application** usage initiated in the State and ANMOL tablets were being procured and provided to ANMs. Although, training regarding the ANMOL Portal were conducted, some technical issues in the portal itself were leading to improper usage.
- **DVDMS** indenting was found functional in both the districts but in Lower Subhansiri, functioning in offline mode due to internet connectivity issues.
- **Family Planning- Logistics Management Information System (FPLMIS):** The application was not found to be functional in the State as ASHAs are not comfortable in using the application and indenting done through the application remain pending due to less response from the parent facilities.
- **e-Sanjeevani** not functional due to connectivity problems during teleconsultations.
- **Poshan Abhiyan** was not under health department, login credentials not available and thus data not available.
- **Health Management Information System (HMIS)** data entered and was up to date.

### Assam

- **RCH Portal:** The portal was active in the State and successfully tracking women dropout for institutional delivery.
- **ANMOL Application** only implemented in aspirational districts in the State and accessible to the users.
- **AB HWC** portal updated with all the HWC data regularly.
- **Health Management Information System (HMIS)** data updated regularly and utilised widely for planning, review, and monitoring.

Regular analysis and feedback provided to districts.

- **Drugs and Vaccine Distribution & Management System** was implemented only at the district level. Down below, lack of computer system and interrupted internet hampers the usage.
- **PFMS Portal** implemented at all levels and 100% transactions done through it.
- **IHIP-IDSP (Integrated Disease Surveillance Project)** application was functional and found data entry since August, 2021.
- **Nikshay Portal** actively enrolled and data updated except in Silchar district where notification and treatment data found slightly mismatched.
- **NCD Portal:** Data found updates at PHC and HWC levels in the State.
- **Electronic Vaccine Intelligence Network (eVin):** All the stocks were maintained and IT successfully employed to improve vaccine stock. However, temperature logger were not found to be in working condition.
- **e-Sanjeevani** was found active in the State and teleconsultations were being taken up by CHO with proper linkages to PHC. Also, a 24 X 7 Command and Control Centre was established at National Health Mission, Assam office with “eSampark”, “Sarathi 104” and “Consult a Doctor” options active.

## Bihar

- IT Applications like **RCH Portal, HWC Portal, HMIS, Nikshay, e-Sanjeevani, DVDMS, e-RaktKosh** were being used. The CHOs and ANMs at AB-HWCs were provided with tablets for entering the data. However, the data entry into the portals was found to be irregular and inadequate.
- MOs, Staff Nurses, Lab Technicians, Pharmacists and MPW-M/F had been trained in using IT-Based applications.
- The State had adopted the e-Sanjeevani and e-Sanjeevani OPD models for teleconsultation. Only general OPD consultations were available

whereas specialist services were planned to be started shortly.

- DPMU at Lakhisarai and Jamui were collecting the data but were not analysing it for programmatic insights.

## Haryana

- **RCH portal, HWC-Portal, Nikushth portal, Nikshay, DVDMS, e-Sanjeevani, e-VIN portal, NCD portal, FP-LMIS** were found functional and used regularly by the staff.
- **Maternal & Infant Death Reporting System (MIDRS):** The State had launched a centralized new mechanism to gather information regarding maternal deaths, infant deaths, and stillbirths from the health facilities at various levels of the health system.
- **Health Management & Information System** was being used in most of the health facilities of the State and data management was found proper.
- **E-Upchar**, another new and State specific online initiative of Haryana State Health Resource Centre (HSHRC) has been implemented in all 22 District Civil Hospitals.
- **ASHA PAY & ASHA Sarvekshan:** The application was found to be widely used at the Primary Healthcare facility level.
- **Bio Safe Application:** The State as also initiative this application for the monitoring of disposal of bio-medical waste. It was found to be widely running in outsourced mode and status can be checked online.
- **ODISCMS application** for procurement and distribution of essential drugs and other consumables where health establishments are linked with the respective Central Drug Centres was launched by the State Government. However, E-Upchar was not found to be linked with the ODISCMS causing duplicity of efforts of stock management. The application was not being updated on a real-time basis in any medical establishments and did not capture the data of planned purchase of other medicines in specific programmes.

## Karnataka

- **RCH portal, NCD portal, NIKSHAY, e-Sanjeevani, HMIS, ABARK, e-RaktKosh, NIKUSHT, ANMOL** found functional at all secondary care facilities of the State. However, data entry on NIKUSTH portal is done at the block and district level.
- **DVDMS:** Found functional at the State headquarters, DHs, Taluka Hospitals, but within the facility there were no linkages with the drug dispensing counters.
- **IHIP implementation** was in initial phases in the State as the application was launched in October 2021 only.

## Mizoram

- IT applications like **e-Sanjeevani, NCD and HWC Portals** were found functional in the State but were very under-utilised. Low uptake of IT portals due to lack of training and network issues in rural regions.
- **Mera Aspataal** initiative were not being fully implemented at the health facilities.
- **eVIN** functionality was hindered by a huge gap in Supply Chain and indenting mechanism is largely underutilized as indenting done in eVIN only after receiving vaccines at CCH.

## Odisha

- **RCH Portal** usage was found to be limited by the service providers due to lack of connectivity and handwritten registers and records are used more.
- **NCD-HWC app, AB-HWC portal & ANMOL** were found to be functional at SHC HWC. MO-NCD portal is being used in PHC & UPHC-HWCs.
- Among the available IT Applications under the NHM, **Nikshay and IHIP** were not fully operational at AB-HWC in PHC/SHC levels due to common internet connectivity challenges.
- **Odisha State Medical Services Corporation (OSMSC)** has demonstrated excellent work in procurement & supply chain management.

State's own drug distribution system "**e-Niramaya**" has been operationalised. E-indenting is being carried out through the software and supply of drugs is being done through a dedicated fleet of vehicles by OSMSC.

- **e-VIN** was not found to be fully functional as indenting of vaccines, logistics and temperature monitoring gaps observed across the facilities.
- **FPLMIS** was only found to be functional up to Sub centre level.

## Rajasthan

- **Integrated Health Management Information System (iHMIS)** has been integrated with Mera Aspataal portal to receive feedback from patients. However, the latest reports were not available, the response rate was poor (only around 5%) as well as a mechanism for tracking the same patient during subsequent visits to the hospital was lacking.
- **e-Upkaran** was found to be functional up to the PHC level, but all the equipment were not enrolled in the dashboard. The DEOs reported a lack of orientation training, and an absence of manuals/guidelines was observed. The users were not able to track the previously registered complaints, as an option was not available in the system.
- **e-Aushadhi** was functional at the PHC, CHC and DH level, and was available for inventory management. There is improved estimation / forecasting of drug need and stock control across the facilities because of daily entry of the drugs dispensed. Stock indent was not uniform across the facilities visited. Stock register was however not tallying with stock status in e-Aushadhi.
- **e-RaktKosh:** Digitization of blood banks is in nascent stage. Out of six major components for management of the blood donation life cycle, Notification System, and a centralized Blood Inventory Management System have been implemented. No orientation training has been provided to the Data Entry Operators (DEOs) on e-RaktKosh.

- **e-Sanjeevani OPD** was functional only at the District Hospital level and has not yet started at the level of SDH/CHC/PHC. Teleconsultation services were provided during COVID-19 times through toll free number. However, delayed response time to patient calls was observed through patient feedback discouraging the use of services. Poor internet connectivity and exhaustion of data packs lead to disruption of services.

## Puducherry

- IT applications such as **AB-HWC Portal, RCH and HMIS portals** were found to be functional, but use of the data generated from these portals for improving the service delivery by facility or district level managers were found to be minimal.
- Supply Chain Management System needs to be further strengthened and streamlined with implementation of **Drugs and Vaccine Distribution Management System (DVDMS)** as it will address the existing loopholes in the system and will also minimize the time lag and human error.

## Sikkim

- State had not implemented key IT initiatives like **DVDMS, e-Sushrut, e-Vin, e-Sanjeevani** etc.
- All facilities were found to be lacking in the necessary hardware equipment to implement and monitor the programs through the various IT applications under the National Health programs except availability of tablets with CHOs. ASHAs were not provided with smartphones so far in the districts visited.
- Community based assessment checklist entries were pending in the NCD app and were mostly maintained in the manual form.
- HWC portal entries were pending in most of the HWCs visited.
- There is no mechanism to review the quality of HMIS data uploaded by peripheral facilities. The facilities failed to show **HMIS** reports for previous months.

- The State has streamlined use of IT applications at the facility level such as **HMIS, NCD portal, IHIP, RCH-II, NIKSHAY, Simple-app, etc.**

## Tripura

- **RCH portal, IDSP, Nikshay, PFMS, NCD application, RBSK portal, eVIN and AB-PMJAY portal** are functional, but internet connectivity remains a challenge.
- **Supply Chain Management Software (SCMS):** The State has its own drug procurement software for management, indenting drugs and vaccines up to the PHC level. The SCMS is linked with DVDMS through Application Programming Interface (APIs).
- Due to lack of internet service providers, healthcare professionals were using mobile hotspot or using their personal mobile phones instead of tablets.

## Uttar Pradesh

- **RCH portal:** Data entry in the RCH portal is being done at the BPMU/Block level. The data entered in the ANMOL tablet can also sync with RCH Portal.
- **ANMOL Application:** Data entry in ANMOL tablet is being done by ANM directly but not in use currently.
- **HWC Portal** is operational for daily and monthly reporting of programmatic data. Status of AB-HWC infrastructure is regularly updated in the portal.
- **NCD application:** Data is being entered in the portal for Population based Prevention, Screening, Control and Management for AB-HWCs.
- **Drugs and Vaccine Distribution Management System (DVDMS):** Though DVDMS is being implemented, the indent from HSC, PHC and CHC is still generated on physical forms.
- **Health Management Information System (HMIS):** Data entry is being done by the ANM in UPHMIS mobile application which is verified by the BPMU.



- Family Planning - Logistics Management Information System (FP-LMIS) for recording information on Family Planning, Nikshay Portal- under National Tuberculosis Elimination Programme, Integrated Health Information Platform under Integrated Disease Surveillance Programme, e-Sanjeevani & telemedicine, BCPM-MIS for ASHA payments and Nikusth were also found to be functional in the State.

## West Bengal

- **RCH Portal:** The State has adopted a new robust portal- **MatriMaa** for tracking of Eligible Couples, Pregnant Women and Children. Real-time data entry is done at 3 levels i.e., at sub-centre, delivery point and from block level.
- **ANMOL Application** is also replaced by State specific application – MatriMaa. Service providers upload their SC/UPHC data or due list through the designed SC's Tablet or from any Android Mobile Phone. 801 Service providers in Rural and 33 in urban are utilizing the application for RCH reporting.
- **HWC portal** is being utilized by 193 Subcentres, 21 Primary Health Centres & all 17 Urban Primary Health Centres for record keeping of monthly & daily performance.
- **CPHC NCD Application:** The State specific APP and NCD portal will soon be operationalised. Village-wise ANM and ASHA mapping and Referral Facility tagging have been completed.
- **Store Management Information System portal** – State specific portal for indenting, inventory control and payment of Drugs and equipment is functional till DH/SDH facility level. CHC/RH has also been given the facility for using the SMIS software for indenting and inventory control.
- **Health Management Information System (HMIS):** Computer, other hardware, Internet connectivity, power supply, etc. were found available at all levels. At Block level, dedicated trained DEOs are responsible for data entry on HMIS. At Sub centre level, the ANMs are engaged in manual reporting (paper-based MIS) with duplication of data recording in ANM daily book, RCH register, format for block level data entry etc. There was no system of supervisory checks or validation by the MO IC facility/CHO.
- **Swasthyaingit**, a State-specific portal, rolled out on 1st of August 2021 for providing tele-consultation services. In Nadia District, 72 doctors and 33599 patients are registered, and 35702 consultations held till 15 November 2021. In North 24 Parganas, 224 doctors are registered in portal and a total of 34067 sessions are conducted till October 2021.
- **Nikshay Portal:** 5040 & 3276 TB patients registered in 2020 and 2021 respectively. Medicines for treating tuberculosis are distributed through Nikshay Aushadhi portal.
- **IDSP Portal:** P and L report is being entered from District level - done by IDSP EAS report is being entered from Block level - done by block level EA
- **Nikusth Portal:** Entry is done by all 17 blocks in Nadia District. Troubleshooting done from the district through remote Access Software.
- **POSHAN Abhiyan** is not under Health Department hence no data is available.
- **e-RaktKosh portal:** Blood banks are utilized through e-RaktKosh portal for Blood Bank Management. Jeevan Shakti portal (State specific GIS-based portal) is also developed taking into consideration the local population to manage donor registration and blood donation camp registration.
- **Electronic Vaccine Intelligence Network (eVin):** All vaccine & vaccination related logistics are done through eVIN by 58 Cold Chain Points in the districts visited.
- **Family Planning- Logistics Management Information System (FPLMIS):** All Family Planning Commodity indent & issue up to Client are done through FPLMIS portal by Government facilities including 90 Service delivery points and 468 Subcentres in Nadia district.

## Recommendations

- There is a need for integration of IT applications running in the States preferably in Ayushman Bharat Health Account (ABHA) ID of Government of India.
- Instead of creating duplicate portals and applications, States should first prioritize to implement IT applications created by Ministry of Health & Family Welfare.
- Every State should set up committees for integration of IT applications and with preference for synchronising it with Govt-developed applications.
- Duplication of team's efforts in maintaining paper based and IT based records need to be reduced substantially.
- Providing adequate infrastructure to mitigate connectivity issues. The State may consider establishing internet kiosks in the villages or sub-centres in PPP or CSR mode to facilitate tele-consultations and uninterrupted usage of online applications.
- The real time use of IT initiatives can be improved by using the data for purpose of planning and monitoring. Supervisory visits by the higher authorities can be undertaken in this regard.
- There is a need for improving the capacity building and orientation of service provider in using the IT applications.
- Annual training should be conducted on data entry and management of various tools for all the staff handling data. Data Entry Operators (DEOs) should be made aware of manuals/ guidelines availability. In addition, data quality at each level can be enhanced by capacity building of DEOs.
- IEC/ Intensified Advocacy Communication & Social Mobilisation (ACSM) activities on creating community awareness on the newer activities under the program such as Nikshay Poshan Yojana, usage of funds received under Nikshay Poshan Yojana and the latest diagnostic and treatment facilities available at public health facilities needs to be done.



## TOR 3: Cross Cutting Themes

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# TOR 3: Cross Cutting Themes

## Objective to See

### a) Human Resource for Health

1. Availability including distribution, acceptability, quality, and productivity of human resources; HR related processes and policies to tackle the existing and future challenges across rural and urban areas e.g. HR management including specialist cadre, HRMIS and capacity building, Training programs offered- specialty, for- doctors/nurses/paramedical.  
To assess the mechanism for in service (RMNCH+A, CD, NCD) and pre-service training (ANM, GNM etc.) for all cadres of staff- Regular and Contractual.  
Observe the state/district training plan and calendar and progress thereof.

### b) Indian Public Health Standards

### c) Quality Improvement

- a. Commitment of the state to improve the Quality of services at all levels.
- b. Assess preparedness of facilities for NQAS certification / LaQshya / MusQan.
- c. Mechanism of the state NQAS certification of Public Health Facilities.
- d. Assess preparedness of the state for National NQAS certification of Public Health Facilities (40% DHs, 12% of each of SDHs, CHCs, PHCs & UPHCs; and 2% HWCs (Subcentres) in the year 2021–22; and cumulative 50% DHs, 25% each of SDHs, CHCs, PHCs & UPHCs and 10% HWCs (HWCs) in the year 2022–23).
- e. Extent of adherence to Surveillance assessment protocol of NQAS & LaQshya certified facilities.
- f. Strategy and plan for part NQAS certification of SUMAN notified facilities.
- g. Strategy and plan for scaling-up of Kayakalp initiative in the State, so that every facility is a Kayakalp facility.
- h. Evaluate the strategy and plans of the state implementation of LaQshya and MusQan initiatives.
- i. Extent of integration of Mera-Aspataal (MA) feedback system (percentage of each category of health facility) and utilization of MA data for addressing patients' feedback.

**d) Legal framework, and accountability**

- a. Review the implementation of Health regulations (e.g., PCPNDT, MTP, CEA, BMW Rules, Drugs & Cosmetic Act, etc.).
- b. Assess whether IEC/campaigns are being undertaken to spread awareness about several health regulations.
- c. Review if appropriate authorities/Complaint Committees/Counselling Centres etc. are being constituted under relevant legislations.
- d. Review the institutional structure under NHM for constitution, capacity, and performance.
- e. To explore the accountability framework (PPPs, audits, convergence) in place to oversee the institutional structures under NHM.
- f. Review of the decentralised planning process, outcomes.
- g. Monitoring, evaluation, supportive supervision.
- h. A review of all relevant IT applications.

**e) COVID-19 – preparedness, response, and challenges with reference to ECRP I and II****f) Financing**

- a. Financing - fund flow and extent and quality of fund utilization.
- b. PPP- Nature of contract and payment mechanisms. Identifying existing problems in the arrangement.

# TOR 3A: Human Resources for Health

## National Overview

Since 2005, the National Health Mission (NHM) with its two sub-missions (NRHM and NUHM), has attempted to bridge the gap between the requirement and availability of Human Resources for Health (HRH). More than 4.5 lakh Healthcare Workers (HCWs) have been added to the health workforce using the various provisions under NHM, bringing about considerable improvement in the provision of health services. Despite the increasing capacity of the country to produce doctors, nurses and other cadres of HRH, this gap persists in the public health system, being more pronounced for specialists than other cadres, and more in the rural areas than in the urban facilities.

The COVID-19 pandemic has drawn attention to the critical role of the HRH. Despite facing physical, psycho-social and logistical barriers in the line of duty, the HCW have challenged to provide both COVID-19 related and routine health services. Restrictions imposed over the past two years have boosted the reliance on IT initiatives for training and capacity building. At the same time, the pandemic has adversely affected implementation of some health programs, routine on-site trainings, and managerial processes such as recruitment and postings of HRH.

Teams of the 14th CRM assessed the adequacy and availability of HRH, analyzed processes for recruitment and rationalization, policies for workforce management and reviewed the status of capacity building initiatives in the States.

## Key Findings

### Availability of HRH

- Gaps in the availability of HRH across the six major service delivery cadres is a universal phenomenon across the States. The States of Sikkim, Puducherry and Arunachal Pradesh are adequately staffed. However, an appreciable vacancy is noted in HRH availability in the states of Rajasthan and Haryana, resulting in overburdening of the existing workforce.
- The lack of Specialists is the most pressing concern across all the States, because of which many CHCs are functioning like PHCs. The reported shortage of Specialists ranged from

22% in Puducherry, 39% in Karnataka, 45% in Arunachal Pradesh, 50% in Tripura, Rajasthan and Odisha, to as high as 67% in UP and 72% in Bihar.

- More than one-third of the posts of Medical Officers (MO) are vacant in several states (31% in Assam, 37% in Bihar and 45% in Karnataka). PHC level MOs in Rajasthan reported the additional weightage for their service given in PG Entrance exam as a major motivating factor for serving in the rural areas. Similar benefits for in-service MOs serving in difficult areas is a policy adopted by Assam.
- Vacancies for Staff Nurses and ANMS were reported to be as low as 10% in Assam, to as high as 43% in Uttar Pradesh.
- Shortage of program management staff and accounts managers were found to be adversely affecting the overall implementation of health programs, and quality of monitoring and supervision in Bihar and Rajasthan.
- The process of recruitment in Assam, Mizoram, Rajasthan, and Sikkim are centralized at the State level. For recruitment of contractual staff, flexibility at the district level was reported in Arunachal Pradesh and Karnataka, promoting decentralized recruitment wherever feasible.
- Irrational deployment and lack of HR rationalization was observed in many instances during the visit. Higher vacancies in the rural areas and concentration of HRH in the urban areas was predominant in Assam and Karnataka. Some facilities in Sikkim had more HR in position than what was required as per the facilities' case load. In Mizoram, it was observed that key HRH were posted in the facilities without assessing the presence of supplementary cadres and equipment necessary to enable optimal functioning of the in-place HR.
- NHM incentives for attracting and retaining HRH were being leveraged in several states. Hard-area allowances in Mizoram, and incentives for vaccination staff in hard-to-reach areas of West Bengal were being given.

Flexible funding options were being utilized to provide higher remuneration in Aspirational Districts in Sikkim, Karnataka, and Haryana. 'You quote we pay' for attracting Specialists was being used by Uttar Pradesh and Karnataka. While Haryana has also intended to utilize the provision of 'You quote we pay', its implementation is lacking. Assam and Rajasthan despite facing several challenges in the availability of HRH, are not capitalizing on NHM incentives.

- States of Arunachal Pradesh, Bihar Sikkim, Odisha, Karnataka, Puducherry, Uttar Pradesh, and West Bengal have the Specialist Cadre in position. Odisha and West Bengal also have Public Health Cadres. Haryana, Mizoram, Tripura, Assam, and Rajasthan had neither of these enabling cadres.
- It seems that States (e.g. Bihar, Tripura, Rajasthan and West Bengal) are not adequately using the NHM flexibility for salaries, especially for Specialists. Though many a times low salaries are cited as reason for unavailability of HRH, evidence on this has not been shared with CRM teams. In addition, delay in payments of salaries in Mizoram and Rajasthan were reported.

## Workforce Management

- The COVID-19 pandemic has decelerated activities related to the recruitment cycle. Recruitment has not been done for 18 months in Tripura, and for the past 2 years in Assam for Nurses. Despite having adequate number of sanctioned posts, recruitment has not been carried out in Rajasthan for the past four years.
- Modes of recruitment varied from state to state and cadre to cadre. Walk in interviews, written tests and Objective Structured Clinical Examinations were being used for recruitment of service delivery staff in Arunachal Pradesh. Karnataka was employing Community Health Officers (CHOs) on merit and computer-based recruitment tests, while computer skills were tested for Staff Nurses. Sikkim was not conducting any skill or competence assessments.



- The lack of stringent monitoring mechanisms and supportive supervision contributed to lack of updated knowledge and skills of the HRH at and below the district level. The absence of such a robust system was highly noticeable in the states of Assam, Rajasthan, Bihar, and Karnataka. However, the team from West Bengal reported that an efficient system of monitoring and supervision in the visited districts resulted in a highly motivated staff.
- Regarding workforce management, an HRH Policy has been developed by the states of Tripura, Odisha, and Bihar. Robust transfer and deployment policy was present in Tripura and Odisha. Mizoram had a transfer policy, but it was not being implemented stringently. The lack of transparent transfer mechanisms was leading to attrition in Rajasthan as rampant outbound transfers from the high priority districts led to vacancies. Absenteeism of HRH was a challenge faced by the health systems of Assam and Bihar.
- Some states like Tripura, Odisha and Karnataka have adopted the performance appraisal process. Based on the performance against key deliverables, incentives are being given to individuals and teams. Commendation for exemplary services and team-based incentives to CHOs have been given by the state of Karnataka.
- The Human Resources Management Information System (HRMIS) has been developed and adopted by some states as per their selective needs. Arunachal Pradesh is using the HRMIS for contractual staff only, while Mizoram is using the HRMIS for salary disbursement. The HRMIS is still in the process of development in Bihar.
- Some innovations in HR management and good practices were observed in the States-
  - Odisha has robust HR policies. Their long-standing contractual HRH are regularized, promoting retention of the HRH.
  - Bihar has employed a professional agency for recruitment and developed a calendar and SOP for the recruitment process.
  - Contractual employees under NHM Assam have been given a job guarantee till 60 years, resulting in secure and satisfied employees.
  - Mizoram is contributing to Employee Provident Funds for all HRH with a salary of less than Rs. 15,000/-.
  - During the pandemic, Rajasthan used state funds to engage qualified nurses as 'COVID-19 Health Assistants (CHA)'. At times of low number of cases, they supplement the routine activities in the health facilities like NCD screening. Good coordination was witnessed in the ANM-ASHA-Anganwadi worker trio at the primary care level.

## Capacity Building

- As per the recent provisions by the National Board of Examinations (NBE), District Hospitals (DH) fulfilling certain criteria can initiate DNB post-graduation courses in select specialities. The state of West Bengal and Mizoram have initiated DNB courses in some of their DH.
- State level training institutions are established in Rajasthan and Odisha. Functional District level training centres and skill labs were reported from Haryana and Arunachal Pradesh as well. West Bengal has been regularly conducting trainings from State developed resource packages, and Training of trainers on paediatric COVID-19 management. Bihar has been liaising with development partners to support their capacity building initiatives.
- Training calendar was found in Haryana and Arunachal Pradesh, however a formal training needs assessment had not been conducted. Training calendars at the district level were not found in Sikkim and Rajasthan. While Training logs were not diligently maintained in most states, a good practice was observed in Champhai district of Mizoram where a log of trained HR would be kept, and trained HR would conduct a session at the facility to share their learnings with untrained HR.
- Induction trainings for select cadres were being conducted in Arunachal Pradesh, and

were in the planning phase in Bihar. Karnataka was conducting Induction Trainings for regular cadre HRH, but not for HRH under NHM.

- A long gap in the conduct of trainings were noted in Tripura, and for the program management staff in Karnataka. The observed quality of CHO training in Rajasthan was not up to the mark for various reasons including lack of training resource material and language barriers.

## Recommendations

### Availability of HRH

- The States should consider creation of Specialist Cadre for attracting qualified post-graduate HRH in the necessary specialties. This will also enable differentiation of their skill set from MBBS Medical Officers, promote rational posting of Specialists and deputation to facilities where their skills can be optimally utilized. Creation of the Specialist cadre will be a step towards providing due recognition to their qualifications and import.
- It is recommended that States adopt the Indian Public Health Standards (IPHS) and strive to put in place the requisite HRH. The states adopting IPHS should ensure that adequate number of posts are sanctioned for all facilities as per the recommended IPHS norms.
- Rationalization of HRH is imperative to ensure that the right persons are placed at the right facilities for optimal utilization of their skills. While deputing HRH, the HR Nodal officers should bear in mind that adequate infrastructure, logistics and supplementing cadres are available so that an enabling environment should be present along with the HRH.
- NHM provides a basket of choices with respect to incentives and flexibility to the States for engaging specialists and other cadres of HRH. Options such as 'You Quote, We Pay', 'Hard-area allowance', 'Top-up incentives', among others are popular options being used by some States. The enabling mechanisms under NHM may be utilized for attracting and

retaining HRH, especially in the Aspirational and High Priority Districts. The States can also consider non-monetary incentives such as provision of housing facilities near the health centre. In-sourcing Specialists, liaising with Medical Colleges and leveraging the provisions under upcoming District Residency Program are also options that the States may deliberate using.

### Workforce Management

- States that have adequate sanctioned posts but have not conducted recruitment drives for several months and years should expedite the recruitment process on priority. States may consider engaging empaneled recruitment agencies and developing a recruitment calendar for better management of the process. Wherever the Districts have the capacity for conducting recruitments, decentralized recruitment should be promoted.
- Standard ToRs / Job Descriptions should be developed and discussed at the time of recruitment. States may consider adopting skill-based assessment tests for engaging service delivery staff to ensure competent HRH is available in the public health system.
- Monitoring and supportive supervision needs immediate attention and quality of supervisory visits needs to be greatly improved. All efforts should be made to ensure that new guidelines and recommendations are percolated till the field level service delivery staff. Mid-level managerial trainings can be considered to build the capacity of district/block level program officials to monitor and review the programs.
- Rewards and recognition for exemplary HRH and dissemination of practices adopted by 'Heroes' within the district and State can be used as motivating factors for the HRH.
- HR Policies, transparent transfer and exit policies need to be developed in some states. In States where such policies exist, their implementation should be strengthened. States may consider predefining mechanisms of career progression for their HRH that may promote retention.

- A robust HRMIS could go a long way in tracking HRH and improving HRH management. States should consider developing robust HRMIS systems that would smoothen HR data management.

## Capacity Building

- Skills and competence of HRH is as important as the number of HRH available in the facilities. Capacity building in all the States needs to be enhanced by developing functional State level model Training Centres. The State Training Centres should have on their roll expert resource persons and adequate infrastructure, equipped with training aids to create a vibrant learning environment. Wherever feasible, the State training centres may liaise with neighboring Medical Colleges to expand their range of faculty. Efforts should be made to also establish District Training Centres as hubs for skill development within the district itself.
- Training Needs Assessment should be conducted by the States and evidence-based State and district training calendars should be developed. The States may consider displaying the calendars on State NHM websites so HRH may also volunteer for trainings as per their areas of interests, especially for Medical Officers interested in undergoing trainings of LSAS/ CEmONC and mental health.
- Leveraging on the provisions by NBE, States should identify DHs where DNB and Diploma of NBE Courses can be initiated.

## State-specific Findings

### Assam

#### Availability of HRH

- The HR planning and deployment power is centralized at the state level. The State has established the Medical and Health Recruitment Board which is a very good initiative. Since January 2018, the Board has recruited 1803 Doctors and teaching faculty of medical colleges.

- At the state level it is estimated that there is a vacancy of 31% doctors, 10% ANMs and 11% Staff nurses. The aspirational district visited (Hailakandi) had a higher vacancy of 48% doctors, 21% Staff nurses and 31% ANM.
- Provisions are available in allotment of PG seats for doctors, where extra weightage marks and certain preference are given to those serving as Medical officers in the hilly, tribal and peripheral parts of the State.
- Since there are posts sanctioned from both Director of health services and director family welfare, there is some duplication of positions sanctioned from DHS/ DFW and NHM. Lack of administrative capacity of administrative staff like JD, SDMO makes it difficult at the JD / CMHO level to monitor or redeploy as per need of the districts.
- No financial or non-financial incentives are being used to attract or retain HRH working in difficult areas.
- The vacancy of doctors in rural areas and simultaneous concentration in urban areas indicates the need for rationalized HR redeployment.

## Workforce Management

- Average time taken for completing a recruitment cycle is around 5 months. There is a high recruitment load at the state level specially on NHM HR sanctions due to the centralized recruitment system.
- Recruitment of Nurses and other Paramedical Staff has not taken place under NHM for the last 2 years.
- No rotational or transparent transfer policy in the State contributes to the high vacancy of staff in difficult areas.
- Contractual employees under NHM have been given a job guarantee till 60 years of age which have reduced attrition of skilled manpower.
- There is a lack of monitoring from the state and district regarding work output of human resources. Long absenteeism was also observed in both the districts visited.

- The CHO posted from RHP background receive more confidence and trust from the community, than staff nurses posted as CHOs.

### Capacity Building

- There are 7 medical colleges in the State which have capacity of 1100 Graduate and 730 seats of Post graduate seats available. Since almost all student they get PG seats there is lack of MBBS medical officer in the district.
- There are 65 BSc Nursing and 50 GNM seats are available in the nursing college in the State.

## Arunachal Pradesh

### Availability of HRH

- Centralised recruitment at the state level is conducted for regular post under Health Department. The Public Service Commission is tasked with the recruitment of Specialist and MO (MBBS).
- Medical officers are predominantly recruited through the Department of Health and Family Welfare, Government of Arunachal Pradesh and most of the positions are filled. There is an overall preference for government jobs among the residents. This is evident in the current HR numbers for the health department.
- The ratio of doctors: population (in the public sector) is close to 0.6 per 1000 population (0.7 per 1000 including AYUSH). The ratio of doctors: nurses is 1:1.6.
- There are practically no gaps between sanctioned and in-position numbers among ANMs and staff nurses in the state.
- Approximately 45% of the specialist positions in the state are vacant.
- There are district-wide differences in HR numbers across the state. Districts with the lowest number of HR include Kamle, Shi Yomi and Dibang Valley. Districts with the highest number of HR are Itanagar Capital Complex, East Siang, and Upper Subansiri districts.

### Workforce Management

- Decentralized recruitment at the district level is conducted for all contractual post under NHM. Walk-in interviews are also conducted at the district level for the post of Specialist, MO (MBBS), MO (DS) and MO (AYUSH).
- The interview process is as per qualification, age, local residence, and skill-assessment. The skill-assessment is done through written test followed by Objective Structured Clinical Examination.
- Recruitment for new positions in Arunachal Pradesh: Programme Management (DPM, DAM, DCM, DAM) staff for 4 new district Kamle, Itanagar Capital Complex, Shi yomi, Pakke Kessang as approved in RoP 2021-22 and Programme Management (DPM, DAM, DCM, DAM) staff for Leparada and Lower Siang is under process.
- The HRMIS is in place only for the contractual workforce. It is not implemented for the regular staff within the state.
- The COVID pandemic highlighted HR challenges pertaining to Shortage of staff numbers (specific districts) and in the Skill-set of the workforce, particularly for Ventilator use.

### Capacity Building

- The state has a recently launched medical college called the Tomo Riba Institute of Health and Medical Sciences (TRIHMS). The institute has an annual intake of 50 MBBS students. The state also has eight ANM Training Centres with an annual capacity of 540. There are five nursing schools with an annual capacity of 300.
- Training sites for the state are available at the following locations: RCH Training Hall, Naharlagun, TRIHMS, Bomdila (West Kameng), Pasighat (East Siang).
- Induction Training for staff is conducted after completion of every recruitment process. There is no/ minimal backlog in these trainings as reported by the State.
- A formal Training Needs Assessment for the health staff is not yet undertaken. Program specific trainings are conducted by respective programme at both State and district level.



- There is a provision for Trainings for Finance Staff which are conducted at State Level by Finance Management Group, NHM. Some staff have received specialised training in public health management through the support of the NHM.
- In the current training calendar for 2021/22 details like SBA training, comprehensive abortion care, BEmONC, Dakshata, EmONC, LSAS training for medical officers, training of nurse practitioners and midwives, gestational diabetes mellitus training, PPIUCD and injectable contraceptive training for medical officers are given.

## Bihar

### Availability of HRH

- The State of Bihar has a severe shortage of HRH in almost every cadre, with the overall vacancies ranging from 37% for MBBS Medical Officers, 52% for Nurses and 72% for Specialists to 97% for Dentists.
- The State has a Specialist cadre available and an in-principal approval for public health management cadre has been obtained.
- Longstanding vacancies of key programme management (PM) staff like District Planning Coordinator (DPC), District Community Mobilizer (DCM) seen, affecting overall implementation of programmes.
- 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).

### Workforce Management

- 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. Calendarization and SOP for recruitment activity is in place.

- The State has an HR Policy in situ, and is in process of developing an HRMIS.
- Campus Recruitment Policy has been approved through the Governing Body but has not yet been rolled out.
- 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.
- It was also observed that there is limited career progression and succession plan for employees.

### Capacity Building

- Development partners are being utilized for training of service delivery staff in districts.
- However, regular training for all cadres of staff and supportive supervision of ANMs and ASHA facilitators is found to be a weak area.
- The State is planning for conducting a robust induction/ orientation training for all new joiners, and exposure visits for employees.
- Initiatives like AMANAT program is rolled out across and is enhancing knowledge and skill of Labour Room staff.

## Haryana

### Availability of HRH

- There are high vacancies in the regular positions that the State should endeavour to fill on a priority basis in a time bound manner. These vacancies were observed especially in terms of MOs / Specialists in PHCs, CHCs, SDHs & DHs in the Districts of Fatehabad and Nuh (Mewat).
- The staffs employed under NHM, Haryana are offered a 5 (five) percent salary increment annually to motivate them and ensure retention. The State also provides incentives

to doctors posted in difficult areas which is Rs 10,000/- per month for medical officers and Rs 25,000/- for specialists. The salaries are also dispersed in a timely manner for staff employed both regular and contractual.

- Frequent attrition is seen in the visited districts of Fatehabad and Nuh (Mewat) mostly in the case of medical officers posted at various levels of healthcare facilities. The position of the District Programme Manager, NHM of Fatehabad District has also been vacant since 2019.
- It has been observed that although functional ambulances were available at healthcare facilities there was a shortage of drivers to operate them optimally.
- The implementation of the scheme of 'You Quote We Pay' for postings of MOs/ Specialists in difficult areas has been widely publicized by the NHM, Haryana, but the actual implementation of the scheme has been found to be lacking especially in context to the postings in the Districts of Fatehabad and Nuh (Mewat). Even though there are provisions for performance incentives for the healthcare staff there was a lack of initiative to offer hard areas allowance.

### Workforce Management

- For the recruitment process of different cadres of staff, written tests and computer efficiency tests are conducted both for State and Districts level recruitments for regular and contractual vacancies. The process of recruitment from publishing of the advertisements to appointment takes around 2-3 months.
- The Grievance Redressal Mechanism needs optimization to address & resolve the grievances / complaints of the staff

### Capacity Building:

- The State of Haryana has 22 District Training Centres and 4 Skill Laboratories, although none were situated in Nuh (Mewat) District. The training calendar for various levels and types of training are well defined and planned.

- The DoH&FW / NHM, Haryana offers training for doctors/nurses/paramedical and non-medical staff regularly.
- To ensure effective dissemination of the information imparted during the trainings, pre and post tests are conducted during the training process.
- The staff is posted for multiple programmatic trainings at different times which makes it difficult for all the necessary staff to be trained. Consolidated or integrated trainings may be more effective.

## Karnataka

### Availability of HRH

- Total number of posts sanctioned by Government of Karnataka in regular cadre are 69,667 and approved under NHM are 30,353.
- Usually, the recruitment process is centralized, done once in a year by the recruitment commission/board established at the State level, but if any additional posts are sanctioned, then it is done twice in a year. Also, some flexibility is there with District Health Society to conduct recruitments of contractual staff as per the State guidelines.
- State provides classified incentives to the staff for serving in difficult areas/hard-to reach areas.
- Karnataka has 60 Medical Colleges that is 10 Medical Colleges per 1 Crore population, despite this the vacancies of 39% specialists and 45% MBBS doctors is hampering the range of services available in the secondary care facilities.
- Since that has vacancy of, when interacted at the grassroot level, the reasons for such vacancies were due to absence of plan to regularize under NHM, lack of regular promotion avenues, no increment after certain basic level, no proper medical reimbursement, and only 10 days of paid sick leave per annum.
- 31 posts from various departments are vacant in Hari Hara general hospital and

new 64 staff nurse posts are sanctioned for Taluka hospitals in the financial year 2021-22 under NHM in Davanagere district. So, recent vacancies were observed due to newly approved posts in RoP 2021-22 and recruitment of ANMs, Staff Nurses, Medical Officers, and Specialists of NHM who got selected in regular cadres.

- For recent vacancies and newly approved posts in RoP 2021-22 recruitment is under process at District Level and to fill up gap of Medical Officers PG completed students are posted on one-year compulsory rural services.
- The specialist cadre is limited to the postings of specialists in the urban areas and additional incentives over MOs. This needs proper restructuring with time bound pay scale and their availability both in rural and urban areas.
- Recruitment of specialists was done once in 2017-18 through 'You Quote We Pay' to implement initiative.

## Workforce Management

- As mentioned by the state officials the average time taken from advertisement to onboarding (recruitment cycle) is 30 to 90 days but from staff interviews it is found that the average time taken for recruitment is minimum 6-9 months.
- Selection of ANM and staff nurse is done based on the merit and computer skills whereas selection CHO was based on the result of online examination held with full transparency.
- A district officer is given charge of multiple programs that are unrelated to each other, components of a single program are seen by different program officers, so reorganization of program TORs is urgently required for better implementation.
- State has robust performance appraisal system but there was no HR or retention policy available for NHM staff.
- Team-based incentives are provided to CHOs/MLHPs and the primary care team to boost morale.

## Capacity Building

- Karnataka has 60 Medical Colleges, including DH with Medical Colleges in two districts- Davanagere & Bangalore.
- DNB is not initiated in the districts visited. The DH is attached to private medical college thus, it is difficult for DH to initiate DNB courses due to duplication of beds on which seats are claimed.
- The Government Nursing School, Davanagere has 30 seats per year and is also offering 7 various para medical courses with capacity of 20 seats each.
- There are no functional District Training Institutes in Davanagere & Yadgir. In Davanagere, building is available, but HR is not sanctioned.
- In the state no system of providing induction training to NHM, no trainings to District Program Officers, BPM provided to support monitoring and supportive supervision.

## Mizoram

### Availability of HRH

- Mizoram has a very centralized system for all policies pertaining to HRH, starting from recruitment to resignation.
- There were 2061 staff under NHM and NUHM in the state by November 2021. A team of five members at the State Programme Management Unit look after the HRH of the state, headed by the State Nodal Officer.
- Overall availability of the HRH in the state can be considered substantial, sans few cadres: Specialists, ANMs and Pharmacists. The visited district (Mamit) had the required number of HRH in place.
- The paucity of specialists in the state was extremely visible as nowhere at the CHCs were there any specialists, leading to CHCs functioning as PHCs only.
- In case of Champhai district, pharmacists were not available anywhere except in the UPHC. This meant that the responsibility of drug dispensation and uptake of DVDMS was taken up usually by the MO and the staff nurses.

- The availability of ANMs in some of the Sub-Centres was also an area of concern in the Champhai district. In some cases, there was either an ANM or a male health worker but not both. In one of the remote Sub-Centres near the Myanmar border. Despite the presence of a huge refugee camp in the area, there was no ANM or male health worker posted to the area. Only a Health and Wellness Officer (HWO) looked after the catchment area population, with the support of the ASHA.
- Irrational postings were visible. For instance, only an EmONC trained MO was posted in a CHC without an Anaesthetist or an LSAS trained MO; and an X-ray technician was present where there was no X-ray machine. Another example was at the DH Mamit where 6 LTs were posted in a 26 bedded district hospital, and the average caseload per LT per day was found to be 3 tests.
- One major area of concern was the lack of knowledge about the true number of sanctioned posts for a given facility at the district level and below. Though at the state level, a proper gap analysis for vacancies was being done using the RoPs, almost none among the CMOs, MS and the facility in-charges were aware about the sanctioned posts. This shows lack of a comprehensive HRH plan and could be one of the reasons for irrational postings and poor service provision.
- As an enabling mechanism, the State offers Hard Area Allowance to Doctors, Nurses, Health Workers (Female and Male), Pharmacists Lab Technicians and X-Ray technicians posted in difficult terrains.
- Salaries for the NHM Staff were usually delayed by 2-3 months. The process starts with the HR wing at the state NHM office preparing the list of all staff and sharing it with the Finance department. The finance department then undertakes the disbursement at the state and to the district level. Delayed fund transfer was cited as the reason for the delays.
- direct access to MOs and Specialists at the DH through phone and WhatsApp.
- Most of the HRH did not receive any Job descriptions or ToRs for their respective roles, except for those under NVBDCP and NUHM.
- It was mentioned by some of the HRH that there is an unsaid rule of giving preference to people working with the NHM for a long time whenever recruitments for regular positions take place, however there was no policy or mechanism as such.
- In case of regular cadre appointments and transfers, it came up that though there was a transfer policy, some of the HRH posted in the hard areas remain there for decades, hence difficult area postings were not preferred.
- All staff with salaries less than 15000 (at the time of joining) are eligible for EPF. It is a voluntary exercise but most staff members who are eligible do opt for it. The HR Nodal officer maintains the relevant list for the same.
- The State has a leave policy for the NHM staff, and also followed the Maternity Benefit (Amendment) Act, 2017 across the state for all NHM staff.
- The state had an e- HRMIS, which can be seen on the State website. The e-HRMIS has the records of all the staff: regular and contractual. However, its functionality is limited to the disbursement of salaries of the SPMU staff only.
- Although the staff is not programmatic anymore, but the process for salary and allowances remain pool-based and hence due to delineation, the benefits of allowances are limited to certain staff within the same cadre.
- The state government provides vehicular support to the MOs at the PHCs, but the same is not extended to the MOs recruited under NHM, making it difficult for them to reach the hard areas under their jurisdiction.

## Workforce Management

- The State has attempted to strengthen the Doctor-Patient Relationship by creating a system where the patients usually now have

## Capacity Building

- To improve the availability of specialists, the State has introduced DNB training at the



Civil Hospital Aizawl for the fields of General Medicine, General Surgery, Paediatrics, Anaesthesiology and Obstetrics and Gynaecology.

- Capacity building and training seemed to be a weak link in the State. There were no training plan or training calendar prepared for the HRH. There was inadequate documentation of the training conducted.
- The process of receiving trainings seemed haphazard and the facilities received intimation about a certain training from the state only a few days prior. This meant that not all the HRH received the requisite training. For example, an NPCDCS PBS training was conducted in March 2021 where 6 Health and Wellness Officers, 23 Health Workers and 19 ASHAs were trained, however, how many were left to be trained was not documented anywhere. There was also training module in the HRMIS or the HMIS.
- A good practice was observed in Champhai, where the DPM maintained a log entailing the types of trainings in which the HRH of the district has been trained. It was being maintained by name and by the type of training but not facility-wise.
- Another good practice found was knowledge sharing sessions were done by the trained HRH of the UPHC, promoting cross-learning on subjects such as bio-medical waste management, awareness, and prevention of 2nd wave of COVID, infection prevention and control, collection of blood and urine sample etc.

## Odisha

### Availability of HRH

- Specialist cadres including public health cadre were developed and incentives for difficult areas, specialists, etc. has been made to attract and retain skilled staff.
- Despite a good HR policy, lack of specialists and specialties in District Hospitals. Most of the SDH and CHC lacked specialists, resulting in referrals directly to DH.

- Limited vacancies were found for Program Management staff.

### Workforce Management

- The State has demonstrated an excellent HRH policy for regular as well as contractual human resources.
- There is a mechanism in place for regularizing contractual staff after a defined period of satisfactory service. This has resulted in a highly satisfied and motivated field medical & para medical workforce.
- The interaction with beneficiaries revealed a high level of trust upon the service providers across all levels in both the districts visited.

### Capacity Building

- Efforts were taken up by the State and district authorities to build capacities of the service providers by holding regular trainings, however prioritizing the right training package was needed.

## Puducherry

### Availability of HRH

- The UT has Specialist Cadre in place, but still has a vacancy of Specialists to the tune of 22.6%. The State UT does not have a Public Health cadre.
- Adequate numbers of health care facilities with adequate HRH for most of the cadres are in place. In fact, the population coverage of a health facility in Karaikal region is lower compared to the population norm.
- There was a vacancy of 6.1% of GDMOs, however, regular MO MBBS in place are more than requirement as per IPHS.
- The UT deposes contractual Medical Officers at Sub-centers, in place of CHOs. However, a high turnover of MOs posted in SC was observed as many of them leave the posting in a few months to pursue post-graduation. Till such time a new MO is recruited, there is loss of continuity in service provision to the community.

- There was no vacancy of Dentists, however they were not as per IPHS requirement.
- There were 17.7% vacancies for ANMs, 16.4% pharmacists and 18.4% of Senior LTs are per data shared by the UT.

### Workforce Management

- Workforce management in the UT needs strengthening as UT-specific HR policies, HRMIS, and robust grievance redressal mechanisms were found to be deficient.
- Rational posting of the HRH was not being done, and other than for DEOs, integration of HRH was not observed. In districts where program specific vacancies existed, lack of integration adversely affected service delivery.
- Performance based incentives for the PHC & SHC team were yet to be rolled out.

### Capacity Building

- The services provided by the primary care staff was limited to RMNCH+A services, and a need for multi-skilling of the HRH was evident.
- A lack of training plan and calendar was observed.

## Rajasthan

### Availability of HRH

- State has adequate number of sanctioned posts in 4 main service delivery cadres (Staff Nurses, Lab techs, Pharmacists, and doctors). However, there are still a large number of vacancies particularly under NHM as for the last 4 years there hasn't been any recruitment. There is overall 30% shortage of HR (State average) which increased to 50% for districts like Jalore.
- State does not have a Clinical Specialist cadre. Despite the glaring vacancies of Specialists in the visited districts, provisions for in-sourcing of specialists, or NHM provisions for attracting and retaining specialists were not being utilized.
- Public Health Cadre, and Public Health Management Cadre is neither available nor there is any discussion on these cadres. IPHS

is known but not considered for creating sanctioned posts of HRH.

- A major hindrance to filling up of posts at district and block level is the recruitment process prevailing in the state. All the recruitments under NHM happen at state level and there has been a long gap in the recruitment cycle, including CHOs.
- One of the major reasons reported for higher vacancies was low salaries and no revision of initial salaries. State/District staff also reported delay in payment of experience bonus.
- Position of State Finance Manager is vacant at the State level. Positions of 4 District Accounts Managers and 400 Block Accounts Managers are vacant.
- There were quite a few examples of irrational deployment of Anaesthesiologists i.e., DH Jalore had 2 Anaesthesiologists, while there was no Gynaecologist. Similarly, CHC Bhinmal had 2 Anaesthesiologists, without any surgeon or Gynaecologist, so no Caesarean sections were conducted in the CHC, Bhinmal. The MCH at DH Karauli had 4 Gynaecologists and 3 Anaesthesiologists.

### Workforce Management

- Rajasthan has put nurses as COVID Health Assistants (CHA) from its own resources thereby providing an additional pair of hands at SC level.
- The CRM teams in both the districts met many highly motivated officers and staff who despite the challenges were carrying out functions beyond their call of duty. There is generally good co-ordination between ASHA Sahyogini, Anganwadi worker and ANM.
- Lack of Transfer Policy and incentivization in High focus areas / difficult geographical areas. There are outbound transfers from the distant districts -a rampant phenomenon resulting in huge vacancies of sanctioned posts in all major service delivery cadre.
- ASHAs requested a change of colour of saree from Blue to any other colour as regionally, it is colour of mourning or worn by widows.

- Overburdening of existing staff due to multitasking was observed.

### Capacity Building

- It was observed that trainings and refresher trainings were not being properly done on a regular basis resulting in lack of skills across all major cadres. The district lacked an availability of a training plan and calendar along with lack of resource persons/ TOTs.
- The Jalore team observed CHO training being done in ANM training centre. Salary/ Entitlements of CHO were not dispersed for last 2 months. Daily diary and reading materials were not available. Single resource person available for entire training for 6 months
- Rajasthan has carried out 21 months' training of many MBBS doctors in many specialties but have not offered any differential salary or incentive and hence failed to utilize the skills acquired by such doctors.

## Sikkim

### Availability of HRH

- The State has specialist's cadre in place. Adequate number of in position staff were found at the visited facilities. In the last few years, recruitment of many MOs has been done by the State.
- Adequate numbers of the HR is in place at the facilities, but there is no comprehensive plan in place for ensuring availability of HRH in the State.
- The HR recruitment is majorly a Centralized process in the State. This is largely due to Sikkim being a small state and limited capacity and experience of the districts in these matters. The HRH at district level is planned and posted by the State, and there is very little role to be played by District Health Society in planning for the requirements.
- Further, it has been observed in the Rural Health Statistics reports that there are large number of vacancies against sanctioned positions of health HR for specialists in the State. State has been urged to fill up the specialist's position at the earliest.

- The State has operationalized a SNCU at Aspirational district (West Sikkim) through provisions of flexible funding under NHM by recruiting a Paediatricians under NHM in the district.
- Irrational deployment of the staff was observed, such as visited CHC is facing crunch in specialist positions, whereas, in one of the visited PHC-HWC 47 staffs are available (West Sikkim District). The reason for the availability of the surplus staff at some of the visited healthcare facility was reported that it's due the State government's policy of "One Family One Job".

### Workforce Management

- The State has no process of undertaking any skill assessment or competency assessment at the time of recruitment.

### Capacity Building

- Though, the available staff at the visited healthcare facilities reported that they have been trained on different components, but it is observed that the knowledge part is poor among the staff.
- The orientation training on selected components, such as bio-medical waste management, is felt necessary for the staff.
- There is no training planning or calendar at the district (West Sikkim District).

## Tripura

### Availability of HRH

- At primary care facilities – across PHCs there was no dearth observed for required MOs; there were 3-4 MBBS MOs, 1-2 AYUSH MOs, and a Dental surgeon in most of the facilities. At the SHC level, it was observed that in absence of MPW-F, the facilities were not being considered as a functional HWC.
- As per ROP 2020-21 approvals, more than 50% of the specialist posts are vacant in the state. The secondary level facilities reported a shortage of specialists which led to underutilization of infrastructure (Emergency, SNCU, NBSU, OTs) and affected service

delivery (C-section in CHC and SDH, major surgeries, Orthopedic surgical procedures, ENT surgical procedures, etc. in DH).

- Specialists like Radiologists, Pathologists, etc. are either not available or inadequate. Rational utilization of available specialists is a major concern. The existing specialists are found to be either overburdened (Anaesthesiologists) or frequently deputed across the facilities (Pediatrician) or underutilized (orthopedic surgery, ENT).
- There is a high vacancy in the post of CHOs, as out of 104 CHOs, only 14 are in place in the districts.
- One of the main reasons for attrition of some cadres (contractual Pharmacist, HMIS assistant, administrative staffs, and Account assistants) was reported to be low remuneration.

### Workforce Management

- State have HRH policy, Transfer and posting deployment policy, Performance-based incentives policy for CHOs. But there is no policy on workplace Sexual Harassment or grievance redressal at the facility level.
- The state has not recruited any HR in the last 18 months.
- Across the 24\*7 PHCs, the health care workers also shared their concern regarding security and demanded a security guard, especially for night duties.

### Capacity Building

- It was observed that capacity building was needed for all cadres of HRH. The Data entry operators needed orientation to the various IT applications that they had to operate. The service delivery staff needed to be trained about the latest guidelines such as BMW management, Infection prevention and control, and program specific updates in policies.
- Despite the great need for capacity building, limited trainings were taking place in the State. A methodic training calendar or plan was lacking.

## West Bengal

### Availability of HRH

- The state has created three cadres i.e., Public Health and Administrative Services for all program managers, health services for clinical service delivery staff (including Specialist Cadre) and medical education cadre for pre-service training.
- Shortage of Specialists at secondary care facilities is concerning for both the districts visited. Similarly gaps in numbers of Medical Officers, Staff Nurses, LT, and other staff at primary care facilities were also reported.
- Limited vacancies were found for Program Management staff and cadres such as CHOs in both Nadia and North 24 Parganas.
- In terms of remunerations, alternate vaccine delivery incentive of Rs.120 was provided for vaccination staff in hard-to-reach areas and Rs. 200 for staff reaching by boat in north 24 Parganas District. Further, state directive of a 15% hike in salaries of all contractual staff is being planned to be rolled out in the district as well.
- In North 24 Parganas, for contractual positions of Staff Nurses and Medical Officers, joining was refused despite issuance of engagement letters to the selected candidates. Reasons for this revolved around low remuneration rates and lack of benefits.
- Under NHM, since 2020-21, 78 personnel have joined the HRH workforce in North 24 Parganas District. In Nadia, a total of 36 staff were engaged for COVID-19 Duties. 17 of these staff continue to serve in COVID related duties.

### Workforce Management

- Monitoring of performance of ASHA is being done in an exceptional manner by the district North 24 Parganas. Detailed progress on all indicators is monitored and supportive supervision is being provided by the Block and District ASHA Program Coordinators. However, such mechanisms were not found in Nadia district.



- Qualifications of staff recruited under different posts, both regular and contractual, are in line with their job responsibilities.
- The staff stationed at various positions in both districts were found to be highly motivated and technically proficient. Interaction with beneficiaries revealed a high level of trust upon the service providers across all levels in both the districts visited.

### Capacity Building

- Initiative was undertaken by the district authorities to build capacities of the service providers by holding regular trainings on state developed resource packages on Dengue, snakebite, and Kala Azar.
- Paediatric COVID-19 Management Package was also rolled out through District TOT for SNCU staff and Medical Officers.
- DNB diploma courses have been initiated at the SGH and SDH for MBBS graduates in North 24 Parganas. Seats are present in six specialities across 9 Centres. Similarly, in Nadia, the program has been running since last two years with 14 seats in five specialities at the DH level. These are attracting not only state candidates but also aspirants from all over the country.

## Uttar Pradesh

### Availability of HRH

- State has created a Specialist cadre and has notified the 3,620 Specialist posts to be filled quickly.
- NHM supports a workforce of more than 73,000, however, in many of the health facilities visited, there was a shortage of human resources.
- The State has a high vacancy in regular cadre: Dentists (71%), Specialists (67%), ANM (43%). The vacancy of specialists under NHM is also high (57%).
- 'You Quote, we pay' was being used for specific Specialist cadres. Specialists in Mahoba were being sourced from neighboring districts or states thrice a week.

- Rational distribution of HR is also required.
- There are gaps of more than 35% between the number of Staff Nurses and MPWs required as per IPHS, and the number of sanctioned posts. Regular cadre posts of staff nurses, lab technicians and MPW (male/ female) constitutes less than half of the estimated requirement of HRH in the State.
- In U-PHCs, 75% Medical Officers, 73% Staff Nurses, 52% LTs, 82% pharmacists and 90% ANMs are in position. This includes regular as well as contractual Staff.
- Recruitment and retention of MBBS doctors is a major challenge for AB-HWCs.
- *Hausala Sajhedari* is an initiative to engage private sector health care providers in family planning service provision under government schemes wherein private hospitals/ nursing homes/institutions /individuals can get accredited/empanelled with the government and provide Family Planning services under guidelines.
- Under the programme, there are around 27 empanelled facilities, 10 Clinical Outreach Teams, and 63 empanelled surgeons. FST, NSV and IUCD services are provided. COT Team covers 5 public health facilities in Fatehpur.

### Workforce Management

- The process of recruitment has been slowed down for the last two years due to COVID-19.
- The State is adopting a computer-based test for recruitment of CHOs. Approx. 53,000 candidates have taken this Computer based Test (CBT).

### Capacity Building

- Capacity building activities and supportive supervision was being done in a very program specific manner, and holistic capacity building activities were lacking.
- State has signed MoU with Dept of Yoga and Naturopathy of Dr Ram Manohar Lohia Avadh University for 3-day yoga training of CHOs, so that they can conduct regular yoga sessions in their respective AB-HWC



**Health & Wellness Centre, Dharampur, Namsai**



**AMANAT Initiative for Skill building, Bihar**



**HRH in West Bengal**





**Motivated LT in PHC in Rajasthan**



**Motivated MO IC of CHC Bhinmal in Rajasthan with a Vision for his CHC**



**Motivated and Dedicated Staff in the Labour Room at SDH Hindaun, Rajasthan**

# TOR 3B: Indian Public Health Standards

A set of standards called the Indian Public Health Standards (IPHS) were first developed in 2007 - and revised in 2012. These standards cover health sub-centres (HSCs), Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District Hospitals (SDHs) and District Hospitals (DHs). The IPHS provide guidance on the infrastructure, human resource, drugs, diagnostics, equipment, quality, and governance requirements for delivering health services at public health facilities across various levels.

NHM, in an effort to catalyse the commitment under National Health Policy, has envisaged 50% of the facilities to be IPHS compliant by 2025-26. For the assessment of IPHS at facilities visited during the 14th CRM, IPHS 2012 were used as reference.

## Key Observations

- In most of facilities visited in 13 states, secondary care services including emergency care services were being provided.
- The core human resources for health, and specialties as per DH strengthening guidelines were available at most of the district hospitals visited except for some very far and remotely situated district hospitals.
- But performance monitoring is not happening as required to assess the types and quality of services being provided at the public health care facilities.
- Most of the facilities visited across the 13 states, were not compliant to IPHS norms.

## Recommendations

- States should start the certification process of all the public health care facilities with assessment checklist as a starting point as recommended by IPHS 2022.
- The human resource across all facilities needs to be strengthened as per IPHS norms.
- Orientation of all staff is required on implementation of IPHS norms.



- Performance monitoring also needs to be strengthened to further assuring the types and quality of services being provided at public health care facilities as per IPHS 2022.
- States should undertake a detailed gap analysis as per IPHS to make 50% of the facilities IPHS compliant by 2025-26 which also a vision of NHM extension.

## State Specific Observations

### Arunachal Pradesh

Most of the facilities were not IPHS compliant which calls for initiating implementation of IPHS on priority for all facilities in the state. In both the districts, Namsai and Lower Subansiri, facility staff were not aware of IPHS.

### Assam

The SHC-HWCs visited were complying to the IPHS 2012 population norms. However, there is no adherence to the designation linked to specialist services as per IPHS norms.

### Bihar

None of the health facilities visited was IPHS compliant.

### Haryana

- The healthcare facilities visited in the districts of Fatehabad and Nuh (Mewat) were not compliant to IPHS 2012 norms in terms of infrastructure availability, services delivery, and available manpower. There is a shortage of specialists and general duty medical officers in all levels of healthcare facilities in the districts.
- Health facilities were not available as per population norms given in IPHS.

### Karnataka

- Although the state had good infrastructure, none of the facilities were IPHS compliant in terms of infrastructure, services (including diagnostics), drugs, equipment, etc.

- District Hospital, Davanagere has a shortfall of Human Resources- 63% specialists, 61% Staff Nurse, 56% Lab Technicians and 31% MOs, Drugs (74%), Diagnostics (63%) and specialties (42%) as per IPHS.

### Mizoram

- The posting of human resources is not as per the IPHS norms in the state with a lack of decentralization in HR related practices like no HR policy (recruitments etc.).

### Odisha

- Both District Hospitals and Rourkela General Hospital were largely compliant to IPHS. Environment Friendly initiatives like Herbal Garden were available at all the facilities.
- The existing package of laboratory services and specialists needs to be expanded as per IPHS benchmarks.

### Puducherry

The infrastructure of PHC, CHC and DH are compliant to the IPHS norms, however the number of health Facilities is not as per the population norms in IPHS. For example, only 24,365 population was covered by CHC Thiruvallur in Karaikal region.

### Rajasthan

- Orientation of health care functionaries for IPHS 2012 norms was assessed at all levels (PHC, SC, CHC, DH) however none of the staff was aware regarding the requirements for IPHS.

### Sikkim

- None of the facilities visited in the state was found to be IPHS compliant.
- Considerable number of Human Resource were in position in peripheral facilities as per gap analysis conducted for HR.

### Tripura

- None of the facility in the state is IPHS compliant. The Services provided at various levels (DH/SDH, CHC & PHC) are not as per

IPHS. E.g., In DH OPD- General Medicine, O&G, paediatric, surgery, orthopaedics, dermatology, psychiatric, dental, Eye and Ayurveda services were provided. But ENT, Physiotherapy and some specialist services were not being provided at DH level.

## Uttar Pradesh

- Most facilities did not adhere to IPHS standards.
- A third of the rural population in the State has been deprived of primary healthcare infrastructure, according to the norms of the Indian Public Health Standards. However, recently, the State has created a specialist

cadre and has notified the 3,620 specialist posts to be filled quickly.

## West Bengal

- Barasat DH, Basirhat DH and Taki RH were providing services as per IPHS with available infrastructure and human resources, whereas B N Bose Hospital was not compliant to IPHS.
- Population norms for health facilities at primary level were not as per IPHS. E.g., PHC was catering to a population of approx. 70,000.
- Regular posts have been created as per the IPHS. There was significant vacancy of Specialists, GDMO, Staff nurse, GDA and Sweeper at most of the DH and SDHs.

# TOR 3C: Quality Improvement

## Introduction

WHO has defined Quality of care as 'the extent to which health care services provided to individuals and patient populations improve desired health outcomes

Quality Assurance (QA) is a cyclical process which needs to be continuously monitored against defined standards and measurable elements. Under NHM, across the country, this is done as per the guidelines on the subject and assessment standards. The CRM teams reviewed the progress on the defined basis and have come up with observations.

The Kayakalp Award Scheme, launched on 15th May 2015 promotes 'Swachhata'(cleanliness) - Hygiene and Infection control practices in Public Health facilities. *LaQshya* programme, launched in 2017, focusses on reduction of preventable maternal and new-born mortality and morbidity associated with the care around birth. In order to capture the voice of patients and their experience, a centralized IT platform i.e., 'Mera Aspataal'/ 'My hospital' was launched in 2018.

With the advent of time, National Quality Assurance Standards (NQAS) have laid out a systematic process for building both institutional and clinical capabilities. Thereby, supports the implementation, scaleup and sustainability of quality of care at national, district and health-facility levels.

By the end of the third quarter of FY 2021-22, among the 13 States/ UTs visited for CRM, NQAS certified facilities at national level are 283 and numbers certified at the State level are 429.

## Key Findings

1. The roadmap for achieving NHM targets for NQAS certification of public health facilities was not distinct across all visited State/ UTs, except Haryana.
2. Readiness of the state for uptake of quality certification of HWCs (in numbers) and MusQan scheme are not particularly encouraging.
3. Members of the SQAU/DQAU lacked a supportive supervision and mentoring field visit strategy for on-site support.

4. In the context of patient-centred care, the following are observed.:
  - a. Display of citizen charter and information about the services, clinical conditions, entitlements etc. were noticed only in Arunachal Pradesh, Haryana, Sikkim,
  - b. At the primary level, patient satisfaction surveys and integration with “Mera Aspataal” were found to be less common. Except in West Bengal, it was noted that it is being performed for NQAS/LaQshya certified facilities at the secondary care level. Despite the fact that District Hospitals/secondary care hospitals are integrated with Mera Aspataal, data analysis and decision-making quality improvement are still a challenge.
  - c. Adequate and clean Patient amenities - drinking water, toilets, clean linen, food, 234324 etc. was observed in all the visited facilities of Sikkim.
  - d. Provision of Respectful Care including maternity care (provision of LDR beds, alternate birthing position, birth companion, privacy): was noticed at most of the visited facilities in Arunachal Pradesh and Sikkim which were allowing family members/spouse as birth companion.
  - e. Except in Arunachal Pradesh, there was no well-established grievance redressal system.
  - f. Quality Teams have been established at state/district as well as at facility level in Arunachal Pradesh, Haryana, Rajasthan, Sikkim etc. However, it was noticed that complete minutes of meetings were missing, as well as clear action areas for quality improvement.
  - g. Only in Sikkim are departmental SOPs are documented and followed by employees.
  - h. Except in Sikkim, the majority of the facilities visited were not undertaking audits (such as prescription audits, medical audits, and death audits).

## Key Recommendations

1. Preparation and implementation of a well-defined, robust road map for NQAS certification at the state/district level for facilities targeted for FY 2021-22 & afterwards as per DO No. Z-18015/26/2020-NHM-II dated 1st October 2021.
2. Regular monitoring by the State and District Nodal Officers for implementation of Quality Assurance Program; and data validation by the State and District of the scores given by the facility.
3. Optimal and reasonable use of NQAS External and Internal Assessors, as well as TISS professionals (those who have completed the PGDHQM-Post Graduation Diploma in Healthcare Quality Management programme) for mentoring health facilities in order to help them achieve NQAS certification.
4. Conduct of awareness workshop for orientation of staff on newer initiatives like quality standards for HWCs, MusQan for child friendly health facilities with the support of Quality & Patient Safety Division at NHSRC
5. Uptake of SUMAN notified facilities for part NQAS certification as outlined under “SUMAN guideline” and Guidance note circulated to all State/UTs i.e., “Roll out Quality Assurance under SUMAN”
6. Conduct of regular bi-annual SQAC and quarterly DQAC meetings
7. Formation and operationalization of Quality teams at PHC/CHC level
8. The State/UTs need to accelerate internal assessment under NQAS, LaQshya and Kayakalp. After Internal Assessment, identified gaps should be prioritized to develop time-bound-action-plan. Monitoring of progress on gap closure status at the State level. Efforts should be made to close the gaps and preparing the facilities for State and National level Certification.
9. Formulation of Quality Policy, departmental SOPs, and its dissemination to end-users within the health facility both in Primary Care & Secondary care level.



10. The Quality improvement tools and technique like 5 Why, 5S Process mapping; PDCA may be adopted by the facilities to improve Quality of services.
11. Specialized hospital architects and skilled officials from health dept. should be involved before finalizing design of hospitals pertaining to the hospital structural planning /architecture planning.
12. Training of service providers on SOPs and the relevant policies and guidelines at all levels of the health facilities is required.
13. Engagement of the public/community/ PRI members for monitoring support and enhanced responsibility in maintaining the cleanliness of premises, sanitation and hygiene in the hospitals and surrounding area is important. Activities towards this may be undertaken by the RKS.
14. Training of staff on Bio-medical waste management rules 2016 (as amended) and linkages of peripheral health facilities with the Common bio-medical waste treatment facilities for timely transport, treatment, and disposal of waste
15. Implementation of Mera-Aspataal initiative below the District Hospitals (HSC/APHC/ Block PHC/ equivalent HCF) to measure the patients' satisfaction by capturing patient experience while in the health facility. Utilization of analysed data to further improve the quality of care and enhanced decision-making for patient-centric care.
16. Deployment of robust Grievance Redressal System including dedicated helpline number, resolution of the complaint within a stipulated time-bound manner and provision of feedback
17. Ensured adherence to regulatory and statutory rules and acts for following:
  - a. Bio-medical waste management Authorization
  - b. Linkage with CBWTF
  - c. NOC for fire safety measures at health facilities
  - d. License for Blood Bank/ Blood Storage Unit
  - e. Electrical Safety Audit
  - f. AERB Authorisation
  - g. Calibration of Measuring equipment (calibration)
18. Conduct of death audits, medical audits and prescription audit on a regular basis  
State should accelerate the pace to improve Quality Assurance activities under NUHM particularly North-Eastern state (Sikkim).

## State Findings

### Arunachal Pradesh

- Citizen charter was displayed in almost all facilities but it was not up to date. District Hospital Namsai has recently been certified by State for LaQshya.
- All hospitals visited have 'No Smoking' policy and no one was observed smoking in the hospital premises.
- There is a complaint box in hospitals facilitating grievance redressal.
- The concept of Respectful Maternal Care is acknowledged and facilities are trying to implement SUMAN guidelines.
- With the State having one NQAS and one LaQshya Government of India certified facility, District Hospital in Namsai district is still struggling to achieve NHM targets for NQAS certification.
- The facility level quality team comprising of Medical Superintendent and gynaecologist and the District quality team is established, but according to the committee, due to lack of man power, they are not able to get certification at present.
- The District Hospital is State certified for LaQshya and they are preparing to get national certification.

### Assam

- At a PHC-HWC, good sanitation measures were observed, including a deep burial pit and the date of the previous septic tank cleaning.

- NQAS/LaQshya certification was not achieved at any of the facilities visited.
- Mera – Aspataal is not integrated at any level, for patient feedback

## Bihar

- All the main components of quality assurance like NQAS, LaQshya, Kayakalp program is being implemented across the state though an accelerated pace is required to ensure a time bound approach for quality certification of prioritized health facilities. Low awareness on LaQshya and NQAS was observed.
- COVID-19 pandemic affected the pace of NQAS mentoring cum assessment visits of Potential Facilities, so far Begusarai, Rohtas, Arwal, Patna, Kaimur, Munger and Bhagalpur mentoring visits have been conducted.
- Quality Conclave was organized on 1st October 2021 to accelerate the quality improvement initiative
- Adequate number of internal and external assessors, Campus immersion at Administrative Staff College of India, Hyderabad has been completed in two batches.
- Quality Assurance program are limited to certain facilities and institutions like District Coaching team and Facility Quality Circles needs to reinstate.
- LaQshya, Kayakalp, and NQAS program was not reviewed during monthly meetings and district lacks a time bound action plan (TBAP) for quality certification of prioritized facilities.
- Service providers required refreshers on all Quality Assurance measures and immediate need to induct the health care providers on Quality management tools and process of Quality improvement.
- Standardized case-sheet, record and register were found at the visited facilities but there was inconsistency observed pertaining to maintenance of the record and register. However, it was also observed that, multiple records and report were maintained by clinical staffs. Duplication of information was found at DH.
- Standardized protocols, Job aids and Poster were displayed at the visited facilities, but these were not displayed at strategic locations.
- Good hygiene and cleanliness practices observed at District Hospital and housekeeping team was provided with adequate quantity of cleaning materials. A periodic survey was being carried out by facility team pertaining to the quality assurance activities. Hospital infection prevention and control practices are being improved using the Nurse mentor approach at DH and some of the targeted facilities.
- However, at few facilities it was observed that Infection prevention audits and adherence to universal precaution was compromised. Use of departmental checklist and housekeeping checklist was used in limited areas. Disinfectants and Hub cutter are not available at the point of use in all the visited facilities. All the visited facility has not designated an “Infection prevention nurse” to conduct periodic audits and surveillance of infection prevention practices.
- Statutory compliance like Authorization for AERB, Electrical and Fire safety, was not available at most of the visited facilities.
- Concept of “Respectful Maternity Care for promoting Positive Birthing Experience was not implemented and majority of facilities were not aware of Respectful Maternity Care.
- District has identified potential facilities for Quality certification but a gap analysis report and Time Bound Improvement Plan (TBAP) were not available with district. Repeat assessment, Peer Assessment practice have not been conducted since last year.
- Patient feedback mechanism and grievance redressal like Mera Aspataal Initiative is not implemented, while Patient Satisfaction Surveys were being conducted manually at district hospital.
- Staffs require training on simple quality management tool like 5 Why, 5 S and PDSA.
- It was also noticed that microbiological swab and culture sensitive surveillance were not collected from critical care units.

## Haryana

- The IEC was displayed at all levels of care; however, the Citizen Charter was not displayed in the majority of the facility.
- Although IEC was available in healthcare facilities, it was not widely available in the community.
- SQUAU / DQAU meetings were held on a regular basis by the state and the districts. The State's Quality Improvement Team has generally met the goals set for FY 2021-22 in terms of the number of health facilities that must be NQAS certified. Geriatric and Divyaang-friendly structures are lacking in the health facilities visited.

## Karnataka

- Facilities are focused to provide quality services and quality teams available. Training is conducted at least once a month, and a few are conducted quarterly.
- NQAS receives less attention than LaQshya and Kayakalp since it incorporates so many departments. The national level NQAS certifications have yet to achieve at any facility in the districts visited.

## Mizoram:

- The Mera Aspathaal initiative is not being properly implemented in the health facilities.

## Odisha

- Signages were properly displayed at all the visited facilities
- 13 public health facilities were NQAS certified at national level and 19 facilities were NQAS certified at State level.
- One of visited facility i.e., District Headquarters' Hospital-Rayagada is LaQshya certified but not maintaining the standards.
- Fire extinguishers were not available.

## Puducherry

- Drug, diagnostic, diet, and referral services are being provided free of cost to all patients who are accessing public health facilities.

- IEC posters, protocols were well displayed, and emergency supplies were adequate at District Hospital
- The Central Laundry Services for the whole Karaikal region is located at CHC Thirunallar, where all the linens, etc. are being laundered
- Kitchen services at DH and CHC is available however the patient prefers to eat foods from their home.
- The acceptance of the community towards 'Tobacco Free Environment' is commendable but restricted to smoking only. IEC materials on anti-tobacco messages are seen in all the premises of the health facilities visited. Signage of "No Smoking Area" were seen in the PHC, DH and DD Office premises.
- State has a nodal Officer for Quality Assurance Programme. However, in Puducherry UT, there is no well-defined roadmap with the set target for identification of facilities for various certification processes to be carried out by the UT for the FY 2021-22.
- No Nationally NQAS/LaQshya Certified facility in Puducherry UT, as on date, under Quality Assurances Programme.
- The dissemination of the Quality Assurance guidelines is questionable in the whole UT and no district program management unit is available to focus on the quality improvement.
- District Hospitals with good case load and adequate manpower should be shortlisted for NQAS/LaQshya Certification at the National level.

## Rajasthan

- The staffs of the both primary level health facilities & secondary level health facilities are not aware of National Quality Assurance Programme.
- The staffs have not undergone any training related to National Quality Assurance Programme, Quality protocol, infection control practices.
- SQAC has been formed. However, it was observed that DQACs are not functional. Even though quality circles are in place, minutes of

meeting or clear-cut action points for quality improvement were not recorded.

- Poor monitoring & evaluation of Quality Assurance had been observed during the CRM visit.
- Mera Aspataal integration is done only at the DH and SDH. However, Mera Aspataal portal at SDH was not functional since May 2021 as informed by the staffs. Patient Satisfaction Survey & analysis is being done manually only pertaining to LaQshya certification, but interviewed patients denied receiving any feedback.
- At the primary level, none of the facilities were integrated with Mera Aspataal for the patient feedback. Facilities were also not doing any manual survey for obtaining patient feedback on services provided by health facility.
- The visited facilities were not keeping records for quality indicators, departmental SOPs, BMW log books, adverse event records. Furthermore, the facilities did not have the copy of NQAS, Kayakalp.

## Sikkim

- Lack of awareness regarding Quality programmes like NQAS, MusQan, LaQshya Mera-Aspataal at ground level.
- Periodic review of the progress of program by SQAU and DQAUs was deficient.
- Quality Assurance programmes at the urban health facilities has not yet been initiated.
- Except at PHC Dantum, West Sikkim and PHC Chungthang, North Sikkim, none of the visited health facility had constituted quality team for implementation of quality standards. Quality circle was formulated at District Hospital Gyalshing and Mangan
- All the visited health facilities had displayed Citizen Charter at the entrance.
- Signages were displayed in English.
- OPD timings for different services available at the facility were displayed prominently
- Patient entitlement under different health schemes were not displayed except at DH Gyalshing and PHC Dantum
- Adherence to six steps and 5 moments of hand washing was observed in most of the visited health facilities to prevent healthcare associated infection
- The waste bins collecting bio-medical waste was placed in the patient care area & the staff were having adequate and regular supply of personal protective equipment
- In most of the visited facilities, staff were vaccinated for Hepatitis B however, at some of the facilities, staff were not vaccinated for Tetanus Toxoid except at PHC Dantum
- Fire extinguisher (type ABC) was available at most of the visited health facilities however, staff were not trained on its usage. NOC for Fire Safety was available only at State NQAS certified facility PHC Dantum.
- Many of the equipment's like radiant warmer, semi-auto analyser, dental chair, glucometer, x-ray machine, etc. were found non-functional from last six months. As communicated by the concerned district authorities, calibrations of measuring equipment, AMC, repairs, etc. were regulated at the state level only. They want this process to be decentralized so that they uphold accountability for AMC at district level.
- Profound amount of out-of-pocket expenditure were reported during the interactions with post-natal care patients, staff nurses and patient attendant in haemodialysis centre at all visited health facilities. Out-of-pocket expenditure was mainly on Diagnostics, Drugs and Consumables, due to irregular supply of medicine and reagents at the facilities for almost 4-5 months.
- Most of the visited health facilities were allowing birth companion (spouse/family member) along with pregnant women during intra-natal care. Privacy and dignity were adhered at DH Gyalshing with the availability of curtain between the delivery tables, but not available at DH Mangan. Diet was provided to the family attendant accompanying pregnant women. And also, counselling was provided to the mothers and attendant on safe breast-feeding practices and Kangaroo Mother Care, as highlighted by the interviewed staff nurses.



- All visited facilities had maintained patient register (OPD register, IPD register, Nursing Hand-over register, Labour room, Referral register, etc.) completely. Patient details including prescribed investigations, diagnosis was mentioned in the register.
- Most of the visited health facilities had basic amenities for patients like separate toilets for men and women, running water, sitting arrangements, etc. However, linens were provided to the patient only whenever it was demanded by the patient attendant. Facilities were patient friendly as ramps/side grills were available.
- Regarding dietary service, the Kitchen was available in DH Gyalshing, DH Mangan, PHC Dantum and PHC Chungthang. Diets were provided to the beneficiaries as per the diet plan prepared by the Dietician at the DH and MO/IC at the PHC.
- Absence of robust Complaint Resolution System was observed in most of the visited health facilities.
- Both the district hospital (Gyalshing and Mangan) were integrated with Mera-Aspataal (MA) however, integration with lower-level facilities is yet to be commenced. Though district hospitals were integrated but analysed data was not utilized for decision-making and improvements.
- None of the visited health facility were performing Prescription Audit except at DH Gyalshing and PHC Dantum along with the corrective and preventive action plan. However, it was noticed that DH Gyalshing performed their last prescription audit in January 2021 as this facility was appearing for National LaQshya assessment. Followed to assessment it was stopped. This finding suggestive of lack of sustenance of improvement practices once the facility is quality/LaQshya certified.
- Reporting and recording of Key Performance Indicators was practiced at PHC Dantum, PHC Chungthang and at both district hospital (DH Mangan and Gyalshing).
- Team observed one or two cases of maternal death happened in both district (West and

North Sikkim) and one infant death in North Sikkim district in year 2021 however, maternal death audit was not performed at the district level. However, it was appreciated that one case of maternal death happened at HWC Bongten in 2018 were reviewed and closed at District level meticulously.

- Non-compliance to the statutory requirements viz. Authorization for BMW, AERB authorization for radiology set-up, NOC for fire safety, etc. was a common observation across the state.
- External Quality Assurance Programme for Laboratories had not been initiated in any of the visited facilities
- Standard Operating Procedures for the care were available and implemented in the PHC Dantum, PHC Chungthang and DH Gyalshing only.
- The policy for management of records in Medical Record Department was not available. No condemnation policy at the facilities was found at the visited health facilities.

## Tripura

- During the visit, it was noted that the State has 49 Internal and 8 External Assessors.
- So far, 6 DH and 12 SDH are linked with Mera Aspataal, to capture patient feedback on the services received from health facilities.
- District Quality Assurance Consultants were not in position in the facilities visited in North Tripura.
- Unavailability of Hospital Administrators was reported in DH Dharma Nagar; although available at the SDH level.
- It was reported that only 2 SDH, 12 PHCs and 1 UPHC are Nationally/State NQAS Certified. Additionally, 3 LR and 1 M-OT are LaQshya certified. However, sustenance of quality activities in certified facilities needs attention.
- Compliance to AERB, BMW and Fire Safety licenses requires attention in the facilities visited.
- Quality improvement measures were performed adequately in some of the health facilities visited.

## Uttar Pradesh

- Uttar Pradesh has 132 State certified and 45 National certified NQAS facilities. The National certified facilities include 28 District Hospitals (DH), 2 Community Health Centres (CHC), 15 Primary Health Centres (PHC) and 1 Urban Primary Health Centre (UPHC).
- 88 Labour Rooms and 83 Maternity OTs are State Certified under LaQshya and 19 Labour Rooms and 17 Maternity OTs are National Certified under LaQshya, respectively.
- State has 295 Internal and 33 External Assessors under the NQAS. State and District

Quality Assurance Committees are functional and provide supporting supervision to the targeted facilities.

## West Bengal

- Regular Patient Satisfaction Surveys being conducted.
- AERB authorization, license for blood bank & PCPNDT (except in North 24 Parganas), NoC from fire safety were available.
- NQAS, LaQshya, SUMAN and Mera Aspataal integration inadequate across both the visited districts.

# Kayakalp Award Scheme

## Key Findings

1. Out of the total facilities visited during this 14th CRM, Majority of visited facilities of West Bengal were Kayakalp (Sushree) awarded.
2. Most of the HWCs of Tripura were found to be recipients of Kayakalp commendation award.
3. All the visited facilities were found neat and clean.
4. Utilisation of incentives were found in Sikkim, where the Kayakalp awardee facility (PHC Dantum) invested the incentive money towards procurement of micropipettes, reagents, diesel for generator, provision of ID card for staff etc.
  - For Bio-Medical Waste Management, in most of the visited State/UTs, non-adherence to the current protocol as outlined by Central Pollution Control Board/State Pollution Control Board was observed. Such as intermixing of waste, Disposal of PPEs into deep burial pits, Lack of awareness pertaining to changes in BMW Rules 2016 in comparison to BMW 1998 Rules. Though in some places BMW storage area is available, it was not in accordance to BMW Rule 2016.
  - The above observations are uniform for primary care as well as secondary care facilities.
5. Liquid Waste Management was not in place. However, pre-treatment of Laboratory & highly infectious waste was being done in few of the visited facilities.
6. Except few of the points like No smoking policy, Waste management policy to reduce, reuse and recycle waste and No use of single use plastic, State/UTs are yet to implement the newly added thematic area i.e., “Eco-friendly facility” at DH/SDH/CHC level.

## Key Recommendations

1. Inclusion of all Health & Wellness Centres in the scheme needs to be ensured.
2. Implementation of Eco-friendly facility initiative at DH/SDH/ CHC level to be done.
3. Kayakalp winner facilities in 2020-21 may be targeted for the NQAS certification.
4. Ensuring sustenance of the gains achieved after attainment of Kayakalp Awards through periodic monitoring and supportive supervision.
5. Training of staff on Bio-medical waste management rules 2016 (as amended) and having 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 need to establish.

## State Findings

### Arunachal Pradesh

- The State has around 17 Kayakalp certified facilities but none are present in the aspirational district Namsai.
- District hospital Namsai has not applied for Kayakalp assessment because it is still under construction.
- Though Mera Aspataal initiative has been launched in District hospital and patient's information is being entered by the data operator but feedback from the patients have not been recorded in facility due to internet and IT issues.
- CHC Chowkham had Kayakalp assessment in February in which it scored 55.6%. The facilities are mostly getting less scores in Hygiene promotion and support services.

- Among the visited facilities, under Bio-Medical Waste Management liquid waste from the hospitals is directly being discharged into the drain without any treatment. Garbage and biomass are burned on back side of hospital premises. No waste management policy in any facility, e-waste management CBWTF concept is completely absent in all the health facilities in Namsai.

## Assam

- BMW segregation, treatment, and disposal are not as per BMW Guidelines, 2016
- Good IEC material regarding management of bio medical waste including liquid waste management was displayed at some facilities

## Bihar

- Kayakalp award scheme is being undertaken regularly and facility teams were aware on Kayakalp.
- It is being implemented across the state though an accelerated pace is required to ensure a time bound approach.
- The award scheme was not reviewed during monthly meetings and district lacks a time bound action plan (TBAP).

## Mizoram

- Bio Waste management protocols not being followed at sub centres and PHCs.

## Odisha

- There are 586 Kayakalp awardee facilities in Odisha, including 23 DHs, 15 SDHs, 128 CHCs, 286 PHCs, 80 UPHCs, 1-UCHC, and 53 HWCs.
  - Bio-Medical Waste Management has a linked system starting at the CHC level. There was a link with the CBWTF but only up to the CHC level. PHC/SC Bio-Medical Waste was collected and transported to neighbouring CHCs for disposal. BMW pits have been built at the PHC level for the trash disposal.
  - Before being discharged into a municipal drain, liquid waste gets pre-treated.

## Puducherry

### Bio-Medical Waste Management

- The state has out-sourced the waste collection and disposal to a private agency. The agency collects the waste almost every day from all the facilities in the region as per the protocols.
- The biomedical waste handling staff are provided with protective equipment and immunization (Hep B and Tetanus).
- Laboratory and infectious waste are pre-treated before disposal.
- Bio-medical wastes are segregated at source with colour coded dust bins.

## Rajasthan

- Kayakalp Internal Assessment was done in each facility in Karauli.
- The staff working at CHC, PHC, UPHC & HWC knows about Kayakalp, but the awareness about the importance and benefits of the Kayakalp award scheme was the major gap identified. Quality team or Infection control committee was not in place at the primary level health facilities.
- Facilities did not provide any documents pertaining to the committees formed at facility level. The facility In-charge directly enters the Kayakalp scores in the Kayakalp portal created by the state. Some facilities showed an internal score of more than 80% for FY 2021-22, which was not appropriate as per the status seen during the CRM visit.
- Most of the staff at DH and SDH level are aware about the Kayakalp award scheme and have the Quality team in place, but the Quality team members of the team are not aware about their role and responsibilities in the Kayakalp activities. As per facilities' In-charge, Quality team members do the Kayakalp assessment and feed the score into the portal, however the concerned departmental staff was unaware of any assessment done by the team
  - The BMW Management at primary level facilities was very poor. The staff were not segregating waste at the point of



generation, as they were not aware about the same. There was shortage of colour coded bins and liners, and several bins were kept without lids. The dedicated BMW storage area as per BMW rule 2016 was not in place in any facility. Although an MOU has been signed with the CBWTF agency, waste collection within 48 hours is not taking place. In the visited facilities, the pit for disposal of BMW was not available within the premises, hence the BMW was being burnt along with general waste at the back side of the premises. Facilities could not provide the BMW logbook.

- Poor segregation, storage, transport, and disposal of BMW. Collection of BMW was not done as per the timeframe by CBWTF. Staff is not aware about the Infection Control Practices.
- Bio Medical Waste Management at Secondary level health Facilities are not following the protocols. BMW was mixed with the general waste and staff was not aware about the segregation of BMW. The liners were not placed appropriately as per available colour coded bins. The BMW storage area was available in secondary level health facility, but it was not as per BMW rule 2016. CBTWF agency not collecting the waste within 48 hours from the facilities and BMW logbook was also not available in the facilities.

## Sikkim

- The CRM team observed that the state has extended Kayakalp scheme to the Health & Wellness centres for FY 2021-22.
- Number of participating facilities under Kayakalp has increased from 30 health facilities in year 2020-21 to 85 facilities in Year 2021-22. Internal assessment for all 85 facilities has been completed and peer assessment will be completed by the end of November 2021.
- In FY 2020-21, a total of 17 health facilities achieved benchmark score under Kayakalp award scheme which included 04 District

Hospitals, 02 Community Health Centres and 11 Primary Health Centres.

- Although, the state is participating in the Kayakalp scheme every year from DH to PHC level, it is observed that all PHCs/HWCs are still not participating and working towards achieving minimum 70% Kayakalp score on external assessment.
- All the visited facilities were found neat and clean.
- Most of the visited health facilities were following no smoking policy and no use of single use plastic as an initiative under Eco-friendly thematic area of Kayakalp scheme.
- However, the state is yet to implement Eco-friendly thematic area at the DH and CHC level
- Chipping of plaster, wall dampening was observed in few areas of the PHC Dantum, PHC Rinchenpong and PHC Chungthang.
- Key findings under Bio-medical waste management are summarized below:
  - In most of the visited facilities, working staff did not have clarity about changes in BMW rules 2016 vis-à-vis 1998 rules, thereby resulting into non-adherence to current protocols as required under the 2016 rules (& subsequent amendments)
  - Though colour coded bins were available in all the facilities but mixing of waste was observed in few facilities
  - None of the visited health facilities were linked with treatment facility (CBMWTF)
  - Although in-house waste management system (Incinerator or Sharp pits/deep burial) in the near vicinity of the facility was available but as observed, incinerator was non-functional at both district hospital DH Gyalshing and DH Mangan from last 6-months, sharp pits/deep burial pits were filled up to the mark and new sharp pits were under construction. This led to waste storage for more than 5-days at the health facility.
  - Open sewage system was observed in most of the visited health facilities

- Most of the staff reported that they were not given any training on Bio-medical waste management
- Pre-treatment of laboratory and highly infectious waste was being done however liquid waste management (ETP/STP) was not in place and for DH Gyalshing it was in approval process
- Records of waste generation was maintained at PHC Dantum on a monthly basis

### Tripura

- Most of the visited HWCs were found to be recipients of Kayakalp commendation.
- Bio-Medical Waste Management: During the visit, it was noted that PPE was disposed into the burial pits. Therefore, there is an urgent need to address the current PPE disposal mechanism and follow safe practices.

### Uttar Pradesh

- A total of 690 public health facilities have achieved a benchmark of 70% or more in Kayakalp External assessment in FY 2020–21 which includes 106 DH, 215 CHC, 295 PHCs & 74 UPHCs.
- The Kayakalp scheme has been initiated at HWCs. 10 CHCs have been supported under Swachh Swasth Sarvatra Scheme with a grant of Rs. 10 Lakh each in FY 2020–21.

### West Bengal

- Majority of the visited facilities were Kayakalp (SUSHREE) awarded.
- BMW AERB authorizations were available at all visited facility.

Few of the State/UTs have shown worthwhile improvement over the years in term of NQAS, LaQshya, Kayakalp implementation. However, sustaining such efforts would require building the facility and district level quality teams.

# TOR 3D: Legal Framework, and Accountability

While assessing the functional status of various health programmes running under NHM and to understand key drivers and challenges impacting their implementation, 14th CRM also focused upon health system strengthening by way of reviewing the implementation of health regulations (e.g. PCPNDT, MTP, CEA etc.), constitution of appropriate authorities under the regulations and assessing if IEC/campaigns are being undertaken to spread awareness about several health regulations.

Upon review, valuable information about the successful as well as ineffective state strategies, and implementation of the legislative provisions was gathered. In most of the CRM states visited this year, it was generally observed that focus on execution of legislations pertaining to health was diluted. For example, 8 out of 13 states have adopted Clinical Establishment Act (CEA). Although, institutional mechanism under the PCPNDT Act was found to be in place in almost all the states, only Rajasthan and Karnataka have taken steps to enforce the act properly. Despite of the mandatory requirement to document consent in Form C under the MTP Rules, inconsistent practice related to the same was observed in many facilities. There was lack of clarity amongst service providers on various legal Acts like the Mental Healthcare Act, 2017 (MHCA), Bio Medical Waste Management Rules, 2016 (BMW Rules), Atomic Energy 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. Furthermore, the States with adequate orientation lack adequate resources/staff.

However, eminent provisions such as issuance of disability certificates, maximum birth registrations, understanding of confidentiality provisions, prohibition of sex selection, obtaining consent for examination and counselling of victims of sexual violence, mandatory signages under COTPA were observed to be well-known by the service providers in the facilities visited by the CRM team.

## Key Findings

- **The Clinical Establishments (Registration and Regulation) Act, 2010** – The Clinical Establishments (Registration and Regulation) Act, 2010 has been enacted by the Central Government to provide for registration and regulation of all clinical establishments in the country with a view to prescribe the minimum standards of facilities and services provided by them. Of the States visited this year, the Act has taken effect in Arunachal Pradesh, Mizoram and Sikkim vide Gazette notification dated 28th February 2012. The States of Uttar Pradesh, Rajasthan, Bihar, Assam, and Haryana have adopted the Act under clause (1) of article 252 of the Constitution. West Bengal, Puducherry, Tripura, and Karnataka have their own pre-existing legislation. State of West Bengal, Haryana and Karnataka reported constitution of District Regulation Authorities (DRA) under the Act. In West Bengal, registration is monitored at State level and in Karnataka, registration certificates are issued by the DHO. However, the enforcement of the act, as observed from the visits to facilities, remains weak in almost all States.
- **Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994** – The act bans prenatal sex determination in order to stop female foeticides and prevent the declining sex ratio in India. Every genetic counselling centre, genetic laboratory or genetic clinic engaged in counselling or conducting pre-natal diagnostics techniques, with the potential of sex selection, before and after conception, comes under preview of the PCPNDT Act. The institutional mechanism under the Act is in place in almost all the states. However, there is a lack of robust awareness and social mobilization around gender equality. States visited this year that have taken steps to enforce the act properly are – Rajasthan and Karnataka. Key identified problems in the implementation of the PCPNDT Act include – non-maintenance of patients' details and diagnostic records, lack of mapping and regulation of USG equipment, lack of regular meetings by authorities and insufficient inspections.
- **Medical Termination of Pregnancy Act, 2021** – Abortion in India has been legal under various circumstances for the last 50 years with the introduction of Medical Termination of Pregnancy (MTP) Act in 1971. 1971 Act provides for the legal framework for making CAC services available in India. It specifies – (i) who can terminate a pregnancy; (ii) till when a pregnancy can be terminated; and (iii) where can a pregnancy be terminated. Vide Gazette notification dated 24.09.2021, MTP Amendment Act, 2021 came into force whereby certain amendments in the already existing MTP Act were introduced, including, all women being allowed to seek safe abortion services on grounds of contraceptive failure, increase in gestation limit to 24 weeks for special categories of women, and opinion of one provider required up to 20 weeks of gestation. The MTP Rules and Regulations, 2003 detail training and certification requirements for a provider and facility; and provide reporting and documentation requirements for safe and legal termination of pregnancy. The MTP Rules further prescribe that consent needs to be documented on Form C. This year, inconsistent practice related to documentation, Form C and reporting was observed in many facilities. There is lack of clarity about the provisions of the amended Act among programme officers. In Rajasthan, information on MTP was not displayed outside the facilities and in Uttar Pradesh, despite the availability of MTP trained doctor at CHC level, the service was not being carried out.
- **Rights of Persons with Disability Act, 2016** – In order to ensure that the persons with disabilities enjoy their rights equally with others, the act provides for issuance of a disability certificate (also known as PwD certificate or PH certificate or handicap certificate) that certifies the type and extent of holder's disability. Of the States visited this year, West Bengal, Haryana, Assam, Rajasthan, Puducherry, and Sikkim are issuing disability certificate. However, the time taken for issuance of the certificate is prolonged due to technical issues.



In the State of Arunachal Pradesh, neither the information on issuance of disability certificate (as per The Rights of Persons with Disabilities Act, 2016) was stated to be available with general public nor the hospitals have displayed information on disbursement of these disability certificate including the process for obtaining the certificate.

- **The Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013 (POSH Act)** – POSH Act has been enacted with the objective of preventing and protecting women against workplace sexual harassment and to ensure effective redressal of complaints of sexual harassment. The statute aims at providing every woman (irrespective of her age or employment status) a safe, secure, and dignified working environment, free from all forms of harassment. The Act requires an employer to set up an Internal Committee (IC) and The Local Committee (LC) to ensure redressal of grievances of workplace harassment in a time bound manner. Apart from the State of West Bengal, proper implementation of the provisions of the Act – constitution of Internal Complaints committee, proper training, written policy etc. remained absent in other States. In the States visited this year, except for the State of Haryana, Karnataka & Assam, there were no dedicated rooms where the victims can be given an assured and confidential environment for examination, recording of statement etc.
- **Medico-Legal Care Protocols for Survivors of Rape/Sexual Violence** – The protocol and guidelines issued by MoHFW recognize the role of health sector in strengthening legal frameworks, developing comprehensive and multi-sectoral national strategies for preventing and eliminating all forms of sexual violence. Through these, the Ministry not only proposes to provide clear directives to all health facilities to ensure that all survivors of all forms of sexual violence, rape and incest have immediate access to health care services but also recognizes the need to create an enabling environment for

survivors/victims where they can speak out about abuse and receive empathetic support.

The guidelines require every hospital to have SOPs printed for management of cases of sexual violence, including informed consent. During the visits, it was observed that although 'One stop Centers' are available in Haryana, Karnataka and Assam, there is still an immense lack of training of health care providers on the protocol aspects of examination, consent, treatment, counselling, and police intimation.

- **Cigarettes and other Tobacco Products Act, 2003 (COTPA 2003)** - The Act prohibits smoking of tobacco in public places, advertisement of tobacco products including cigarettes, sale of tobacco products to minors, and also provides for penal provisions for violation of the provisions of the Act. Signages in most facilities of the visited states were observed during this year's visit. However, details of the nodal officer/complaint officer are not available in almost all States. Monitoring and supervision of the act is deficient in most states except for the States of West Bengal, Puducherry, and Karnataka.
- **Registration of Births and Deaths Act** – Registration of Births and Deaths which is mandated by the act, is being carried out in majority of the visited States. However, Karnataka conveyed decrease in birth and death registration as a result of COVID-19. State of Arunachal Pradesh, Assam, Rajasthan, and Sikkim reported greater birth registrations as compared to death registrations. But none of the States have taken any initiative for holding joint meetings between Registering authorities and health officials in order to ensure 100% registration of births and deaths.
- **Bio Medical Waste Management Rules, 2016 (BMW Rules)** – Limited compliance for comprehensive adherence of the BMW Rules was observed in majority of the States. Taluk and PHC facilities visited in Karnataka did not use their own burial pits. They evacuated their waste to the nearest common bio-medical waste treatment facility. The later

would send a truck to pick up waste 3 times a week. Most of the states did not have a Common Biomedical Waste Treatment Facility (CBMWTF) established. Proper provision on PPE, immunisation and annual health check-ups to biomedical waste handlers also appeared to be missing. In the State of Arunachal Pradesh, no separate arrangement of COVID-19 waste disposal was observed. The dead foetus was also being buried directly in pit. No authorisation of burial pits with SPCB/PCC. Cytotoxic drugs were buried directly in pit. However, in Puducherry, Bio-medical wastes are segregated at source with colour coded dust bins. The state has also outsourced the waste collection and disposal to a private agency.

- **The Human Immunodeficiency Virus and Acquired Immuno-Deficiency Syndrome (Prevention & Control Bill), 2017** - States like West Bengal and Karnataka have already issued necessary SOPs on safe working environment. However, the provisions of the Bill are yet to be implemented 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, which was observed to be missing in the State of Arunachal Pradesh, Haryana, and Assam.
- **The Mental Healthcare Act, 2017 (MHCA)** – The 2017 Act seeks to provide mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services. These measures include the necessity of setting up mental health establishments across the country to ensure that no person with mental illness will have to travel far for treatment, as well as the creation of a mental health review board which will act as a regulatory body. The states of West Bengal and Karnataka have notified a state mental health authority and mental health review board required to be constituted under MHCA 2017 for hearing any dispute regarding the treatment of patients with mental illness. Assam reported that the establishment of the Mental Health Review

Board is under process. District Counselling Centres for Mental Health was found at Assam, Karnataka and at one district in Haryana, and the same was not operational in Puducherry.

- **Atomic Energy Act** – The Act seeks to provide standards of controlling radioactive substances and measures to be taken to prevent radiation accidents, retain public safety, assure cautious disposal of radioactive wastes, and so on. The establishments visited this year had limited knowledge about the Atomic Energy Act, 1962. TLD badges were not found to be available in the facilities visited this year except for the State of Karnataka. Radiology unit visited in Haryana was not AERB certified. However, those in Arunachal Pradesh, Karnataka and Sikkim had obtained necessary certification.

## Recommendations

- Monitoring and inspection of the legislative requirements should be done by the relevant authorities.
- Documentation, record keeping and reporting by the health facilities should be mandated and regularly monitored.
- Augmenting the capacity of the existing staff shall be done in all facilities.
- Nodal officers ensuring implementation of legislative provisions shall be appointed at District as well as State level. At facilities/hospitals, the hospital manager/in charge shall be made nodal.
- States must organize training workshops to orient relevant health care providers/program officers (public and private) on provisions of various acts such as latest MTP Act and Rules, Birth and Death registration.
- Online portals shall be created for strengthening reporting/documentation mechanism.
- A dedicated IT Cell/Kiosk may be created at the medical facilities to help the beneficiaries. It may be integrated with the IT Cells already available with other Departments of the States so that this may act as a one-stop

facilitation center (e.g. online registration and application of disability certificate).

- All states should prioritize adopting/ adapting the CEA and those that have a pre-existing legislation should also adopt its core principles. States that have adopted the CEA need to notify state rules and constitute and notify counsel of Clinical Establishments.
- Regularity of PCPNDT meetings and monitoring visit to private facilities may be increased in all States.
- A well- defined monitoring, challan and reporting mechanism may be ensured in all States under the COTPA Act and addiction treatment support at all facilities may be provided.
- Bar code and GPS based Biomedical Waste management system need to be rolled out in all districts, and Segregation of biomedical waste at source and at common collection point needs to be ensured in all facilities.
- All health care facilities providing radiology imaging services should be AERB authorized and TLD badges should be available with all the technicians.
- Under the **POSH Act**, the States must ensure mandatory Committees are established with necessary composition and written policy on sexual harassment at the workplace exists in the facilities as per the requirements of the act, along with the dedicated room for counselling/ examination/reporting by the victim.

## State-specific Findings

### Arunachal Pradesh

- Arunachal Pradesh is one of the States who had applied to Government of India for promulgation of **Clinical Establishment Act, 2010**. The act has subsequently been implemented in the state. The authorities were notified, temporary registration of hospitals is done, and data is available for category and type of facility in the State. There are 674 facilities registered. Out of them, 315 are private and 359 are public.
- Implementation of **Registration of Birth and Death (RBD) Act, 1969** is progressing with the statistics department issuing the certificate. Linkages with the health department exists and certain hospitals are issuing the birth certificate and in certain instances, information on disbursement of birth certificate is provided to pregnant / recently delivered mothers and services are directly accessed by citizens from statistics department. While the birth registration stands at 87.7% the percentage of death registration is only 34.5%.
- In the visited facilities, both DH and CHC had obtained **Atomic Energy Regulatory Board (AERB)** license for X-ray facilities. However, TLD badges were not found to be available.
- State is undertaking measures to let people know about the harmful effects of tobacco, especially smoking and chewable forms of tobacco, which is rampant. In the health facilities visited, mandatory public display boards under **Cigarettes and Other Tobacco Products (COTPA) Act, 2003** were seen. However, the details of nodal person were not available.
- Safe abortion services are provided, though limited in number, in the districts visited. Only 4 institutions are registered under Pre- Conception and **Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994** in Namsai; out of these 3 are in Govt. sector. No cases registered under PCPNDT in both the districts in the last one year.
- Information on issuance of disability certificate (as per **The Rights of Persons with Disabilities Act, 2016**) is not available with general public. The hospitals have not displayed information on disbursement of these disability certificate including the process for obtaining the certificate.
- For cases of survivors of sexual offence, protocols, printed registers, and SOPs were not found to be in place. Doctors were also not well aware of the protocols and importance of chain of custody. Internal complaints committee have not been formulated as per prevention of sexual harassment at work place (**POSH Act, 2013**).

- State has neither appointed a complaint officer who shall deal with **HIV-AIDS prevention Control Act, 2017** nor an ombudsman to ascertain implementation of the act.
- State has a mental hospital in place where institutional collaborations with civil society for running half-way homes exist. They are established for those requiring long term care or who need to be stabilized before sending home. The peripheral facilities (districts), however, provide limited mental health treatment. State also do not have State Mental health Authority or review board notified under the **Mental Healthcare Act, 2017**. No district counselling centre for Mental Health was also in place in the visited districts. Hospitals receive a lot of substance abuse patients. A focus on prevention/rehabilitation in this area is required.
- Though DLCs are present under **MTP Act** in most of the districts, regular meetings are not happening; no private hospital has been authorized to perform procedure.

## Bio Medical Waste Management

Colour coded bins are by and large available with BMW practice for segregation of waste in place. The entire state does not have a Common Biomedical Waste Treatment Facility (CBMWTF) established and hence BMW is processed at facility level.

Some facilities have no proper provision on PPE, immunization, and annual health check-ups to biomedical waste handlers. Some facilities treat infectious waste before disposal but most of them dump it in the pit created by the facilities itself in the backyard and most of them do not know about the meaning of colour coding for segregation of biomedical waste.

The facility uses non-chlorinated plastic bags. Most of the facilities do not have puncture proof bags for needles and they store it in some container. There was no designated central storage room where segregated waste was kept. It was collected in the backyard of hospital in an open, inside a large container which is incinerated in the facility itself since no CBWTF is in place. There is no separate arrangement of COVID-19 waste disposal. The dead

foetus is also buried directly in pit. No authorisation of burial pits with SPCB/PCC. Cytotoxic drugs were buried directly in pit.

There is no provision of liquid waste management under effluent treatment plant. The most does not have proper sewage treatment provision. The liquid wasted is disinfected by the reagent before disposing it within facility. The facilities like CHC and District hospital had incinerators but no shredder and air pollution control devices. The biomedical waste bags did not have warning symbol of Bio Hazard or Cytotoxic hazard.

## Assam

### Clinical Establishment Act, 2010

- The State of Assam had the Health Establishment Act 1993 in place which was repealed in September 2015 and the CEA 2010 was adopted in 2015 and rules notified in October 2016. Training regarding the act has been conducted in 27 districts. 5609 allopathy facilities had received provisional registration which is approximately 95% of all the private health facilities in the state and 43 diagnostic laboratories have been provided permanent registration (5 years).
- In the District of Hailakandi, 79 private health facilities and 225 in the District of Cachar have received provisional registration under the act. Penal actions taken and suspension of registration also undertaken after review in certain cases.
- Human Resource for CEA implementation - there is one position of State Co-ordinator approved in the ROP but not appointed so far.

### Medical Termination of Pregnancy Act

- The number of abortions carried out by the facility in the Algapur CHC in the last 6 months was 6 and they were between 6-8 weeks of pregnancy. The form C was available and found filled up for all the abortions carried out. The community was aware of the abortions facility in the CHC but no. of cases low due to COVID.



## **Medico Legal Care Protocol for Rape and Sexual Violence Cases**

- The facility at CHC Algapur did not have its own designated room or a one stop centre in its premises. It was shared by the facility that such a centre existed nearby with a NGO Udichi. However, it was informed by the staff that in the last one year no rape /sexual violence cases have been handled by the facility. No trainings have been found to be conducted on MOHFWs protocol for sexual violence cases and also on the POSCO act. At the DHH level as mentioned by the in Charge Superintendent the MOs were trained in different aspects of the Medico legal case protocol for rape and sexual violence cases, however due to COVID the trainings had not been held for the past one year.

## **Rights of Persons with Disability Act 2016**

- The disability certificate is issued by the District and the Social Welfare Dept. It holds camps in the community for raising awareness on disability and involves ASHAs in these drives and meetings. PwD apply online for Disability Certificate with requisite documents like Income Proof, Identity Proof and SC/ST/OBC proof and submit to CMO Office/Medical Authority. CMO Office/Medical Authority verifies data and assigns the concerned specialist(s) for assessment. Specialist Doctor assesses disability of PwD and gives opinion on disability. The Medical Board reviews the case and assign disability percentage and CMO Office prepares Disability Certificate and generates UDID and Disability Certificate. UDID datasheet goes for UDID Card printing and Card dispatched to PwD. However, due to limited availability of specialists very often the PwD has to travel to Silchar medical college for the assessment.

## **Sexual Harassment of Women at Workplace (Prevention, Prohibition and Redressal Act, 2013)**

- As per the instructions of the State/District the committee against sexual harassment

for women at workplace had been formed at the facility level (CHC Algapur) with the head of the CHC as the Chairman. The two women members were included in the committee but there was no NGO member. Last meeting was held on 6.10.2021 and no complaints had been received by the committee. No display of the of the committee, penal consequences was found in the facility. Two Orientations done on making the staff of the hospital and the periphery hospital aware about the provisions of the POSH act had been held.

## **The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, supply, and Distribution Act 2003 (COTPA)**

- The no smoking signage was found in facilities visited in Hailakandi but name of the person to complain in case someone is found smoking in the premise was not found. Awareness meetings and camps, Nukkad Nataks, meetings with police personnel and school teachers, wall paintings etc had been conducted by the tobacco control cell in the community and institutional level to make people aware about the harmful effects of tobacco and smoking in the public being an offence. The sign boards are limited to hospital premises.

## **Registration of Births and Deaths Act, 1969**

- The birth and death registration unit was present and being undertaken in the premises of the facility of CHC Algapur. The public after the birth of a child applied for the certificate to the facility in the required format. The format is then shared with the District Birth and Death unit who issue the certificate after verification. These certificates are forwarded to the unit at the facility level who issue it to the parents after the signature of the head of the facility. The time taken for issue of death certificate is 1month and for the issue of birth certificate is 3–4 months. Daily application for Birth and death certificate is 2–3 and

monthly 150/160 birth certificates and 55 death certificates are issued. Awareness is undertaken at the community level through the ASHAs.

### **The Immunodeficiency Virus and Acquired Immuno-Deficiency Syndrome (Prevention and Control Bill)**

- The facility follows the safe working environment and occupational exposure prophylaxis. The facility has not appointed a complaints officer to deal with the day to day complaints of the violations of the provisions of the Act.

### **Mental HealthCare Act, 2017**

- The Mental Health Act was notified by the State on 6th July, 2019. The establishment of the Mental Health Review Board is under process. The difficulty is in getting the District Judge as the Chair. The District Counselling Centres have been established in the two districts of Cachar and Hailakandi.

### **PCPNDT Act**

- The last advisory committee was held in 4.09.2021. There were 7 facilities which had obtained registration and 5 were functional. As per the census 2011, the sex ratio in the State is 951 and child sex ratio is 954. Though the district officials opine that the difference is due to natural causes but sex ratio mapping can be undertaken for blocks and villages.

## **Bihar**

- Under **Pre-conception and Pre-natal Diagnostic Techniques (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. Although monthly & quarterly reporting is done on regular basis, state has developed a dedicated website for PCPNDT and developing a portal for complaint management also.

- The **Cigarettes and Other Tobacco Products (COTPA) Act** was enforced but its periodic monitoring and implementation was deficient. A system of challan and reporting system was in place however, awareness about its implementation in facility level was limited. It was an issue of concern that tobacco cessation required Nicotine patch and Nicotine gums that is not part of State EDLs. State has imparted training on de addiction for alcohol & tobacco cessation to few identified staff.
- Work under **Mental Healthcare Act** has been under process.
- **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.
- Institutional bodies like District Health Society, Maternal Death Surveillance Response committee, Child Death Review, Advisory Board (PCPNDT) and DQAC etc. were needed to reinstate.
- Time bound approach to ensure adherence to statutory compliance like BMW authorization, Radiological, AERB, Electrical and Fire safety.

## **Haryana**

### **Clinical Establishment Act, 2010**

- The Districts have constituted the District Regulation Authorities (DRA) under Clinical Establishment Act (CEA) and there is a provision of conducting monthly meetings. It covers all clinical establishments more than 50 bedded and presently the DHs in Fatehabad and Nuh (Mewat) are registered under CEA, 2010.

### **The Pre-Conception and Pre-Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 (PCPNDT Act)**

- Ultrasound facility available in the District Hospital, Fatehabad is certified under The Pre-Conception and Pre-Natal Diagnostic

Techniques (Prohibition of Sex Selection) Act, 1994 (PCPNDT Act).

- Advisory Committee on PCPNDT Act is constituted under which monthly meetings are conducted.

### **The Cigarettes and Other Tobacco Products (Prohibition of Advertisement And Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003, (COTPA)**

- “No Smoking Area - Smoking Here Is An Offence” signage is displayed at Health facilities under The Cigarettes and Other Tobacco Products (Prohibition of Advertisement And Regulation Of Trade And Commerce, Production, Supply And Distribution) Act, 2003, (COTPA).
- Challan books have been distributed to various departments (Roadways, Education department etc.) in the districts. The report about the challans issued is forwarded to Director Tobacco Programme at the State. The DH, Nuh (Mewat) has a dedicated Tobacco Cessation Centre with a psychiatrist.
- Laws which are implemented should be implemented in its full spirit as per the set guidelines. e.g. Signage under COTPA is displayed at health facilities but a well-defined monitoring, challan and reporting mechanism is absent.

### **Medico-legal Care Protocol for Rape and Sexual Violence Cases**

- One ‘One Stop Centre’ in CHC Nuh, and deals with the medico-legal cases of rape and sexual violence from the entire district.
- SOPs have not been issued under Medico-Legal Care Protocol for Rape and Sexual Violence Cases.
- In all CHCs, SDH and DHs of the Districts, Medico-legal works are undertaken 24\*7 and reports are prepared online.

### **Registration of Birth and Deaths Act**

- The registration of all births and deaths reported from the field as well as hospitals are done on an online SARAL portal. The record is maintained in physical hard copies as well.

### **Human Immune Deficiency Virus and Acquired Immune Deficiency Syndrome (Prevention & Control) Bill, 2017**

- The HWCs are following the Central Government (NACO) SOPs/ Guidelines under Human Immune Deficiency Virus and Acquired Immune Deficiency Syndrome (Prevention & Control) Bill, 2017
- No ombudsman under Human Immune Deficiency Virus and Acquired Immune Deficiency Syndrome (Prevention & Control) Bill, 2017.

### **The Rights of Persons with Disabilities Act, 2016**

- Civil surgeon at DH Nuh (Mewat) is the Disability certificate issuing authority for PwDs. The application is filled online and its record is properly maintained. The facility is also disable friendly with ramps.
- In Kurtala, an adolescent with suspected mental retardation was engaging with the team. In discussion with ASHA about diagnosis and issue of disability certificate, it was mentioned that 02 more children with hearing impairment were in the village.

### **MTP Act**

- MTPs services are available at DH and CHC Punhana, Nuh (Mewat). Form C is also duly filled, and record is maintained properly.
- Safe abortion services were not available in the PHCs visited in Nuh (Mewat).
- There are approximately 36 institutions with ultrasound facilities in Nuh (Mewat) district out of which 31 are registered and 5 are sealed/non-operational. The DH Nuh (Mewat) USG facility is non-functional due to the non-availability of Radiologist.

## Mental Healthcare Act, 2017

- District Counselling Centres (DCC) for Mental Health are established in the district of Fatehabad but the same is lacking in Nuh (Mewat) due to lack of space at the DH.

## Atomic Energy Act, 1962

- The establishments have no knowledge about the Atomic Energy Act, 1962.
- Radiology unit at the DH, Nuh (Mewat) is not AERB certified and TLD badges are not available.

## POSH Act, 2013

- A 5 member ICC has been constituted at the DH Nuh (Mewat) in the year 2018. But none of the members have received any training on the guidelines of POSH act though cases are being handled on the basis of national guidelines.
- There is neither any written policy on sexual harassment at workplace nor any display of penal consequences. Since the formation of ICC, the facility has not conducted any workshops or awareness programs on sexual harassment.
- There is no Internal Complaint Committee under the POSH Act.

## Other Observations

- Operational parts of some of medical acts, which are undertaken in a campaign mode, are taken under IEC program.
- The staffs directly implementing the provisions of Medical Acts/Regulations have operational knowledge about these through trainings but lack comprehensive knowledge about the acts and provisions.
- There is no IEC program which directly addresses the provisions of Acts/Regulations.
- There is only one Blood Bank available at District Hospital, Fatehabad. However, its license has expired since 2017 and the process of its renewal is still on.

## Karnataka

- **Clinical Establishment Act is available in Karnataka:** There is no clinical establishment act for public facilities. However, state has its own clinical establishment act named **Karnataka Private Medical Establishments Act, 2007.**
  - Certificates are issued by the DHO to register 795 private clinics and hospitals under the KPME act.
- **The PCPNDT Act** is implemented albeit a limited number of PCPNDT meetings were conducted in 2020-21 due to C-19. 88 ultrasounds facilities are registered under the PCPNDT act (6 are gov centres) in Davanagere and 31 (4 are gov centres) in Yadgiri. Awareness generation through IEC/BCC campaign is being done.
  - Form F is available and being properly filled in. DHO keeps track of all ultrasounds done with corresponding Form F. At DHO, we checked one case: One diagnostic centre received 100 patients in the month of October 2021 and there were 100 forms F for those related patients, acknowledging the functioning of the PCPNDT act.
  - One court case was filed 3 years back and it is still pending.
  - In Davanagere, the PCPNDT advisory committee convened meeting 3 times in 2021. Minutes of the meetings were available. Agenda points included renewals; registering the new scanning centres; purchasing new equipment.
- **The Medical Termination of Pregnancy Act (MTP Act)** is implemented but Form C available only at Taluk and district hospital levels.
  - Private facilities need to submit a certificate of approval to district authorities to notify and be authorized to conduct abortion services (Form B).
  - All facilities have admissions and evacuation registers (full details available



at DHO. Facilities send those data to DHO).

- Records of MTP act at DHO show the number of abortions carried out by the facility and what weeks of pregnancy it was done in the last 6 months. Those data are collected by DHO monthly.
- **The Implementation of the Harassment of Women at Workplace (Prevention, Prohibition and Redressal) Act, 2013** clearly requires further improvement.
  - At district hospital, there is a committee set in place to tackle sexual harassment of women at workplace - SAKHI since 2019 but because of COVID-19 the committee has not met regularly. There was one complaint of sexual harassment received in 2021 but the case was closed as the staff was transferred.
  - Similar committee is not constituted below the district hospital for taluk hospitals or PHC level facilities.
  - There is also no written policy on sexual harassment at the workplace.
  - Training on POSH Act has not been conducted.
- **Medico-Legal Care Protocol for Rape and Sexual Violence Cases** is available at district level (one SAKHI centre per district). There is separate building for this called SAKHI/One stop centre with 8 staff, including a legal advisor to provide free treatment and mental health counselling. The centre is run by both health and family welfare and women and child welfare departments.
  - Between November 2019 and March 2021, there was a total of 77 cases (60 below 18 years old and 17 above 18 years old). More cases were reported from rural areas indicating that vulnerable populations are reached.
  - In interaction with women, it was found that they did not pay for any services provided at One Stop centre except for transport for her arrival.
- An awareness program was conducted at community level as well as schools.
- **Registration of Births and Deaths.** Birth certificates are mandatory to register kids at school level and other administrative procedures. As such the birth registration rate is high.
  - Birth and death registrations have decreased as a result of C-19 (in 2019, there were respectively 9537 births and 1384 deaths registered, 4596 births and 1021 deaths in 2020 and 4848 births and 1367 deaths in 2021).
  - Gov facilities have the credential to issue birth and death certificates through E-JANMA portal.
  - When birth or death happens at home, households go to village panchayat who will input the Birth/death Certificate into E-JANMA.
  - When a birth happens in a government facility, the parents report the birth to the government facility withing 21 days.
  - When it is registered within 21 days, the mother gets a SMS to inform her that the birth certificate is ready, and she can download the birth certificate from her phone.
  - Then she can come back to the hospital to get a print-out. She will pay 5 rupees.
  - For older people who did not have birth certificate issued, they need to go to municipalities to do the necessary.
  - If a delivery or death happens in a private facility, they need to visit the local body (bloc panchayat). They will issue certificate through tehsildar registrate.
- All facilities have SOP on safe working environment and occupational to HIV under **Human Immune Deficiency Virus and Acquired Immune Deficiency Syndrome Act**. The districts have a nodal complaint officer for the entire district and ombudsman available Bengaluru to look into grievances related HIV/AIDS Act.

- **The Mental Health Care Act:** The state has notified a state mental health authority and mental health review board. There are 10 counselling centres at district level out of which 9 are available [not sure whether it is at district level or state level.] Community mental health counselling available in the urban areas in Davanagere district.
- **Atomic Energy Act, 1962.** Radiology unit and all X-Ray centres are AERB certified however, more training of staff is needed. There is a Nodal Focal Point (from DHO) which inspects X-ray facilities and assess whether those centres are AERB compliant.
- **Blood Bank licencing:** Blood bank licence seems to be available for both public blood bank and private blood bank entities.
- **COPTA:** Most health facilities had “no smoking” area sign
  - Davanagere district was declared as COPTA High Compliance district on July 31, 2021
  - Innovation: Campaign on Tobacco Free in ASHA’s house of Davanagere district 22 PHC’s, 4 SCs covered.
  - COPTA was included in the monthly crime review meeting. The police conducts monitoring of the COPTA 2/3 times a week.
  - In October 2021, there were 98 cases which gathered 9,350 rupees. The number of cases varies between 80 and 400 in 2021 based on yearly data shared by the program.
  - **Challenges:** Difficult to impose fines on the poor, on shop keepers who have not put a non-smoking sign. They will say that they cannot pay the fine of Rs 1500 as they hardly make Rs 1500 per day. It is also difficult for population in villages to comply because the awareness is not always there.

## Puducherry

- **Clinical Establishment Act (CEA):** All Public and Private facilities (Polyclinics, Scan Centres, Evening Clinics, ISM Clinics, Dental Clinics, Laboratory, Physiotherapy Centres, Day Care Centres) in the region are covered under the CEA.
  - Public Facilities: Out of 34 public facilities, 28 are registered under CEA, 2 have not renewed and 4 have not registered.
  - Private Facilities: Out of 113 private facilities, 46 are registered, 25 have not been renewed and 42 have not registered.
  - Reminders have been sent to 25 private facilities who have not renewed their registration.
  - Notices have been issued to all the 42 private facilities who have not registered under the CEA in the region.
- **PC & PNDT Act:** District Advisory Committee is appointed under PCPNDT Act. Its meetings are held as and when the request for registration application, renewal application and complaints of misuse are received. Eleven ultrasound centres in private sector are registered under the Act in Karaikal region. A case is filed against one ultrasound centre for non-reporting of the ultrasound tests at the sonography centre. Ultrasound facilities are submitting the monthly returns to the DD office regularly.
- **MTP Act:** Deputy Director (Family Welfare) in Puducherry UT issues the permission for operating MTP Clinic. Three facilities come under MTP Act in Karaikal region: District Hospital (Public); Vinayaka Mission Hospital (Charitable trust) and Nandu Clinic (Private).
- **Rights of Persons with Disabilities Act:** As and when the applications are received, a board of Specialist Doctors in the DH examines the disability applicants and make their recommendation to the Social Welfare Department about the extent of the disability of the applicants. Social Welfare Department of the Karaikal region issues the Disability Certificate on the recommendation of the Board of Specialist Doctors in the District Hospital.
- **Medico-Legal Care Protocol for Rape and Sexual Cases:** Written SOP is not available at the DH for handling rape & sexual violence

cases. Cases are dealt as per the advice of the police department. CRM team was informed by the RMO of the DH that the police follow all the procedures for safeguarding the survivor. Informed consent for medical examination is taken from the survivor.

- Survivor is provided with psychological counselling and medical treatment at DH, and medical evidences are collected from the survivor and the perpetrator.
- **POSH Act:** Internal Complaints Committee (ICC) is constituted at the DH. Although the ICC is existing and functional, the composition is not as per the Act. One sexual harassment complaint was received by the ICC in 2019. The case is also registered against the employee in Police. The ICC upon enquiry suspended the employee for one year. After one year of suspension, the employee was reinstated, and the case still continues. Only one-time awareness programme was conducted for the employees of DH regarding prevention, prohibition, and redressal of sexual harassment at workplace. Composition and names of the ICC members are not displayed in DH and DD's Office. Punishment under the Act is also not displayed in DH and DD's Office. In the DD (Immunization) office, no such Committee has yet been established.
- **The Cigarettes and Other Tobacco Products (Prohibition of Advertisements and Regulation of Trade and Commence, production, Supply and Distribution) Act, 2003 (COTPA):** The acceptance of the community towards 'Tobacco Free Environment' is commendable but restricted to smoking only. IEC materials on anti-tobacco messages are seen in all the premises of the health facilities visited. Signage of "No Smoking Area" were seen in the PHC, DH and DD Office premises. District Tobacco Control Cell is not yet established in the region. There is no well-defined monitoring, challan and reporting mechanism been set up and notified by the Competent Authority

to conduct periodic enforcement drives and implementation of the anti-tobacco measures. CRM team was informed by the DD's Office and RMO that the Police department is dealing with the enforcement of COTPA, 2003.

- **RBD Act:** Facilities have registers for entering birth and death details. Birth and Deaths are informed to the Municipality/Commune Panchayat once in a week by the health facilities. Birth and Death Registration is almost universal in Puducherry Union Territory as per the CRS 2019 report.
- **Bio Medical Waste Management Rules, 2016 (BMW Rules 2016):** The biomedical waste handling staff are provided with protective equipment and immunization (Hep B and tetanus). Laboratory and infectious waste are pre-treated before disposal. Bio-medical wastes are segregated at source with colour coded dust bins. The state has outsourced the waste collection and disposal to a private agency. The agency collects the waste almost every day from all the facilities in the region as per the protocols.
- **MHCA:** The DH (RMO) and DD's Office are not aware about the notification of the State Mental Health Authority and Mental Health Review Boards. The District Counselling Centre (DCC) for Mental Health is not operational in Karaikal.

## Rajasthan

### Clinical Establishment Act (CEA), 2010

- The State notified the CEA in 2013 and amended in 2015, however they report that standards set by GoI are not realistic for implementation of the Act.
- Some provisional registration for CEA exists but there are very few permanent registrations (2500 in number).
- Some facilities empanelled under the Chiranjeevi scheme are in accordance with the standards, vis-à-vis structural or process quality, and they can be reviewed for listing under the CEA.

### **Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994**

Tremendous effort has been made by the State towards controlling sex selective abortions. Female child mortality is almost at par with male as per official records, indicating a positive shift in attitude towards the female child. Some initiatives include:

- Wide scale IEC activities have been done; 3847 USG centres are registered across State.
- Surveillance of women who have already had 2 girl children once they reach first trimester of third pregnancy
- Sting operations are undertaken upon suspicion of sex determination or sex-selective abortion.
  - Rs. 3 lakh is given as an incentive to informant and Rs. 1.5 lakh is given as an incentive to decoy mother who assists the sting. The latter is given police protection in several cases.
- Community interviews in Karauli suggest that sex determination is not done anywhere in the vicinity and facilities have clearly marked out that they do not carry out sex determination
- Moreover, community perceptions in Karauli (Ghadika Gaon), suggest that the outlook towards the girl child is becoming more positive.
- In Jalore, Form F is available at facilities but the Act and notification is not displayed at some facilities.
- Community in Jalore district mentioned that CHC has an USG in OT. There is also an absence of good record keeping for CAC services provided, which requires further investigation to ensure that these are not sex-selective abortions.

### **Medical Termination of Pregnancy (MTP) Act, 1971**

- Information regarding MTP Act was not displayed outside facilities either in Jalore or Karauli

- Forms were available in Jalore and the community reported abortions in Karauli, but it could not be verified if post abortion care is being provided in an appropriate manner.

### **Right of Persons with Disability Act, 2016**

- An online portal designed by the Govt. of Rajasthan is available for registration of persons with disability.
- In Karauli, people with disability were registered on the portal, following which a specific physician (depending on area of disability) examines the patient.
- This is then signed off by the Principal Medical Officer and further shared with the CMHO, who issues the disability certificate.
- It was mentioned that the process of CMHO approval is done once every 2-3 days and this was verified across facilities with similar responses.
- Every Monday, there is a camp at DH which verifies disabilities. ENT, Orthopaedic, Psychiatrist and Ophthalmologists are available for the certification.
- Similar process was reported in Jalore though the team did not observe any such camps being carried out.

### **Prevention of Sexual Harassment of Women at Workplace (POSH) Act, 2013**

- In Karauli district, there was no structured approach to address issues under the POSH Act.
- At the district hospital, complaints were filed directly with police and the Medical jurist would then look into the issue. No Internal Complaints Committee (ICC) was instituted to address the matters independently.
- At SDH Hindaun, an Internal Complaints Committee has been instituted, which is headed by a female doctor, though no complaints have been received as yet.
- POSH has not been implemented in Jalore. ICC was not found to be instituted or functional in any facility and no complaint drop boxes were found there.



### Medico-Legal Protocol for Rape and Sexual Violence

- In both districts, medical officers or medical jurists were present to attend to medico-legal cases including those relating to rape and sexual violence.
- In Jalore, police stations were attached to CHC and DH from where complainants were taken to the health facility for further examination, etc. (similarly to the DH in Karauli).

### Cigarettes and Other Tobacco Products Act, 2003

- Signage against Tobacco usage were found outside all facilities, however, nodal person for addressing complaints was not found in most facilities (apart from SDH Hindaun).
- Awareness activities were regularly being undertaken in schools pre-pandemic.
- Tobacco cessation clinic and nicotine replacement therapy were offered at DH in Jalore and Karauli, though follow-up of patients was not being done.
- Jalore has also put a target for ANMs to help at least three pregnant women quit chewing tobacco. Appreciation certificates will be provided for the same.

### Registration of Births and Deaths Act, 1969

- MCH hospital in Karauli is the office of Sub-Registrar of Births and Deaths. Dedicated staff and facilities are available for online registration.
- Aadhaar card is essential for birth/death registration, however, many people are not aware about this requirement, leading to incomplete coverage of vital events.
- Death registration is significantly incomplete as compared to the birth registration. 617 deaths were reported, however only 185 were registered at MCH Hospital and DH alone during 01 January 2021-10 November 2021, leading to only 30 percent registration of deaths.

- Birth registration is above 90 percent.
- Birth and death registration is also being done at the CHC level, and birth certificate is issued in the name of parents immediately during maternal discharge.
- In Jalore, birth registers and reports are being maintained very well.

## Sikkim

- **Clinical establishment Act 2010:** Sikkim has enacted/adopted the CEA in 2012. So far 222 units were registered under the private establishment and 183 units under State Government Establishment. Number of CEA registration by type of provider was also shared by Dr Barun Subba. CEA registration is not made online so far but planning to have a state portal for the same.
- Under the **Pre – Conception and Pre- Natal Diagnostic Techniques (Prohibition of Sex Selection) Act, 1994 – PCPNDT Act**, the team observed that regular meetings of the State Supervisory board have been conducted. The minutes of the meetings are in place. The State has undertaken the mapping exercise in this regard for focused attention. However, it was informed that sex selection is not preferred by the community.
- **MTP Act:** The Gynecologist, District Hospital, West Sikkim District informed that there were 12 abortions in last 12 months in the hospital, no abortion was done at DH Mangan. Form C is maintained and was also shown to us.
- **Rights of Persons with Disability Act 2016:** It was clarified that the CMO is responsible for screening of the disabled persons, but the actual certificate will finally be issued by the State's Social Welfare Department.
- **POSH Act 2013:** The new committee with 6 members with Gynecologist as the Chair is newly formed at the District Hospital, West Sikkim District. Meeting is yet to be convened, but no such cases were reported in regime of the previous committee also. Such committees were not functional at the 2 PHCs visited.

- **Medico-Legal Care Protocol for Rape and Sexual Cases:** The Medical Superintendent reported existence of SOPs for taking informed consent, conducting medical examination, evidence collection and providing psychological and medical treatment to survivors. The facility used to have 1/2 cases in a month but informed that no active cases at present.
- **COPTA 2003:** No smoking advertisements were displayed in health facilities, government offices and in public places (fine is INR 300/). But implementation is limited as people were smoking in the hospital premises. Similar is the case of law regarding selling of tobacco only in packets and not loose. Tobacco selling shops are everywhere.
- **Registration of Births and Deaths Act:** Medical officer is responsible for issuing birth and deaths certificates in Sikkim. Birth registration is complete. Confirmed from DH/PHC/SC that the certificate of registration is distributed at the place where the childbirth has taken place. The health workers fill the form and ensure that birth certificates are provided for each birth. The application for death registration is usually filled and submitted by the dead person's dependents. It was reported that there will be some cases where it has not been performed and hence is not likely to be 100 percent as in the case of birth registration. One PHC reported 84% coverage of death registration. The district health authorities complained that they have 100 percent birth registration, but in HMIS it's not showing up due to higher estimated number of births than actual numbers.
- **Bio Medical Waste Management 2016:** Biomedical waste management facility was limited and is left unattended. The reports given by DH and PHC and Sub Centres were conflicting. According to district hospital the black category waste will be taken by the Municipalities. One Sub Centre also informed about transporting black category waste to

PHC. Red category is stored in DH for 3 days and after treatment disposed elsewhere. The incubator for yellow waste management not working in district hospital. There was no system for disposing bio medical waste in the 2 PHC's visited.

- **The Mental Health Care Act 2017:** The Mental Health clinics are functional at DHs under the Mental Health Care Act 2017
- **Atomic Energy Act 1962:** X ray unit in the district hospital was reported to be AERB certified. TLD badges were not available as it must come from the State Health Department who procured that.

## Uttar Pradesh

- District Hospitals are providing Comprehensive Abortion Care services. As per the mandate of **MTP Act** documentation is maintained, post abortion contraception and counselling services are provided. At CHC level, though MTP trained doctor is available in Mohaba still MTP is not happening. ASHAs & ANMs in both districts were well versed with the facilities providing safe abortion services, and were also accompanying women to facilities for these services. Most of them were aware about the legal implications as per the provisions MTP Act 1971.
- **VISHAKHA committee** notification seen at the district level
- The **birth and death registration** are happening at the community, SC, CHC and DH level.
- **Biomedical Waste Management** guidelines are not diligently followed at most of the facilities visited.
- There is lack of IEC Material on **PCPNDT Act** for public Awareness.

## West Bengal

- **Clinical Establishment Act, 2010**  
The State has a pre-existing legislation

in relation to Clinical Establishment Act. The state constituted a State Council and District Registration Authorities for clinical establishment. It is operational through online portal. There is pre-designed checklist for different establishments, and any agency applying for new establishment or renewal need to apply online. This is followed by field visit by experts and online approval. Registration is monitored at state level. The state health officials opined that the process is smooth and well defined. They are facing it easier to work in the online portal.

- **Rights of Persons with Disability Act, 2016**  
All DH visited were found to be issuing any Disability certificate to the patients.
- **Sexual Harassment of Women at Workplace (Prevention, Prohibition & Redressal) Act, 2013 (POSH Act)**  
Internal Complaints Committee have been constituted in both the districts and training have been carried out in POSH Act. There is a written policy on sexual harassment at the workplace by the state Government and facilities were found to be compliant. Not a single complaint has been lodged till date in any of the observed facilities.
- **Medico-Legal Care Protocol for Rape and Sexual Violence Cases**  
The districts are largely compliant on medico-legal protocol. Informed SOPs are available and they are followed. Basic medical treatment as per need is provided to the survivors.
- **Registration of Births and Deaths Act, 1969 [RBD ACT]**  
Online registration system was found to be operational in all the observed facilities. Entry of all birth and death events reported at the hospital are carried out and the certificates are made available on time.
- **The Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production,**

#### **Supply And Distribution) Act, 2003, (COTPA)**

IEC materials written as “No Smoking” are available in all the visited facilities. Separate COTPA cells are available in both Districts. They were found to be working in coordination with civil and police administration to implement the GOI guidelines within facilities. Further, tobacco cessation counselling have been found to be carried out at some of the facilities. Dedicated tobacco cessation centres have been functional in DH, with dedicated counsellors. In both the DH, the counsellors working under COTPA cell were trained by district tobacco control cell.

- **Biomedical Waste Management Rules**  
All BMW management staff are vaccinated with TT and Hepa B. Most of the facilities are largely compliant with BMW guideline. The common collection points were identified, and colour coded with the hospital except for Dr D N Bose SD Hospital, Barrackpore. The collection, transportation and disposal of BMW are carried out within 48 hours. All the bags/containers/ bins were labelled with the warning symbol of biohazard. The staff were trained in BMW management and Needle stick injury.
- **The Human Immunodeficiency Virus And Acquired Immuno-Deficiency Syndrome (Prevention & Control Bill), 2017**  
The state circulates the SOP on safe working environment (gloves, aprons, masks) and occupational exposure to HIV (post exposure prophylaxis) to all the facilities, and they are following it. Needle stick injury register was found in the emergency room of Barasat DH.
- **The Mental Healthcare Act, 2017 (MHCA)**  
State has notified a State Mental Health Authority and Mental Health Review Boards. Dedicated District Counselling Centre (DCC) for Mental Health was not found in DHs, but psychiatrists are posted there. Compliance with regulatory and statutory requirements are found to be optimum.

# Accountability Framework

## Background

The framework of National Health Mission envisions a health system which is accountable and responsive to people's needs of the population. This is also one of the key core principles of National Health Policy framed in 2017. The institutional mechanisms established under NHM, Mission Steering Group (MSG) and the Empowered Programme Committee (EPC) at National level, State Health Mission/Societies at state and District Health Mission (DHM)/City Health Mission (CHM) at district level have overall responsibilities of planning, implementation, and monitoring. Other convergence and coordination strategies adopted by the Government to establish an accountable public health system includes empowering community and involving elected representatives, administrative/technical personnel, representatives of NGOs, social workers, and members of the community in VHNSCs, MAS, Rogi Kalyan Samitis to support fund utilization, decentralized planning, and e-Governance through monitoring of data through HMIS. Effective grievance redressal system, display of citizen charters, involvement of PRIs/ULBs, regular visits of supervisors to the facilities are some of the mechanisms adopted for ensuring accountability at the facility level.

## General Observation

### Institutional Framework

- State and District Health Mission and State and District Health Societies are in place and functional in all the states visited. However, due to pandemic, the frequency of meetings was reduced in almost all states.
- Program Managers are deployed/recruited by the states under State/District Health Societies.
- States like Karnataka, Haryana, Sikkim, Arunachal Pradesh have discrete models of integration with the directorates. The programs are being spearheaded by the Directors and supported by the program consultants/ managers recruited under NHM.
- VHSNC are formed in all states and fixed day services through VHNDs are being delivered to the community using the funds available with the community.



- In almost all states health functionaries like ASHAs were available 1 per 1000 population in rural areas.
- In urban areas, Mahila Arogya Samitis are formed and trained in most of the states however, still in process in some districts of state like Mizoram and Karnataka.
- Although states have reported functional Rogi Kalyan Samitis at facility level, the role of RKS in improving quality and patient amenities was found to be limited. The activities undertaken by RKS included local purchase of equipment, medicines & consumables, bill payments for cleaning and hygiene maintenance, etc. The regularity of meetings was an issue in most of the states.
- Varied level of convergence reported at State, district, and city with various departments WCD, water and sanitation, environment, Urban development etc. Convergence was higher at the level of the districts and panchayat.
- ULB involvement in implementation of urban health was dependent upon the proactiveness of the local leaders, some districts reported provision of support from Urban local bodies for mobilize community for service deliveries, improving sanitation and provide safe drinking water.

### Decentralized Planning

- Prospective planning remains a weak area of NHM implementation as indicated by the documents of village, block and district plans were not available in any states. The district health action plan in most of the states is the budget sheet reflecting the key priorities of the states.
- In most of the states the ROP available online for the reference of districts and blocks. However, some of the districts/blocks were not aware of the ROP.
- No other plan for LWE, HPD, etc. was available with the program officers.
- Haphazard construction at the healthcare facilities indicates lack of prospective plans in the states.

### Accountability

- Grievance redressal mechanisms are available in all the states visited. Almost all the facilities visited had complaint boxes, help desks were available in facilities like SDH/DH only. A centralized call centre was also available to register complaints however, the utilization and awareness of toll-free number was an issue.
- Supportive supervision mechanism in all the states visited needs strengthening specifically at the level of block and districts. No plan available with the state/district/block officials for conducting regular visits to field. The officials received no formal training and checklists for conducting supervisory visits.
- With assured feedback system not available. No mechanism to link it with planning.
- Monitoring of the PPP initiatives is done by the state and district officials only however, no robust mechanism available for monitoring.
- Citizen charter available in almost all the facilities visited although the format was not comprehensive as per IPHS and there were issues regarding regular updation of data.
- PRI involvement improved over years and convergent actions reported by the states to track COVID cases and to overcome vaccine hesitancy.
- In most of the states, health worker like ASHAs covered under the various social security schemes- Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY), Pradhan Mantri Shram Yogi Maandhan Yojana (PM-SYM).

### Health Management Information System

- Facilities reported availability of HMIS however, issues with internet connectivity, and data entry were reported. In some facilities, it was difficult to find the person responsible for data entry into the portal.
- In none of the state's data entry operators were trained on the data elements, so it was difficult to retrieve facility level data.
- System for data validation, checking before uploading the same on the portal and

availability of data validation committee or systems to regular physical verification of data was not reported by any team among the states visited.

- In most of the states HMIS was being utilized for planning, review, and monitoring.

## Recommendations

- State & District Health Missions needs to be more proactive by taking regular program review and also provide necessary policy support. Every state needs to prioritise decentralized planning. State plan should take into account the District Health Action Plans.
- DHS be more accountable for planning, implementation and outcomes for various programs considering funds available under XV FC and PM-ABHIM.
- Orientation of district officials (including architects & engineers) needs to be done on the preparation of the District Health Action Plan (DHAP), infrastructure planning, preparing prospective plans with a mechanism to maintain infrastructure.
- Convergences with various departments like Municipal Corporations, Water and Sanitation department, Women and Child Development, etc. at block, district and ward level needs to be strengthened for universal coverage and effective implementation of programs.
- Coordinated action and the fragmentations of various programs at state and district level led to multiple Program Officers that are unrelated to each other, so reorganization of program TORs is required, for more responsive and accountable system.
- States should consider implementation of PHMC as per the recommendations of NHP 2017 & GoI guidelines.
- Supportive supervision needs to be strengthened with use of structured templates for planning, supervision, and monitoring.
- Orientation and capacity building of the HR responsible for data entry into HMIS and establishment of mechanism for data validation including Data Validation Committees.

- In the absence of true data, decision making will suffer, weakening link with accountability.

## State Specific Findings

### Arunachal Pradesh

- Full functionality of the institutional mechanisms for providing oversight function to NHM at the State level viz., State/ District Health Mission, and DLVMC (District Level Vigilance and Monitoring Committee) for monitoring the implementation of NHM are yet to be operationalized as per guidelines.
- VISHWAS (Village Based Initiative to Synergize Health, Water, Sanitation), envisaged as platforms for 'local action' on health at community level and serve as key programme component of communalization, is yet to pick up in the State.
- The DHAP was largely the budget sheet reflecting priorities and was prepared keeping in mind NHM as the sole funding source. Map all available sources of funding and plan health system in coordinated manner in District level planning.
- Rogi Kalyan Samiti's were not found to be providing oversight function for quality improvement in the hospital. In CHC Old Ziro, it was observed that more than 90% of the funds were booked in a single meeting defeating purpose of untied funds.
- Help desks were not found to be established in the high-volume facilities like DH. Complaint box seems to be the means by which citizens could submit their grievances to health authorities.
- Citizen charter was seen displayed in most of the facilities. Data in certain instances (e.g., DH Lower Subansiri) were not updated.
- Information on entitlement-based initiatives like JSSK, Free drugs & diagnostics initiative etc. were limited among the public and IEC to address these information gaps were largely not found to be in place in the field. The OOPE incurred by public, especially on medicines, had this factor contributing, among other things.

- No MDR/CDR done in last one year and no state report is available.

## Assam

- The annual NHM planning process is initiated by preparation of Block Health action plan which is submitted to the District. The District Plan is developed after meetings and discussion with the district health officials and consideration of the Block plans and submitted to the state.
- The grievance redressal committee/ cell had been formed in the facility under the chairmanship of the Head of the facility. The last meeting had been held on 10.02.21 wherein it was decided to open the complaints box once every month and discuss the complaints found. The citizen charter was found displayed in the facility.
- The RKS meetings were being held regularly and the PRIs were members in it. There was help desk and complaints box to receive the complaints from the public. The availability of drugs was prominently displayed with updated as per current stock.
- On approval of the ROP for the State the approved activities separately under each component is shared with the district along with the requisite guidelines for implementation.
- There is a monitoring and supportive supervision plan followed by the State and District to monitor the facilities and activities at the field level. Based on the field observations action points with timelines are developed which is uploaded on the State NRHM website along with name of the officer responsible for the same. The State also conducts review missions in the lines of CRM in the districts.

## Bihar

- It was noteworthy that all payments are made electronically through PFMS.
- District Health Action Plans and Block Health Action Plans has been disseminated.
- e-Janani application for online viewing of JSY payments has been initiated by the State

- The accounting software is being restructured for using as a management tool for fund management and decision-making MIS
- Disability certificate, death & birth registration certificates are being provided by DH.
- State has dedicated toll-free number (104) for Grievance re-addressal and it has resolved more than 90% of complaints received.
- It is worth mentioning that State has functional de-addiction centre at all District Hospitals and a blueprint document for its set-up has been drafted by the State.
- Improve utilization by regular monitoring through Video Conferences and meetings. Identification of areas of slow pace of utilization and provide greater thrust on them.
- Regularize RKS meetings and transfer of RKS money to RKS account to provide greater involvement of RKS members.
- Capacity building of finance staffs at State and Regional levels on regular basis. The financial performance of Districts and Blocks to be monitored on regular basis.
- Engagement with State for enforcement of various Regulations and Act for adoption/ adaption.
- Awareness about Grievance re-addressal needs attention.

## Haryana

- District Health Society has been constituted in both the districts.
- The district health department engages with WCD for involving Anganwadi workers. Water and sanitation department has been engaged in fluorosis control. The department is working in synchrony with the police department to enforce various public health legal measures. For immunisation purpose, Anganwadis and schools are being utilised.
- Convergence with the Departments of Women & Child Welfare, Youth Services, Sanitation, and Education may be explored for a coordinated approach to achieve the objective of providing health facility to all and creation of awareness among the beneficiaries.

- District level RoPs of the SPIPs are available and funds are allocated as per approvals.
- Citizen charters were available at almost all the visited facilities and timing of the facility was displayed. However, Citizens Charter was not displayed at the DH, Nuh (Mewat)
- The Public-Private-Partnership (PPP) was observed in the establishment of Ultrasound Units and supply of blood. Only one ultrasound facility is operational at the district hospital in PPP mode and expenditure of the patient in this regard is met by the Central Government.
- Similarly, there is one blood bank in District level but there are blood storage facilities at the Sub-divisional level hospitals. If there is a shortage of any blood group at the storage facility or at the blood bank at district level, the Sub-divisional Hospitals arrange bloods from private agencies and patients are adequately compensated accordingly.
- Decentralized planning process was noticed at the State level. At the Districts level, it was observed that it was centred with the district medical authority. 4. Districts have the provision of conducting regular meetings to monitor various programmes.
- Targets assigned to health establishments under various programmes are monitored by the District Authorities through VCs twice a week.
- All the specific programmes are being monitored separately on the IT platforms maintained for the purpose.
- Regular monitoring of the implementation of the plans may be ensured by supervising authorities at appropriate level.
- Reward and punishment system may be adopted for each medical establishment to encourage implementation.

## Karnataka

- SHS/SHM and DHS/DHM available in the states. Most of the program directors are from the regular services and are being supported by consultants under the various NHM programs. The DHS usually meets every month with corresponding agenda. However, due to COVID-19, they met every 3 months in 2021.
- State has office of Commissionerate to establish convergence across various departments. Intersectoral convergence at the level of Districts was good, e.g.: the District Collector and CEO, district Davanagere played active role in management of COVID-19 and involving various departments like education, WCD, water and sanitation, etc. District Health Action Plan was not available in the districts, the role of districts in ROP preparation was found to be limited.
- RKS/ARS met at least twice a year and discussed utilization of funds. All PHC facilities and taluk hospitals had a Rogi Kalyan Samity (RKS) or Arogya Raksha Samiti (GoK) with adequate representation of CMO, assistant commissioner, and elected body as well as religious minorities. Members of VHSNC are also member of the RKS at PHC/SHC level.
- Untied Funds are being utilized for various health activities like maintenance of health facilities (water, solar system repair), purchase of drugs or/and items related to C-19 prevention. Record keeping like agenda, minutes of meetings and other proceedings are properly maintained.
- VHSNC in the state consist of 23 members including the school headmaster and member of PRIs. The meetings were held monthly to discuss utilization of funds (amount received Rs. 10,000) for activities like emergency transport, care of anaemic patients, provision of nutrition/protein diet to pregnant women, cleaning supplies for villages.
- Other activities included identifying people with different diseases who require follow up, keep the village clean and mosquito free
- Good coordination with PRI/ULB. Most of the members of this committee also belong to RKS.
- **Aspirational district:** Yadgiri District, as per the Champions of change dashboard developed by the NITI Aayog the delta ranking was 25th out of 112 districts in the month of September 2021. Also, the Health and Nutrition score has increased to 83.7 in the September month as compared to August 2021.



- **Citizen charter** was displayed at most of the facilities in the local language however, patient rights and duties need to be added to the format.
- Various **social security schemes** - Pradhan Mantri Jeevan Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY), Pradhan Mantri Shram Yogi Maandhan Yojana (PM-SYMY) are available in the districts and ASHAs are also covered under them.
- No orientation of the facility, village, block, and district level officials on prospective planning. Orientation of PRIs, and other community leaders on various NHM activities will help generating awareness and better health seeking behaviours of the community.
- Use of PIP for planning purpose- Most of the facilities visited were not able to present the PIP and were not aware of other plans.
- Grievance redressal processes not operational. In one PHC, they do take complaints, but complaints remain in a box only. Those data are not used for action. Lack of linkage with 104 GR and health help line.
- PPP is available only at district and taluk hospitals (CT-scan, Krishna diagnostic, dialysis service, BRS)
- Ensure every member attends VHSNC meetings and women are more represented: only 4 women out of 23 members are part of the VHSNC
- Most of the ASHAs conduct regular VHSNC meetings, however some members conveyed non-attendance by 1 or 2 ASHAs
- Presently, there is no mechanism to validate the data being entered in the HMIS at the facility level. No physical verification is being done by the district officials.
- Frequency of supportive Supervision and monitoring visits is poor.
- Awareness generation on registration of grievances through 104, health help desk at high volume facilities, facility level linkages of grievances received locally to be registered under 104.

- Also, Grievance redressal, death audits, fire safety and electrical audits, Mera Aspataal at DH etc. needs to be strengthened to improve accountability and governance.

## Mizoram

- Lack of Coordination, Supervision and Monitoring.
- MAS Formed however no meetings have been conducted.
- Awareness about the schemes was present among the population.
- Yearly target/ estimated population eligible under scheme – Not provided by SNO for AB PM-JAY. The number of golden cards issued were 11,118 and the number of beneficiaries provided services in AB PM-JAY were 37, 607.
- State to ensure proper monitoring and supervision of the implementation of PMJAY.
- Regular Monitoring and supervision by PHC MO and District Officials.
- Options may be explored for solarization of health facilities.
- Ensure timely training of staff.

## Odisha

- No plan for training of Human resource on LSAS and CEmONC
- Central PSUs were not empanelled with BSKY scheme
- Community awareness of the scheme was lacking
- Additional specialist to be made operational in DH - explore DNB
- Training of doctor / paramedics in LSAS and CEmONC
- Central PSUs in the State to be empanelled in BSKY
- Extensive community awareness campaign for BSKY

## Puducherry

- At the State level Puducherry State Health Mission, State Health Society, Executive Committee, Programme committees are in place.

- At the District level, District health Mission and District Health Society are in place and functional.
- Districts are not aware or not involved in the preparation of DHAP.
- The District Health Department engages with WCD for involving Anganwadi workers for health-related activities.
- Municipal Corporation is engaged for Sanitation, for sanitation outsourcing agent has been given responsibility for the segregation of garbage and collecting from the localities.
- The MOs are in contact with the police department for various public health legal measures.
- PMNDP has been implemented through in-house mode in two districts- Puducherry and Karaikal with 24 dialysis machines.
- There is a dedicated isolated dialysis unit for the seropositive cases at both facilities.
- Dialysis services are provided free of cost to all the patients.
- All the staff was efficient in their roles and responsibilities.
- Record keeping and registers were also well maintained.
- The enrolment for PM-JAY scheme is good in the district and claims are being settled, though there is some delay in payment.
- 27,588 beneficiaries are yet to receive the health insurance card.
- A fully resourced district programme unit is required to function optimally.
- Ensure all key vacant postings are filled in a timely manner
- Dissemination of guidelines and terms of reference and expected outcome to all the implementers and service providers.
- Adequate display of IEC for community awareness on services and schemes
- Promote and encourage institutional delivery below District hospital (CHC, PHC)
- Inter-departmental convergence needs to be strengthened.

- Effective use of data (HWC portal, HMIS, RCH portal etc.) at all levels of facility level for better program monitoring.
- Hub and spoke model for sample transportation may be explored.

## Rajasthan

### Intersectoral Convergence

- Constitution of VHSNCs is as per Gol guidelines.
- One-day trainings are offered to the VHSNC members. Main agenda topics of the VHSNC meetings revolve around enhancing quality of care, access to care, and promotion of IEC activities for health and wellness.
- The annual sum of Rs 5000/- is generally used for refreshments, banner preparation, and minor purchases by the VHSNC. The account is jointly operated by the ASHA and a ward member. Beyond the nominal monthly namesake meeting, participation of VHSNC in health promotion activities was minimal.
- CRM team was not able to identify any VHSNC that were involved in health needs assessment of their village or preparation of the Village Health Action Plans (VHAPs) or community-based monitoring of any services delivered either at the village level (through MCHN sessions or AWCs or ASHA) or at the facility (HWC) level, thereby, defeating the purpose of communization of health services under the NHM.
- The VHSNC members with whom the CRM team was able to interact were mostly unaware of their roles and responsibilities, powers of the VHSNC, availability of untied fund at village level and guidelines for utilization of that fund.
- Some of them even did not know that they were members of the committee nor had they attended any meetings in last six months. One of the VHSNC members in a HWC village on probing commented, “meeting to bas naam ki hoti hai, sarpanch pati, ASHA aur ANM behenji kuch likh dete hai aur sign ke liye kitab ghar 23 bhej dete hai.”

- Meeting is for namesake, only the husband of Sarpanch, ASHA and ANM put some proceedings and send the record for signature to our homes.
- Although outreach services (VHNDs/UHNDs/special camps) are organized, there was minimal engagement or dialogue with the community for organizing these services at village level.
- In one of the villages visited, the CBAC assessment camps were organized in courtyard of ASHA's home, which, was not convenient for the community to go to.
- Unless community is involved in and participates in planning (time, location, day, resource
- In Karauli district, during village visits, it was observed that open field defecation was a norm
- According to the villagers, only around 3-5% of households (HHs) use toilets. Although around 60% of the HHs have constructed toilets, they rarely use the constructed toilets. Water unavailability is the primary reason for non-use of constructed toilets, while hard stone terrain is the primary reason cited as a constraint for construction of toilets.
- The Jalore team interacted with members of 2 Mahila Arogya Samitis (MAS)- the Yellow and the Bal group. The MAS conduct meetings on a monthly basis in the Anganwadi Centre, however, did not have a fixed day approach. More than 50% of the MAS members of these groups had received trainings at the MCH Hospital in 2013 and 2018. ■
- The members are dedicated to raising awareness about various health issues such as cleanliness and sanitation, maternal and child health, various government schemes and motivate the community for COVID-19 vaccination.
- They use opportunities such as trips to the market for buying vegetables and milk to interact with other women of the community.
- The meeting details such as issues discussed and attendance of members are diligently recorded in the Meeting register. The NUHM Program Manager frequently attends and supervises the meetings. Issues such as Chiranjeevi Yojana, COVID-19 vaccination, seasonal infections, NCDs, malnutrition, ANC, PMSMA etc were discussed over the last three meetings.
- The meetings were suspended for three months from April to June 2020 due to the lockdown, however, continued during the second COVID-19 wave while following COVID-19 appropriate behaviour.
- The MAS receives a fund of Rs. 5000/- annually, which has been utilised to procure tables and chairs, and install fans in the Anganwadi Centre.
- In Karauli, all the 34 operational Mahila Arogya Samitis have ten members and the constitution is as per GoI norms. The bank account is jointly operated by the Chairperson of MAS and ASHA. Untied funds of Rs. 5000 are generally used for refreshments provided at the meetings and cleaning of the Anganwadi centre where the meetings take place.
- Around 24 six meetings were held in a time frame of six months. The duration of the meetings averages 1-2 hours and the meeting was seen to be attended by all members.
- Activities of MAS include distribution of Albendazole/iron tablets and ORS packets. Due to the pandemic, the frequency of the meetings was hampered, thereby disrupting the activities. The sanctioned untied fund amount was also decreased to Rs. 3000 due to the unspent balance on account of the pandemic.
- The functioning of the Rogi Kalyan Samiti (RKS) or Rajasthan Medical Relief Society (RMRS) was observed at CHC, Mandrayal in Karauli.
- It is a six-member society headed by the District TB Officer and constituted by the Sarpanch and other prominent members in the community. Any troubleshooting at the facility is undertaken by the Sarpanch who visits the CHC at night to oversee the service delivery.

- However, no planning process is undertaken at his level as he assumes that all mandates come from higher authorities. No training or capacity building activities for the RMRS members has been undertaken.
- Meeting proceedings are maintained, but not universally at all facilities across the districts. Administrative decisions on recruitments, purchases and logistics are undertaken at the meeting, according to the proceedings.
- The sources of RMRS fund includes user charges (OPD and IPD) and insurance payments/receipts from Mukhya Mantri Chiranjeevi Swasthya Bima Yojana. No cash donation from the community was observed in Karauli. In Jalore, the available untied fund utilisation is decided singly by the Sarpanch. The funds were used for constructing toilets within the premise of SC for OPD patients along with rainwater harvesting pits. Purchase of medicines is also undertaken from the untied funds. In Karauli, the bank account is not jointly operated as the MO-IC is the only authorised signatory.
- It was observed that the RMRS funds are generally used for minor purchases and repairs along with settlement of consolidated pay to the staff who are let go. During the pandemic, the funds also went towards donation of pulse oximeters and oxygen concentrators (OC). A separate expenditure register is not maintained although all vouchers are kept. The utilisation certificate is being prepared on a monthly basis.
- Intersectoral coordination with other departments was not observed in both districts. Interactions with the Sarpanch of Gadhika Gaon informed the Karauli Team on the pervasive gender inequality.
- The female Sarpanch attested to not partaking in any PRI activities except where her signatory powers were required. Instead, her husband would take part in the planning, execution, and monitoring activities. She also did not have any knowledge of the new XV-FC initiatives or in fact, any activities in the health sector.
- A Corona Core committee consisting of school principal, BLO, VDO, Patwari, members of State livelihood mission, ASHA and AWW was formed at the village level during the first COVID-19 wave that ensured COVID appropriate behaviour at village level. This initiative can set a precedence for intersectoral action for other health related activities.
- PM-JAY: PM JAY (Chiranjeevi Scheme) was operational across facilities. Utilisation was low as reported by the coordinators at the facility (5-6 cases at Gudachandraji and 25 odd cases at SDH Hindaun).
- Gold cards are issued by e-Mitras (common service centres) in the district.
- The reason for low utilisation as suggested by the staff was that several queries are raised by the insurance company post COVID-19. This leads to rejection of claims and consequent OOPE, hence beneficiaries are not inclined towards the scheme.
- The Health Management Information System (iHMIS) has been integrated with Mera Aspataal portal to receive feedback from patients.
- District Hospital, Karauli has a functional iHMIS for both OPD and IPD patients.
- Patients were able to give feedback through the Mera Aspataal portal. However, the latest report was not available and information till only 31 March 2021 was available. The response rate was poor (only around 5%).
- A mechanism for tracking the same patient during subsequent visits to the hospital is lacking. e-Upkaran portal.
- e-Upkaran is available up to the PHCs, but all the equipment is not enrolled in the dashboard. ■ Most of the equipment users were aware of the procedure to register the complaint through the Toll-free number.
- The DEOs reported a lack of orientation training and an absence of manuals/guidelines was observed.



- DEOs/ Users are not able to track the previously registered complaints, as such an option was not available in the system.

## Recommendations

- Training of VHSNC members on health needs assessment at village level, preparation of village health action plans accordingly and community-based monitoring needs to be taken up on priority.
- VHSNC members need to be sensitized regarding their roles, responsibilities, and powers without which quality of services at village level and accountability of health system for delivering the required services will remain a distant dream.
- State level modules for capacity building of VHSNC should be developed and training of VHSNC and PRI members should be ensured. All the committee members should receive a proper induction training regarding checklists for community-based monitoring of the services delivered at the village level and through various facilities (SC, PHC, CHC, SDH, DH) detailing their roles and responsibilities towards ensuring their community's health and wellbeing.
- It is recommended that the State changes the colour of the ASHA sari to a more acceptable colour such as pink, to increase motivation and ownership levels among the ASHAs.
- Recruitment of ASHA supervisors as per the GOI norms will facilitate routine supportive supervision for ASHAs is vital. Supportive supervision should be mandated to enhance their service delivery attributes.
- Strategies to bring minority community women into the fold of MAS, VHSNC and RMRS should be formulated, like holding puppet shows, street plays and other audio-visual programmes which have not been organised frequently.
- Provision and optimal utilization of Untied Funds and constitution of Jan Arogya Samitis (JAS at SC/PHC-HWC) with proper representation from PRI members needs to be ensured.
- Automate drug supply chain processes including indent, demand, and supply planning, ensuring the availability of drugs at most health facilities (PHC, CHC, SDH, DH). It could be expanded till the HWC-SHC level also.
- There is a need to expand e-Sanjeevani OPD services, patient feedback through Mera Asataal portal and e-RaktKosh across various health facilities (HWC-SHC, PHC, CHC, DH, etc.)
- Fixed time schedule should be considered for improving uptake of e-Sanjeevani OPD services.
- More intensive IEC is needed to popularise the e-Sanjeevani specialist services.
- The State may consider establishing internet kiosks in the villages or sub-centres in PPP or CSR mode to facilitate tele-consultations.
- The e-Upkaran dashboard should be accessible at all levels and should have the option of tracking previously lodged complaints.
- Data Entry Operators (DEOs) should be made aware of manuals/guidelines availability. In addition, data quality at each level can be enhanced by capacity building of DEOs.

## Sikkim

### Institutional Framework

- The State Health Mission and District Health Mission committees in place, however regular meetings of State Health Society (SHS) and District Health Society (DHS) could not be conducted in last year due to COVID-19 pandemic.
- It was observed that RKS Committees are in place at the facilities however the meetings are not regularly conducted. The State may plan for differential allocation of Untied Grants to these committees based on the case loads of respective facilities. The minutes of the meetings were shown at most of the facilities visited. No information was available regarding DLVMC and VISHWAS at the facilities visited. The involvement of

ULBs in implementation of urban health was reported to be limited.

- The VHNDs were conducted regularly with a participation of 12-22 members from the community.
- The newly added CHO (MLSPs) and ANMS were working together in Sub centres, however some frictions due to clarity of tasks were reported.
- The RKS were existing but were unable to share details of funds received or utilized.
- The multispectral or inter departmental cooperation is required but is reported to be limited in the district

### Decentralized Planning

- Centralization of planning/implementation/monitoring activities at the State level with regards to approved activities observed by the CRM team. Though a Block programme manager is posted at the PHCs in State, DPM in all districts, no formal training has been given to BPMs and other key planning person in the State.
- The District ROPs are issued in time to the district, however, the district ROP lacks details with regards to the activities approved such as if 5 Bio medical pits are approved for the district, the ROP may mention the names of the facilities where these pits are approved. This would enable the District Health Society to monitor the progress.
- Further, it was observed that since most of the activities are managed centrally, there is mismatch in the approved activities in District ROPs and sanction letter issued to the districts. The amount sanctioned to the district is for activities such as HR, incentives, Untied grants, mobility etc. Further, the District has very limited role in planning, though as per records, DHAPs were prepared till 2020.
- The State is receiving funds under various sources such as NHM, Aspirational District programme, NE development fund, Tribal Ministry etc. The team observed that Health department has very limited role

in monitoring the infrastructure work sanctioned for health facility through any other fund else NHM funds.

- It was observed that the DH hospital Mangan, North District is under construction since many years. The source of funds is not NHM, the health department has no role in its monitoring and were not aware the timeline decided for its completion. Similar case was observed at PHC Chungthang, North Sikkim.
- The approach area in front the hospital was under construction, making it highly uncomfortable for a patient/pregnant woman to reach hospital.
- The involvement of urban local government in implementing urban health programme is reported to be nil in the district. The office of the local panchayat was adjacent to the 3 out of 5 facilities visited.
- The head of the local government are in the RKS committees and is reported to be involved in planning services in the facilities. Hence there is scope for further strengthening decentralized planning.
- District plans are prepared under the leadership of District Magistrate. Though the plans get approved and funded mostly at the State level. DM informed that delegation of funds directly to DM will augment their role in improving the efficiency of the expenditure on health facilities and services.

### Accountability

- Grievance's redressal boxes were kept in the district hospital and one of the PHCs visited. According to the DMO the complaints are mostly related to cleanliness of the toilets for patients using the health services. According to him some cases the patients themselves are responsible as they leave it unclean after use. Supportive supervisory visits were not happening as all staff were busy in fighting COVID-19. PPP is not applicable at the district level and sub district level due to lack of private sector
- It has been gathered based on the meeting minutes, available IEC material and

community interactions that the PRI members are informed about the NHM activities. It was noted that PRI members are actively participating in the wellness activities/celebration of days etc. The team interacted with PRI member (Dzumsa, Village Council, North Sikkim).

- PMJAY: The District Authorities informed implementation of PMJAY is a challenge as those really needing those benefits were not in the eligibility list. According to national criteria all SC & ST population are entitled while many of them from this State are well off and do not come forward for such benefits. The district is only able to enrol 8000 out of the 30,000 targets. Many of those in the target group are unwilling to enrol while others who are poorer are out from national eligibility criteria. There is a plan at the state level to prepare a new list, which is again delayed due to COVID-19. Patients utilizing health care from West Bengal are not getting the benefit as Bengal is yet to implement PMJAY.
- Citizen's charter is displayed in district hospital and one of the PHCs
- The health workers were not updating the health information data on a regular basis was not an effort to guide them perform better. Most of the records are handwritten except for NCD. For NCD dual record maintenance handwritten and app based were noted and the app based were incomplete when compared to the former. This could also be due to poor internet connectivity issues.

### Health Management Information System

- The Sikkim State has data connectivity issues in the interior areas. The State informed that they are under deliberation with some service provider where they will have access to work through offline mode as well. The team observed that the data is uploaded by the data entry operator at the PHCs. The ANMs at the SCs visit the PHCs/DHs once in a month for monthly meeting along with the data. The same is uploaded by the DEO. There is no system in place for data validation, checking before uploading the same on the portal. There is no

data validation committee in place or systems to regular physical verification of data.

- State may use these portals to generate work plans for ANMs/GNMs for better follow up. The State may institutionalize to regularly review the programme based on the reports generated through HMIS. This would help in improving the quality and updation of data under HMIS.

### Key Recommendations

- The State should try to comprehensively plan for activities especially Infrastructure development. The rationale for development/construction of new facility, location for construction of new facility, design/layouts of the building should be approved by the health department before initiation of infrastructure works.
- This will ensure that the construction work would be completed in a time bound manner. State may plan to orient the PRIs on the new initiatives under the Mission.
- Health workers needs to be trained further for reporting the data on HMIS.

### Tripura

- At facilities, separate treatment and medicines were available for the patients registered under PMJAY. In case, the medicines were unavailable, drugs under AB-
- PMJAY are purchased from local pharmacists, which are then reimbursed on case-to case basis.
- Under PMJAY only general services and C-sections were covered at the DH.
- Untied fund and medicine shortage are usually compensated by adjusting drugs between the general stock, AB-PMJAY stock and through local purchase using untied funds.
- RBSK: RBSK activities is one of the best practices of the state; and are found to be well organized.
- RSKS: RSKS activities were not observed in DH- Khowai, while found to be satisfactory in North district.
- Owing to strong HR status under the referral transport system, the number of ambulances

may be scaled up equitably while ensuring technical capacity mix (ILSBS/ALS) commensurate to the need. More fund allocation for HR training and for GPS enabling are also recommended.

- As it is envisioned that services delivered through primary care facilities are to be
- Delivered free of cost and that PM-JAY is meant for secondary and tertiary level of care, the existing practice of empanelling primary level facilities under AB-PMJAY is not recommended.

## Uttar Pradesh

- Grievance redressal systems though seen in both districts are in their nascent stage. The platforms of GR are limited for the community. Though there were no help desks, there were complaint boxes in the public health facilities.
- At places, the staff takes patient feedback as per the guidelines of quality assurance. However, the grievances were not seen as part of the agenda of the RKS meetings.
- Other platforms of grievance redressal e.g. public dialogues (Jan Samwad) are not available
- Expired fire extinguishers were observed in DWH, Mahoba.
- Accountability processes-community action for health at the RKS, HWC and VHSNC level is not undertaken.
- Need to implement the Community Action for Health Initiative through which community

monitors and also supports health care providers in making best of health services available to the people.

- The concurrent audit and RKS audit should be done immediately, and a proper action taken report be prepared to improve the internal control mechanism.
- Proper Monitoring and supervision should be done so that funds may not lapsed due to lack of knowledge (e.g., Gram Pradhan not knowing about the VHSNC and SHC/HWC funds)
- Every month the SOE must be collected from all the health facilities along with agencies before sending the FMR and SFP to SHS by the DHS.

## West Bengal

- Citizen charter and information about the services and entitlements were displayed in all the facilities.
- Rogi Sahayata Kendra (May I help you) were established to provide accurate information to the patients about the services available.
- Respectful Maternity Care (R.M.C): Labour tables curtains at all points. RMC posters well displayed at most of the high case delivery points
- Grievance redressal boxes were available at all levels of facilities and a Grievance Redressal committee was formed at DH and SGH level for redressal of grievances.



# TOR 3E: COVID-19, ECRP I & ECRP II

## Background

The on-going COVID-19 pandemic affected the routine activities and also demonstrated need to develop resilient health systems. The Government of India provided support to the States/UTs through various Central Sector and Centrally Sponsored Schemes to further equip the healthcare facilities at primary, secondary, and tertiary care levels.

Support was provided to the States to deal with the COVID-19 crisis through various response packages and schemes. The Government of India supported states through 'India COVID-19 Emergency Response and Health System Preparedness Package-I & II' (ECRP-I & II) with an objective to prevent, detect and respond to the threat posed by COVID-19. The activities added new field hospitals, additional oxygen supported beds, new ICUs and HDU with ventilators, RT-PCR labs and testing, and Oxygen Generation Plants.

ECRP Phase I - included strengthening of existing health facilities, the support was expanded to establish critical care oxygen supported beds at identified Dedicated COVID Health Centre (DCHC) and Dedicated COVID Hospital (DCH) and also isolation beds at COVID Care Centre including expanding network of diagnostic laboratories & testing capacity and also procurement of essential equipment's for management of COVID-19.

To further support the States/UTs, in view of the second wave, (ECRP II) was launched to accelerate health system preparedness for immediate responsiveness for early prevention, detection, and management. Establishing dedicated Paediatric care units, Establishing Paediatric Centre of excellence, Augmentation of additional ICU beds in public healthcare facilities, Support for establishing and operating Field Hospitals, Strengthening the referral transport system by augmentation of existing fleet of ambulance, and Support for Liquid Medical Oxygen (LMO) with Medical Gas Pipeline System (MGPS) in the public healthcare facilities etc were some of its main components.

To make a resilient health system, which is in readiness to respond for any future pandemics and outbreaks, Government of India has taken a health systems approach under which besides, ECRP-I & II packages support has also been provided to the states under XV-FC (XV Finance Commission) health grants & PM-ABHIM (Pradhan Mantri-

Ayushman Bharat Health Infrastructure Mission). These initiatives were launched for over six years (till FY 2025-26) to develop capacities of primary, secondary, and tertiary care health systems, strengthen existing national institutions, and create new institutions, to fill critical gaps in public health infrastructure, especially in critical care facilities and primary care rural areas and urban areas. This includes following interventions like support for rural and urban health & Wellness centres, establishment of Block Public Health units, integrated Public Health Labs and Critical care Block hospitals, diagnostic infrastructure, building-less sub health centres to get buildings, conversion of Sub Health Centres and Primary Health Centres to Health & Wellness Centres etc.

Under National COVID-19 Vaccination Programme, COVID-19 vaccine was made available free of cost for all citizens aged 18 years and above irrespective of their socio-economic status at all Government COVID-19 Vaccination Centres (CVCs). Under the 'Har Ghar Dastak' Teekakaran Abhiyan missed beneficiaries for 1st dose and due beneficiaries for 2nd dose are identified and vaccinated through house-to-house activity.

The health system response to cater to COVID-19 pandemic spanned from the one million ASHAs, to the specialist doctors, from the outreach platforms to the tertiary care centres, the procurement and supply systems for medicines, diagnostics and equipment, the reorganization of service delivery in health care facilities, and the re-engineering that required to take place in administrative and programme hierarchies, across institutions, all was conducted in the face of a pandemic that was evolving constantly. The centre and the states put forward their best foot forward to handle the COVID scenario in the best possible ways.

## Key Findings

- Interaction with the Public in the States visited by CRM teams also indicated satisfactory response on efforts taken by the states for managing COVID-19 cases.
- Almost all the states had demarcated their health facilities into DCHs (Dedicated COVID Hospital), DCHCs (Dedicated COVID Health Centres) & CCCs (COVID Care Centres) for the mild, moderate, and severe COVID cases.
- Most of the hospitals have dedicated entry and exit points for catering to COVID patients.
- Pressure swing adsorption (PSA) oxygen generating plants have been installed at DH and SDH level in all the states visited by CRM teams.
- Separate paediatric wards have been established in most of the states and provision of beds with ventilator.
- COVID-19 patients were getting essential medicines, diagnostics, and other necessary services.
- However, during initial stages of COVID-19, the routine and Non-COVID related health care services suffered due to overwhelming engagement of existing staff & resources for managing & mitigating COVID-19 pandemic.
- Generally the health care staff at Public health facilities raised issue of filling the vacant posts of HR & sanctioning more posts so that the health systems is in readiness to respond for future emergency situations.
- The vaccination coverage at the time of CRM visit, in most of the states was above 60% . Except for a few states (Haryana)
- At the time of visit "Har Ghar Dastak" program had started to kick off. This campaign has led to an increase in vaccination coverage in almost all the states. (except Karnataka)
- Vaccination coverage is poor mostly amongst pregnant/lactating women. Cultural diversity was observed as the major challenge to achieving desired vaccination coverage.
- In the some of the visited states, vaccine hesitancy was evident among the community people also.
- To contain COVID-19, the district administration of some of the states, collaborated with the health, education, police, women, and child development departments.

## Recommendations

- To overcome vaccine hesitancy intense awareness campaigns for behaviour change to be carried out.

- All activities under ECRP-II needs to be completed by March 2022.
- The states should regularly update the progress report on the NHM PMS portal of the budget sanctioned under ECRP ,15th Finance Commission or PM ABHIM.
- Orientation and sensitization of district health officials on XVFC, PM-ABHIM for ensuring utilization of allocated money to improve functionality of HWCs, district public health labs etc.
- States need to prioritize filling of sanctioned posts & also sanctioning of addition HR as per the norms indicated under IPHS 2022 guidelines.
- Rational allocation of devices like oxygen concentrators, ventilators, Cardiac monitors, and other devices is required. Each of these equipment needs installation and staff need to be trained regarding operating and maintaining the equipment.
- The utilization or relocation of critical equipment to other facility for optimal use should be looked into.
- Regular training and hands-on practice on oxygen devices is necessary. Even where specialists are available, nurses should be made familiar with such devices, so that they can follow the instruction received from specialist during emergencies.
- There is a dire need to build the capacity of architects, hospital planners, engineers & relevant programme officers for preparing a prospective infrastructure by modifications in the existing infrastructure.
- Capacity building is of utmost important so that, the public health care facilities are resilient and responsive to the needs of both programmatic and future pandemics/ emergencies.
- Every health care facility should have a disaster management plan.
- Emergency mock drills need to be organized & capacity of health care providers need to be augmented for CPR, and lifesaving initial management of coming emergency cases.
- Regular supportive supervision, assessment, and reviewing facility, block, and district readiness is necessary.

- AEFI following COVID vaccination should be reported and followed up.
- Wellness components need to be strengthened beyond primary care also, including at CHC, SDH & DH level to implement the preventive and promotive measures to overcome the shifting pattern of mortalities and morbidities and further averting DALYs.

## State-specific Findings

### Arunachal Pradesh

- The state has been successful in operationalizing 2 DCHs, 39 DCHCs & 59 CCCs across the districts. It has also established PSA plants, 11 paediatric care units, and 1 Paediatric Centre of Excellence in TRIHMS under ECRP II.
- The state has started a mobile CVC for easy and better coverage of COVID vaccination (in district Namsai) and achieved 79% vaccination coverage for the first dose and 59 % for the second dose, till 12th November 2021.
- Oxygen cylinders are available in sufficient quantity in both districts with LMO plants and MGPS. However, a large number of Oxygen concentrators were found to be available at the facilities irrespective of their requirement, occupying scarce space.
- Utilization of funds under various budget heads for the Emergency COVID Response Package was found to be low. 49 ambulances proposed under ECRP II have not been operationalized
- No separate arrangement of COVID-19 waste disposal was found.
- ASHA and ASHA facilitators have not received incentives/ honorarium for the last 5-8 months including that for COVID related activities.

### Assam

- JEEVAN DEEP (Oxygen on wheels) under AAROGYA SILCHAR, the initiative has been taken up by Dist. Administration, Cachar. The vehicles operating 24x7 and manned by

a team of trained Health care workers are equipped with Oxygen Concentrator, Gen-set to provide immediate care to COVID positive patients who are in Home Isolation.

- Portal to view COVID Test results (<http://covidassam.in/>) has been developed by the MIS Cell.
- 'Har Ghar Dastak' program has been implemented in Cachar and Booth Level officers have been deployed for the survey. As per the reports, the actual target is different from the target given by the state and no structured mechanism and format are present to record/report these activities.
- CVCs operations are not as per prescribed norms by GOI at District Hospital Cachar. Lack of Co-WIN verifier for the document verification at CVCs. Poor adherence to Biomedical waste management was observed at CVCs according to CPCB guidelines.
- Vaccination of pregnant/lactating women coverage is low due to unwillingness in most of the areas. Cultural diversity was observed as the major challenge to achieving desired vaccination coverage.

## Bihar

- The state has administered 5.16 crore and 2.13 crore dose 1 and dose 2 of COVID vaccination by mid-November 2021.
- Some good initiatives like 'Tika Express'- Mobile vaccination vans, 'tika wali naav' - vaccination at boats in flood affected districts, 'Jashn-e-Teeka'- rewards and recognition program to recognize COVID-19 Field Level Workers and 'Har Ghar Dastak' programmes helped in ensuring the COVID-19 vaccination at community level. Special vaccination camps in form of 'Maha-Abhiyan' initiative and special session sites at puja pandals during festivals and at airport, railway stations and bus stands for migrants were carried out.
- The ASHAs have significantly contributed to the COVID vaccination drives. Tika-Nama - a magazine was also launched to celebrate stories and hard-work of field workers involved in COVID-19 vaccination.

- Oxygen concentrators (OCs) and cylinders were available at most of the facilities visited, however, OCs supplied through PM Cares Fund was not installed (in Jamui) or were in poor condition and not used (in Barhiya). Similarly, PSA plant installed at DH Lakhisarai was yet to be functional. Overall, Oxygen infrastructure planning was not as per facility design and level of care.

## Haryana

- Hospital and other facilities are well prepared and have dedicated entry and exit for COVID-19 patients. Testing sample is collected at the entrance of the hospital and is being sent to Ambala lab for results.
- PSA plants are installed at DHs of both the districts and SDH Tohana in Fatehabad district with fully functional 3000 LPM (in DHs) and 200 LPM (SDH Tohana) capacity centralized oxygen support to all beds.
- A 38 bedded paediatrics ward was created in the District Hospital, Fatehabad. Oxygen supply plants (10 litres/minute) was installed and eight ventilator beds were made available for the care of COVID-19 patients
- Separate vaccination room is established in every facility. The waiting area has been used for IEC through short videos specially made for COVID awareness where the due list for COVID is displayed.
- 'Har Ghar Dastak' Campaign with a set per day vaccination target and dedicated e-Rickshaw for campaigning for District prevention and augmenting immunization is implemented.
- However, despite this, the vaccination coverage for the districts is less than 50% which needs to be improved through concentrated efforts to reach maximum coverage while addressing the vaccine hesitancy among the adult population.

## Karnataka

- To contain COVID-19, the district administration collaborated with the health, education, police, women, and child development departments to implement



**“Arogya Nandana” Abhiyaana** for screening of Anganwadi, in-school and out-of-school children for COVID-19.

- Panchayati Raj Institutions and Urban Local Bodies showed active participation. The DM and CEO of Davanagere took lead in getting the COVID vaccine and visited various colonies and villages to mobilize people to get vaccinated leading to good awareness and coverage.
- COVID preparedness ensured in both the districts through ICU/HDUs, oxygenated beds, establishing 6KL LMO Plant at DH, 1000 LPM PSA Plant, 500 LPM PSA Plants and 143 Jumbo Cylinders and testing facility of RAT & RTPCR available at above PHCs.
- District health society met regularly with the corresponding agenda to utilize the funds. Despite that, the districts reported 80% to 90% un-utilized ECRP-I and ECRP-II funds.
- Though “Har Ghar Dastak” programme was initiated in the state in Oct 2021 however, the program was not visible in the field.

## Mizoram

- Well utilized ECRP- 1 fund (89%); All the logistics like PPE kits, masks, gloves, etc. were available in the PHCs, CHCs, and DH. No activity has been carried out under ECRP-II as no budget has been released to SHS from the State Treasury. 50% central release has been made to the state.
- With the help of Local Level Task Force and Village Level Task Force, vaccine coverage for 18 years and above is 74% first dose and 51% second dose in district Mamit and 91% and 82% in district Champhai. Around 2300 refugee population were administered with first dose of COVID-19 vaccine under PWI category in CoWIN portal till date. All the health workforce was skilled in CoWIN application.
- DH Champhai had established HDU, which had a single entry/exit point and continuous supply of oxygen. The CBNAAT machines were often placed separately from the Central Lab at the District Hospital in both the districts and the machines were largely used to test the COVID-19 patients.

- CSR support were being used largely to transport patients, ambulances were diverted to the COVID response efforts and used exclusively to transport COVID patients.
- The RBSK teams were also utilized in COVID-19 testing and COVID care centres. Footfall in PHCs, RBSK activities and other services had taken a hit during COVID, the adolescent health days were not observed due to the closure of educational institutions.
- Vaccine hesitancy owing to religious beliefs, fear for AEFI, poor road connectivity with the session sites and absence of public transportation facility was reported.

## Odisha

- COVID Pandemic preparedness was adequate at primary care levels, although COVID Vaccination coverage and implementation of Har Ghar Dastak Campaign was observed to be better managed in urban areas than in rural areas.
- The State has accorded top priority for ensuring Free Drugs and Diagnostics at all public health facilities and has provisioned untied flexi-funds at the facility level for local purchase to fill in for any stock-outs. Through telemedicine, the referrals were directly made to the district level hospitals and CHCs are largely under-utilized.
- Biomedical Waste management was in place in all the facilities however, the infection control rate was poor.

## Puducherry

- Separate isolation ward for COVID was set up at the General Hospital, Karaikal. Each PHC had a concentrator and oxygen cylinder for emergency utilization; PPE kits and masks were provided for all health staff
- 75% vaccination coverage was for the 1st dose of the adult population and 56% for the 2nd dose. Tracking and counselling of eligible beneficiaries who are resistant was done by ASHA, ANM, Mos, and local MLA through door-to-door service and regular update of the status on e-VIN.

- A 500 LPM PSA plant was set up through PM cares fund and the hospital also set up a 6000 litres' capacity Liquid Medical Oxygen (LMO) with MGPS lines to the ward. Oximeter distribution was launched in the district through the district helpline, to temporarily lend oximeters to patients at their nearest health centre.
- Government of India approved and released an amount of Rs 23.35 Cr towards ECRP I out of which an amount of Rs 23.05 Cr was utilized for the approved activities and the remaining Rs 30.00 Lakhs advance (Security Deposit) amount was given towards supply of medical oxygen cylinders. A total of 52Cr received in the form of Grant in Aids are received he treasury, out of which only 3 lakhs have been utilized so far.

## Rajasthan

- The State's coverage of COVID-19 Vaccination, utilization of ECRP-I funding, and availability of oxygen concentrators till the peripheral level is commendable.
- The state has shown a formidable 80% utilization of the funds released under the ECRP-1.
- It has established a good number of RTPCR labs and a good information flow and reporting mechanism from PCR labs to patients, with compilation at the district to state level.
- Facilities have been identified as Dedicated COVID-19 Hospitals (DCH), Dedicated COVID-19 Health Centres (DCHC), and COVID-19 Care Centres (CCC), in case a need arises
- The state has successfully created an "Oxygen Bank" and is adequately equipped and prepared for any upcoming COVID-19 wave. *The SIHFW is regularly conducting training and orientation programs for specialists and medical officers virtually for operating oxygen devices.*
- 368 plants have already been commissioned out of 546 Pressure Swing Adsorption (PSA)

plants planned to be set up for regular oxygen supply. The IT portals for reporting like OCMIS, e-Aushadhi etc. are functional.

- However, at places, the Medical Gas Pipeline System (MGPS) was still not installed. Few facilities in the district have two or more PSA Plants in a single premise.

## Sikkim

- Sikkim has achieved an overwhelming COVID-19 vaccination coverage; first dose 100%, second dose 89.9%
- Provision of standard medicine kits by ASHAs at home for COVID patients under the supervision of the healthcare teams was among the key practices.

## Tripura

- The State has achieved 95.43% for 1st dose and 61.68% for the second dose coverage of COVID-19 vaccination. Mass COVID Vaccination drives for hard-to-reach areas with active engagement of local influencers, community mobilizers, and religious leaders played a crucial role in achieving this figure.
- In DH (North) a large part of the hospital was demarcated for COVID.
- The community clubs constituted in the urban areas also played a significant role in facilitating and mobilizing funds and transportation for the patient during the pandemic.
- The CHOs were all trained in the Induction module and posted to COVID duties, but this side-lined their routine tasks and deliverables.
- It was reported that only 34% of the approved funds were utilized under the ECRP-I. The funds under ECRP-II are yet to be utilized.

## Uttar Pradesh

- In Fatehpur, 15 bedded PICU operationalized in Women DH, while 10 bedded PICUs operationalized in CHC Bindki, Khaga, Jehanabad, and Thariyav. Two bedded HDUs

at PHC Thariyav, Khaga, and Jehanabad along with an increased number of ventilators installed in DH and CHCs to deal with any future surge of cases. Four Paediatric Care Units have been set up, 3 at CHC level and 1 at the District Hospital level. Each of these is 12 bedded with 2 High Dependency Units (HDUs) involving BIPAP etc.

- Special COVID campaigns are planned by the PHC MO I/C, using the ANMs, Staff Nurses under the HWCs with the CHOs as verifiers and administration of COVID vaccines. ASHAs have played a significant role in spreading awareness in COVID and in achieving a 71.3% coverage rate by the state as of 13th November 2021.
- 'Har Ghar Dastak' campaign targeting those who have not taken the first or second dose of the vaccine will be planned.
- Oxygen concentrators have been supplied by the PM Care Fund as well as the State budget (CMO-CMSD). Many have been supplied to the HWCs as well. All 187 (132+55) concentrators of 5L or 10 L from PM Care have been allocated on 14th-15th Nov to health facilities of varying levels in Fatehpur. 93% of them have been installed but only 16% of the installed OCs are functional.
- Separate holding space/dedicated space for surge capacity and triage were not seen for COVID-19 (or for any of the other emergency conditions) in any of the facilities, Field hospitals were not required in districts visited and prefab units are not yet in place.
- Additional human resources such as medical and nursing students were not involved in COVID management within the current year, even during the second wave.
- The Medical Gas Pipeline System for the PSA plants at the District Women's Hospital in Mahoba is not connected to every outlet in the wards

## West Bengal

- Expansion of beds, critical care units, oxygen support were planned across health facilities;

installation of several PSA plants and OCs under PM CARES and NGOs with MGPS installed across 106 healthcare facilities. Procurement of several ventilators, multi-channel monitors, Bi-PAP, and defibrillators to manage the upsurge of cases.

- Around 32 dedicated COVID dialysis units were established covering all districts by the State where COVID dialysis was conducted free of cost and is continuing.
- Paediatric COVID-19 Management Package also rolled out through District TOT for SNCU staff and Medical Officers
- Dedicated 102 ambulances were mapped with the State Call Centre for transportation of patients requiring urgent hospitalization. State had also utilized funds from other resources (e.g.- MPLAD, MLA, ULB) to provide pick-up, drop & referral services to COVID- 19 patients.
- A web portal "Integrated COVID Management System" was developed by the State Government to access real-time information on bed status in all health facilities.
- Video conferencing was made available to admitted COVID-positive patients in hospitals to talk to their families & relatives.
- Extensive community mobilization activities conducted by both civil administration and health department. MAS and self-help groups were counselled regularly by ASHA workers. Online Training given to ASHAs and VHSNC groups for carrying out COVID-related activities. About to roll out "DUARE Vaccination" campaign (door-to-door vaccination) for elderly and disabled individuals.
- However, other program services like RBSK at schools and AWC reduced due to pandemic as MOs were engaged in COVID-19 duties. No special plan in place for overcoming the impact of COVID pandemic on different national programmes.

# TOR 3F: Healthcare Financing

## National Overview

From its inception in 2005–06 till March 2021 about ₹ 2.6 lakhs crores<sup>2</sup> has been released under the National Health Mission by the Ministry of Health and Family Welfare. Effective utilization of these financial resources is critical to achieving the desired health outcomes targeted through various health schemes and programmes. States have been encouraged to build and develop their financial management capacities to provide accurate and timely funds at district, block levels and healthcare facilities. The Department of Expenditure has modified the process for the release of funds to states under NHM. Every State Government will designate a Single Nodal Agency (SNA). This step is undertaken for better monitoring of the availability and utilization of financial resources by the States. Effective and timely utilization of funds has direct implications on improvement of health parameters and strengthening of health care systems of States and the country.

Allocation of state NHM budget is based on Project Implementation Plans (PIPs) submitted by State governments, providing them more power to plan interventions based on their population-specific needs. Both Central and State governments contribute to the implementation of programmes under NHM in the ratio of 60:40 for all States and Union Territories (UTs) with the legislature, 90:10 for hilly and the North Eastern States and 100% for UTs without the legislature. The central sector scheme of 'India COVID-19 Emergency Response and Health System Preparedness Package-I and II' (ECRP-I and II) was released to support states in the management of the COVID-19 Pandemic. The 15th Finance commission has also recommended health grants of Rs. 70,051 crore to strengthen local government for addressing the gaps in the primary health system in rural and urban areas.

The state government expenditure on health for the CRM states ranged from 4.6% to 8.5% of the state budget. For states like Puducherry and Sikkim government spends more than 8% of their budget on healthcare. In Arunachal Pradesh, Mizoram, Tripura, Assam, and West Bengal more than 6.5% of the state budget is allocated for healthcare. Altogether government spending on healthcare is showing a rising trend.

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<sup>2</sup>Utilization of Funds Allocated under NHM, <https://pib.gov.in/PressReleasesframePage.aspx?PRID=1737187>; Funds allocated and key achievements made under National Health Mission, <https://pib.gov.in/PressReleasesframePage.aspx?PRID=1782603>



**Table 1: Government Health Expenditure across the States in 2017–18**

Government Health Expenditure			
State	GHE as % of GSDP	GHE as % of GGE	Per Capita TGHE in Rs.
Arunachal Pradesh	4.2	6.7	9450
Mizoram	3.6	7.6	6770
Sikkim	2	8.2	4660
Tripura	1.8	6.6	1993
Puducherry	1.6	8.5	5250
Assam	1.6	7.5	1392
Bihar	1.4	5	556
Rajasthan	1.2	6.3	1369
Odisha	1.2	5.7	1207
West Bengal	1	6.5	1088
Uttar Pradesh	0.8	5.1	801
Karnataka	0.7	5.5	1476
Haryana	0.6	4.6	1428
<b>India</b>	<b>1.35</b> (% of GDP)	<b>5.1</b>	<b>1753</b>

**Source:** National Health System Resource Centre (2021). National Health Accounts Estimates for India (2017–18), New Delhi, Ministry of Health and Family Welfare, Government of India.

One of the important goals under NHM is to reduce out-of-pocket expenditure. Numerous initiatives are implemented to decrease OOPE under NHM such as free essential drugs and diagnostics, free ambulance services, free blood services as well as free diet and transportation for the patients. As per the National

Health Accounts 2017–18, among the states visited, most of the states have OOPE more than 50% of the Total Health Expenditure. Karnataka, Assam, and Rajasthan are the only states with OOPE of less than 50% while Uttar Pradesh has more than 70%.

**Table 2: Out of Pocket Expenditure across the states in 2017–18\***

Out of Pocket Expenditure (OOPE)			
State	Per Capita OOPE in Rs.	OOPE as % of GSDP	OOPE as % of THE
Karnataka	1549	0.7	34.2
Assam	883	1	35.9
Rajasthan	1688	1.5	49.6
Haryana	2181	0.9	50.4
Odisha	1750	1.8	55.9
Bihar	808	2	58.2
West Bengal	3115	3	69.8
Uttar Pradesh	2393	3.6	72.6
<b>India</b>	<b>2097</b>	<b>1.62</b> (% of GDP)	<b>48.8</b>

**Source:** National Health System Resource Centre (2021). National Health Accounts Estimates for India (2017–18), New Delhi, Ministry of Health and Family Welfare, Government of India.

\*Estimates for North Eastern states namely Arunachal Pradesh, Mizoram, Sikkim, Tripura, and Union Territory namely Puducherry is not reported due to small sample size of household at the state level.

## Key Observations

- The implementation process of the Single Nodal Agency was initiated in all the states visited. Subsidiary bank accounts were opened up to district levels in states like Assam, Karnataka, Mizoram, and Sikkim while for states like Arunachal Pradesh, Rajasthan, Tripura, and West Bengal this process was completed up to block levels. However, in many states, mapping of subsidiary accounts with the Public Finance Management System (PFMS) and linkage with the State Treasury was still pending. For states like Bihar, Haryana, Mizoram, Odisha, Sikkim, and Uttar Pradesh the conditionalities for operationalizing the SNA were not complete.
- Delays in fund disbursement in NHM from the State treasury to the State Health Society still continue to be a major problem in most states visited. In states like Arunachal Pradesh, Bihar, Haryana, Odisha, Rajasthan, Sikkim, Tripura, Uttar Pradesh, and West Bengal the delay ranged from 60 to 100 days while in the case of Mizoram and Puducherry the delay was more than 150 days. Similarly, delays were reported in fund transfer from the state health society to the district level which has a direct effect on the utilization of these funds for different health programmes.
- Past reviews have highlighted the issues of underutilization of NHM funds by the states. Inadequate utilization of financial resources still persists in many of the states visited. It was predominantly seen in many northeastern states. In Assam utilization was 32% while in Rajasthan it was 26.59% till the 2nd quarter for the FY 2021–22. In Tripura, the utilization was around 69% for the year 2020–21 and for the 2nd Quarter of 2021–22, it is 25%. For the Union Territory of Puducherry for the past 3 years, the utilization is only around 50%. The main reason for underutilization is procedural delays due to the late release of funds, inefficiencies of the system owing to the dearth of health personnel and lack of information about routine activities in the district.
- The 1<sup>st</sup> phase funds under the Emergency COVID-19 Response Package showed high utilization by most of the visited states. For the phase-I grants under ECRP, the utilization was seen at more than 90% for the state of Haryana, Odisha, and Puducherry while in other states like Tripura and Karnataka the utilization was more than 60%. The financial allocation under ECRP – II was not yet utilized. The states have planned for the allocation of funds under ECRP-II. However, the funds released to the states were not transferred in most of the districts.
- The states showed improvement in the accounting and auditing measures compared to previous years. Most of the states such as Arunachal Pradesh, Assam, Bihar, Haryana, Karnataka, and Tripura exhibited better compliance for auditing process at the state and district levels and maintaining accounts books. In states like Karnataka, Odisha and Rajasthan bank reconciliation statements were maintained in the facilities visited, whereas, in states like Arunachal Pradesh, Mizoram and Sikkim adherence to these protocols was inadequate. The statutory audits for 2020–21 were observed to be complete in most CRM states barring a few states such as Mizoram, Odisha, Uttar Pradesh, West Bengal, and UT of Puducherry. At district levels, the Concurrent auditing was reported in states like Karnataka, Bihar, and Haryana while in other states the mechanism needs to be strengthened. There is still scope for improvement of accounting measures at district and facility levels in most of the states. This was majorly due to the lack of human resources and their training for accounting at these levels.
- The availability of finance and accounting staff varied across CRM states. It was reported that there is a dearth of finance personnel, especially at district and block levels. States like Arunachal Pradesh, Bihar, Karnataka, Mizoram, Puducherry, Rajasthan, and Uttar Pradesh reported a shortage of finance and accounts personnel. At some PHCs finance-related aspects were maintained by secondary divisions clerks or health staff such as paramedical staff which could lead to poor maintenance of financial and accounting

records and reports. Considering the XV FC, ECRP & PM-ABHIM it is pertinent to fill the human resource gaps in terms of finance and accounts staff for proper utilization and monitoring of the funds available under these initiatives. In some states, coordination between state and district finance personnel was not found satisfactory. Adequate training is required for financial personnel at different levels of health care.

- As regards untied funds, the majority of the states reported that at PHC levels, the most common use was for procurement of medicines. The other utilization includes maintenance, payment for sanitation workers, purchase of water, storage water tank, support to outreach activities, etc. In Assam, the untied fund was utilized for the extension of the cold chain room and rainwater harvesting system. The utilization of untied funds was found unsatisfactory in states like Bihar, Rajasthan, Sikkim, and Uttar Pradesh as the facilities had an unspent balance due to a lack of clarity in terms of utilizing these funds. While facilities in Puducherry reported inadequacy of these funds as per their requirements.
- Direct benefit transfers under JSY, JSSK, NTEP and payments to ASHA are done by the PFMS portal. In comparison to the previous year, the delay in JSY payments has been substantially reduced. In states like Assam, and Haryana there were no delay reports in the disbursement of funds to beneficiaries and all payments were done through DBT. The disbursement of funds to the beneficiaries showed a delay in states such as Karnataka, Puducherry, Rajasthan, Sikkim, Uttar Pradesh, and Tripura. DSC based payments for the TB programme were operational in Mizoram and Odisha. In Rajasthan OJAS (Online JSY and Shubhlaxmi Payment System) software is utilized for payments of JSY beneficiaries. The delay in payments was reported due to poor internet connectivity, poor banking, incorrect details of the beneficiaries, poor follow up and the non-linkage of PFMS.
- The majority of the states visited during CRM, reported OOPE incurred by households

due to purchase of medicine, diagnostic or utilization of services in healthcare facilities. The districts with robust implementation of various government programmes such as JSY, JSSK, free drugs and diagnostics reported lower cases of OOPE with no expenses in government facilities. The information on OOPE for patients covered under Ayushman Bharat PMJAY or any state-specific scheme was not adequately captured.

## Recommendations

- States need to expedite the process of implementation of SNA with mapping and integration across the districts to make financial resources efficiently available to the bottom levels and smooth implementation of healthcare programmes.
- The funds should be appropriately released without delays from the State Treasury including both central and state shares to State Health Societies accounts and from there to District Health Societies to ensure effective utilization of funds.
- For efficient management of funds, states need to adequately recruit finance and account personnel. Capacity building of finance and accounts staff at state and regional levels are needed on regular basis through training for reporting, managing expenditure, monitoring, and maintaining effective financial records.
- The State needs to focus on mitigating the communication gap between district, block, and state finance teams. A proper channel must be established to coordinate financial activities at various levels.
- The financial performance of districts and blocks should be monitored on regular basis. The states should identify and examine the areas and reasons for the underutilization of funds and provide supportive supervision for making corrective actions.
- The State must ensure that there is no duplication of activity from various grants viz. the NHM, 15th Finance Commission and PMABHIM grants and ECRP-1 & 2 grants.

- States should ensure higher allocation to High Priority Districts as per the GoI norms.
- The RKS meetings need to be regularized and their records are to be duly maintained, particularly at the block level. Minutes of meeting, signature of competent authorities and decisions arrived must be maintained properly for all RKS meetings. An annual plan for the utilization of RKS funds needs to be developed with provision to meet any urgent or emergency needs.
- States should focus on improving the process of maintaining the accounts records in facilities at all levels. Periodic bank reconciliation may be done to ensure balance as per bank and balance as per books of accounts at facilities.
- The implementation of programmes and schemes such as JSSK and the Free Drugs & Diagnostics Initiative must be strengthened to reduce high OoPE.
- DBT payments are to be made on a real-time basis to the beneficiaries using DSC. Proper follow-up actions are needed in case of failed payments.

## State-specific Findings

### Arunachal Pradesh

- The state has implemented the SNA guidelines and bank accounts are opened accordingly. The unspent funds have been returned to the SNA.
- The utilization certificate has been submitted for the expenditures under various programmes and activities.
- The maintenance of accounts was found in place at the districts and facilities visited. Financial accounts were maintained digitally at the District Health Society, whereas at all other levels i.e., DH, CHC and PHC they were in manual form.
- Annual expenditure reports were produced only at the CHC visited but not at DH or other facilities. While the Bank Reconciliation was not done at any of the facilities.

- Untied funds were used for procurement of emergency medicines, payment to sanitation staff, diesel generator, stationery, furniture for the facility, construction of boundary wall of HWC, electric connection and purchase of storage tank and motor for water. In CHC it was observed that more than 90% of the funds were booked in a single meeting defeating the purpose of untied funds.

### Assam

- In terms of Single Nodal Agency functionalities, accounts have been opened to district levels.
- There are no delays in the release of funds from the State Treasury and subsequent receipt. The ROPs were disseminated to the districts. However, the overall utilization of funds by the state is low. The utilization till 2nd quarter was reported only 32%.
- Incentives were timely transferred to beneficiaries through DBT under schemes such as JSY.
- PPP modes are in place through proper agreement and the release of funds is as per MoU. However, in terms of monitoring key deliverables and finance, a lack of coordination was reported between the partner agency and the government.
- The coordination between state and district finance officials in terms of management of funds was found unsatisfactory.
- The audit for the FY 2020-21 has been completed and the audit report is awaited.

### Bihar

- In both the districts visited during CRM, payments at all levels were made digitally through PFMS.
- There was an absence of regular reconciliation of JSY payments with the delivery register to ascertain backlogs and committed liabilities. Also pending payments towards nutritional support were identified under RNTCP.
- e-Janani application for digitally tracking JSY payments has been initiated by the state.



- District Health Action Plans and Block Health Action Plans were disseminated along with ROPs at district levels for a better understanding of the financial requirements under each programme and scheme.
- Since 2019–20, for better accounting, concurrent audit mechanism has been strengthened at healthcare facilities. But there is still scope for improvement in the internal control mechanism adopted by the state.
- The digital platform utilized for accounting is also restructured for use as a financial management tool and supplement decision making through MIS.
- The finance and accounts staff lack orientation and training with respect to programme activities that affect the pace of expenditure ultimately leading to underutilization.

## Haryana

- In terms of implementation of the Single Nodal Agency, the account has been opened at the State level and the district's accountants are preparing for the implementation.
- The state has appointed a concurrent auditor and the audit has been completed for the financial year 2020–21 in June 2021. The State is collecting the compliance report on the observations of statutory and concurrent auditors from Districts.
- The districts have strengthened the financial monitoring process by introducing a single data register for multiple transactions. This process is also helpful in easing the audit and tracking payments.
- The funds under ECRP-I were utilised by the districts, however, districts are yet to receive funds under ECRP-II and the 15th Finance commission. The utilization of funds under both ECRP and NHM was inadequate.
- There was no diversion of funds from one pool to another under NRHM.
- Direct benefit transfers under JSY, JSSK, NTEP and payments to ASHA are done by the PFMS portal. All NHM payments except BSNL and electricity bills are being managed by the PFMS.
- As per the interviews with patients, no additional payments have to be done by them to avail health services at government facilities.

## Karnataka

- Districts reported almost 80% funds utilization of ECRP-I, while, for ECRP-II funds are yet to be utilized. The financial resources under ECRP were utilised as risk allowances to ASHA workers, installing PSA plants, oxygen concentrators/cylinders at every level of facility in both the districts and operation costs for COVID-19 vaccination.
- The funds under NHM in the district of Davanagere over the last 3 years reported utilization of 75%, however, in Yadgiri district the utilization has improved from 66% in 2017–18 to 87% in 2020–21.
- The untied fund at most health facilities is fully executed. In both districts, utilization of untied funds pertained to health facility maintenance activities, blood collection camps, cleaning of health facilities, improving water quality, COVID-19 awareness activities, purchase of drugs and payment of biomedical waste transportation.
- In terms of accounting procedures, books of accounts are maintained at the health facilities and are fully updated. Bank Statements and Reconciliation are maintained properly at health facilities. Inventory information is maintained both physically and online through e-Aushadhi Software. Financial reporting goes to the level of primary health care facilities.
- DBT payments were released through PFMS for JSY and ASHA. Delay was reported in terms of payment and incentives to ASHAs and women receiving JSY incentives.
- There is no finance staff/accountant at the PHC level. Limited incentive mechanism provided to non-accounting staff to maintain quality finance reporting system at PHC level.
- The out-of-pocket incidence varied across districts. In Davanagere, patients covered through JSY, JSSK and Ayushman Bharat

Arogya Karnataka did not pay for any health care service, drugs, or diagnostic testing. However, in the Yadgiri district patients had to pay out-of-pocket for lab testing and drugs in both public and private healthcare facilities.

## Mizoram

- The ROP were being timely disseminated to the block level and was being used as the guiding document. The 15th Finance Commission State Level Committee (SLC), and District Level Committee (DLC) had been constituted, facilities had been identified and the plan had also been approved by the GoI.
- The practice of consolidated ASHA payment through the PFMS portal was also in place. The DBT payments coverage was found to be above 80% for JSY, Family Planning and TB schemes.
- Many good accounting practices were observed across the state such as maintaining cash book, bank reconciliation, fixed assets and staff register etc. However, at certain places receipts against expenditure were not available. Payments to staff in form of cash were not maintained in the account book in these facilities.
- The Auditing and internal control mechanisms were in place and Statutory and Concurrent Auditors were appointed. Audit Reports and Audited UCs from the State were yet to be received for the F.Y. 2020–21 at the time of the visit.
- The process for SNA had been initiated but not completed. Due to the delay in the implementation of SNA the 2nd tranche of funds from GoI was pending.
- Delay in fund transfer from State treasury to the SHS was also observed to the tune of 150 days in 2021–22 as compared to the delay of 80 days and 40 days in the year 2020–21 and 2019–20 respectively.

## Odisha

- The books of accounts maintained at Health facilities are fully updated (Cash Book, Bank reconciliation, fixed assets and Staff register).

- The state has ensured timely dissemination of ROPs to block level, and the same is being used as a guiding document by the districts & blocks.
- Consolidated ASHA Payment through the E-ASHA portal is also being ensured. DBT payments coverage is above 80% for JSY, FP, and TB schemes, which is highly appreciated, however, DSC based payments are being made only for the TB schemes. The state is also ensuring DBT based payments for state-sponsored schemes.
- Joint Signatories are used in all banking operations. All the key financial officials at State, District and Block are in position, however, there was a felt need for additional positions at the district/block level considering XV FC, ECRP & PM-ABHIM funds.
- Overall Financial Utilization till the month of September 2021 is less than 50%. Statutory Audit report for at State/District/Block F.Y 2020–21 is pending, resultantly, State has not been eligible for release of the second tranche of funds. Delay in the transfer of funds from the State Treasury to SHS was observed.
- Single Nodal Account is yet to be implemented at all levels.
- Payment lag to beneficiaries due to technical reasons such as inoperative accounts, change in IFSC code, etc was observed. Funds of ECRP-I have been fully utilized while only 6% expenditure was reported under ECRP-II.

## Puducherry

- UT of Puducherry has implemented the Single Nodal Account (SNA) and its integration with PFMS and State Treasury. All the Bank Accounts of Implementing Agencies (IAs) are closed. Unspent amounts in the IAs are transferred to the SNA. Interest accrued during the FY 2020–21 was transferred to the consolidated funds.
- Separate Budget Heads are created in the Detailed Demand for Grants (DDGs) for receiving the funds and mapped in the PFMS.

All the Central Grants are transferred from UT treasury to SNA.

- The Zero Balance Subsidiary account openings for the IAs are under process. Only 4 IAs have been opened out of 233.
- The concurrent audit for the FY 2021-22 for 2 quarters has been completed in the Karaikal region. The Statutory auditor reappointed for the FY 2021-22. Due to COVID-19, The audit report for the FY 2020-21 is yet to be submitted to GOI.
- DBT Payments are made through PFMS Portal. The DBT Payments like JSY, Family Planning, and JSSK are done centrally through the district headquarters.
- Since most of the services are done at District Hospital Level Only. Due to the process of Single Nodal Account Implementation, the DBT payments are stopped from July 2021. However, the application forms are collected and computerized for validation. The DBT portal reporting has been completed up to October 2021.
- For the FY 2021-22 UT has not received any central share so far due to SNA implementation and non-submission of the statutory report of 2020-21.
- The untied fund of Rs. 50000 is very less at the PHC level as per the MOs of UGPHC Nedungadu. For Karaikal region the activity for the FY 2021-22 is being managed through the unspent balance.
- Under NHM the expenditure for the last 3 years for FY 2019-20 is 53%, FY 2020-21 is 45% and for 2021-22 is 55%. For ECRP-I the utilization is 98%. The UT has received approval for funds under ECRP-II and has planned activities accordingly. The process of Procurement has already been initiated through GeM under ECRP-II.
- The delay for the fund transfer from the State Treasury is of around 213 days (7 months) for the FY 2020-21, which needs to be addressed.

## Rajasthan

- The percentage utilization for the year 2021-22 till September was 26.59%. Utilization for districts Jalore was 17.97% and Karauli was 25.88%.
- The state's matching share is not yet transferred, around Rs. 564.97 crores are pending with the state for the FY 2021-22.
- The Single Nodal Agency implementation process is completed up to the Block level.
- The Statutory Audit report for the FY 2020-21 has not been submitted to the GoI, although the due date of submission was 31st July 2021 while the Concurrent Audit report 2021-22 was not received by SHS from the District Health Society.
- Books of account are maintained at DHS Jalore and Karauli manually, as well as computerized, and the same was authenticated by the DDO. Bank Reconciliation Statements are prepared at the DHS and Block levels.
- Rajasthan Medicare Relief Society (RMRS) cash books are manually maintained properly at the Districts Hospital and sub-district level of Jalore and Karauli. Regular meetings of RMRS are held in DH and sub-district levels.
- Age-wise advance registers were not prepared at DHS and CHC and PHC levels. Daily cash book should be closed at District and sub-district level.
- The use of ASHA software for payment is present up to the PHC level. ASHA incentives and salaries of staff are being paid timely by both the DHS.
- Use of OJAS software is observed for payment of the JSY beneficiaries. There is a delay in the payment of JSY beneficiaries at all levels. Pending claims are seen in OJAS software against approval.
- Computerized Human Resource Information System software is being used for crediting the salaries of NHM employees.
- Integration is required for the NUMH, NDCPs and NCDs account personnel at the DHS, CHC and PHC for both the districts.

- Untied funds are being used for electricity, water bill payments, drugs, and supplies. Quality of expenditure can be improved.
- Unspent Balance was available in the bank account of all VHNSC. The percentage spent against the District ROP approval is 15% in Karauli and 0.07% in Jalore till September 2021.

## Sikkim

- The SNA and Single Nodal Account has been implemented at the State Level. At District Level, the training for the same has been going on.
- The time taken in receiving funds from State Treasury to Single Nodal Account is 1-2 months. This delay further leads to delays in the salary of employees at all levels, delays in programme implementation and delays in training, monitoring and supervision.
- The Direct Beneficiary Transfer (DBT) under JSY was found delayed for more than 6 months due to the poor internet connectivity and non-linkage of beneficiaries with PFMS in North District Mangan. This delay should be avoided.
- At District Level, the position of District Account Manager and positions of Assistant are still vacant. The recruitment is not taking place.
- The State has issued District ROPs for faster implementation of the programmes.
- The temporary loan with the approval from the authority was taken at the District level from NRHM to the Immunization pool. It was also observed that disbursement of Untied Funds to PHCs is the priority for DHS.
- The books of accounts were not maintained properly at North District Health Society (Mangan). The cashbooks were unsigned, BRS was not provided, all the vouchers were not available, and Audit report observation was also not available to DHS personnel to review and fill up the gaps.
- The State has appointed the Concurrent auditor for the process of Concurrent Audit of all the Districts and Blocks. The Concurrent

Audit has been in process for the Financial Year 2021-22.

- The Out-of-Pocket Expenditure on drugs and diagnostics was on the high side due to the shortage of drugs in hospitals. The referral transport mechanism in State was not assured hence patients incurred the same expenditure from their pockets.

## Tripura

- The State of Tripura has implemented Single Nodal Agency. The Single Nodal Account under SNA has been opened and mapped with the Public Finance Management System (PFMS).
- The Zero balance subsidiary accounts of the Implementing Agencies (IAs) have been opened below block level. All the accounts till the PHC have been opened and integrated with the PFMS.
- At the Sub-Centre level, approximately 600 accounts are in process of integration with the PFMS and awaiting approvals. The State has 100% registration of the IAs with the PFMS.
- There are separate budget lines maintained for central and state share of Centrally Sponsored Schemes and the SNA is also integrated with the State treasury.
- The state has reported low financial progress of NHM funds. The utilization of funds for the financial year 2020-21 was 69% under NHM. For the year 2021-22, the utilisation up to the 2nd quarter was 25%.
- The funds approved under the ECRP-I were also underutilized. Only 34% of the approved fund were utilized. The funds of ECRP-II are yet to be utilized. However, the state has planned the activities under ECRP-II. District ROPs have been disseminated by the State at the districts level.
- The Central funds for NHM are directly credited to the State Society Bank Account (SNA). A delay of 65 days in the transfer of funds has been observed.
- Financial progress against approval is also monitored at the district level. Books of Accounts have been maintained at all levels



but more capacity building is required at the periphery.

- All payments are being done using PFMS at all levels. Overall, in comparison to the previous year, the delay in JSY payments has been substantially reduced. Direct benefit transfers (DBT) are being utilized for crediting payments to the beneficiaries.
- Though JSSK entitlements were displayed at many of the facilities visited, there was a lack of adequate knowledge among service providers in CHCs & PHCs.
- Regular meetings of Rogi Kalyan Samiti (RKS) to decide expenditure at the facility were conducted. The minutes of the meeting and account of the expenditure of the funds were maintained at most of the facilities. At many facilities, the major proportion of the RKS funds has been repeatedly utilized for procurement of the medicines due to a shortage of funds as well as a poor supply of medicines.
- OOPE expenditure was reported among the patients visiting the facilities. Poor availability of medicines in a public facility, lack of Jan Aushadhi Stores, high transportation costs due to frequent referral to a higher level of facilities, etc. are a few causes which were highlighted in community interaction about high OOPE.

## Uttar Pradesh

- The utilization of funds was found low in the State. Fatehpur district reported zero utilisation under NIDDCP, NLEP, NPCB, NMHP, NPHCE, NTCP, NVHCP, and NPCDCS.
- Poor maintenance of accounts and records was reported in the districts visited. For many expenditures, the utilisation certificates were not collected and submitted. In the case of UCs submitted, the agency did not account for the interest and closing balance. Payment vouchers for many expenditures were reported missing by the accountants.
- The unspent balance for RKS in the district hospital and PHCs were not deposited in SNA.
- The audit mechanisms were not planned timely. The concurrent auditor for the FY

2021-22 was not appointed and the statutory audit for the FY 2020-21 was also not been initiated.

- The untied funds at the facilities were reported unutilised. At sub-centres and PHCs, the untied fund was unutilised for the last three years. No untied funds have been released to any of the 25 Sub-Health Centre (SHS) and 87 Village Health Sanitation and Nutrition Committee. The bank account is still not operational for the CHO and Gram Pradhan.
- Many of the JSY payments for pregnant women are pending despite the ASHA who accompanied the women for delivery receiving her incentives.
- One of the major reasons identified for the pending payments of JSY beneficiaries is that the details filled in forms such as phone number and account details were incorrect, resulting in the rejection of many payments in PFMS
- Secondly, different formats of the register are being used for JSY payment details at DH, CHC, etc. resulting in non-uniform information available with respect to pending payments status.

## West Bengal

- Single Nodal Agency (SNA) has been implemented at the District, Block Levels and regular training has been provided to the concerned officials. Under Single Nodal Agency, mapping of bank accounts of the Implementing Agencies, vendors and other organizations receiving funds in PFMS and separate depiction of interest earned up to March 2021 in the PFMS portal is still pending.
- Under Procurement for ECRP-I, the process of uploading the purchase agreement for all necessary vendors in the HWC Portal is pending leading to a delay in filing claims to External Support Agencies.
- ECRP-II funds are yet to be released to the districts. Meanwhile, the districts incur expenditure from the State Health Budget.

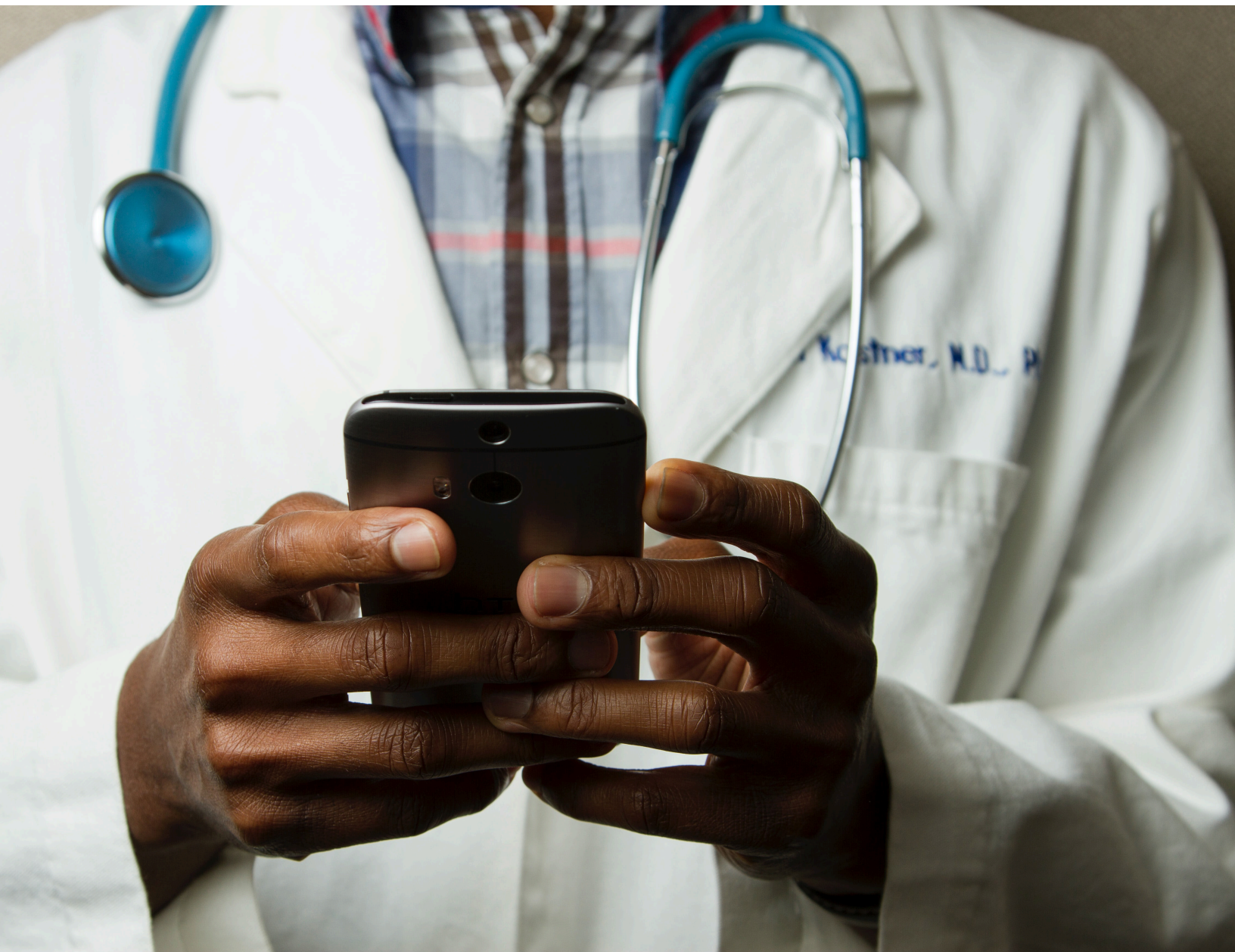
- Appointment of Concurrent Auditor is pending for the FY 2021-22 and submission of Statutory Audit Report along with Audited Utilization Certificate yet to be submitted by the State.
- Central share pendency for the FY 2020-21 and State Share pendency up to 31.08.2021 was reported unsettled.
- Overall utilization rate is low i.e., 32% up to September 2021.
- The average delay period for transfer of funds from RBI Treasury to SHS during FY 2020-21 and 2021-22 stands at 98 and 33 days, respectively.
- Funds allocated to Block level facilities (RH/CHC/BPHC) were not transferred to Rogi Kalyan Samiti (RKS) accounts and were kept in the respective Health Samiti.
- JSY and FP compensation has been made through cheques in few cases despite the presence of DBT in the Districts of Kalimpong, Paschim Mednipur, Alipurduar and Uttar Dinajpur during the FY 2020-21. This was due to the technical difficulties in opening bank accounts for certain beneficiaries
- Report on the failure of any Direct Benefit Transfer (DBT) payment is being taken from the NHM-Financial Information Management System (N-FIMS) which are being cleared after necessary follow-ups.
- Statement of Expenditure (SoE) and Utilization Certificate (UC) format booklet issued for MAS in September 2021 was submitted for monthly and quarterly SoE and yearly UC. One booklet was maintained with MAS and the other with the ULB for reference. Earlier, handwritten documents were submitted.
- In Nadiya District, the central tender has been in place for IEC Materials, Stationery and Refreshment for training in the district. This leads to hassle-free, immediate, and cost-saving procurement.



## **TOR 4:** **Achievements & Challenges**

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## Arunachal Pradesh

### Team Composition

S. No.	Team Namsai	Team Lower Subansiri
1	Dr. Sumita Ghosh, Addl. Comm. (Child Health, RBSK, AH, CAC & AD), MoHFW, Team Lead	
2	Dr. Divya Valecha, Asst. Comm., MoHFW	Dr. Rameshwar Sorokhaibam, Chief Medical Officer, NCDC
3	Ms. Anu Kukreja, Joint Director, MoF	Mr. Prasanth Subrahmanian, Senior. Consultant, NHSRC
4	Dr. Subodh Gupta, HoD Comm. Medicine, MGIMS	Dr. Himanshu Negandhi, Project Director and Additional Professor, IIPH Delhi, PHFI
5	Dr. Rajesh Aggarwal, Director (Acting), CRRID and Associate Professor, PRC, CRRID, Chandigarh	Indu Capoor, Founder Director, CHETNA
6	Dr. Maheshwar Prasad, Ex Civil Surgeon	Dr. Sheenu Bhadana Immunization Consultant, UNICEF
7	Mr. Vineet Mishra, Sr. Consultant, MoHFW	Mr. Shazi Ansari, Consultant, Finance, NHM
8	Ms. Saranga Panwar, Sr. Consultant, MoHFW	Dr. Aditi Joshi, Consultant, NHSRC
9	Dr. Avani Saraswat, NHSRC	
10	Ms. Aashu Ranga, NHSRC	

### Facilities Visited

Sr. No	Namsai	Lower Subansiri
1	District Hospital	Tomo Riba Institute of Health & Medical Sciences, Naharlagun
2	CHC: Mahadevpur, Chowkhom	Mental Hospital, Midpu
3	PHC: Emphum, Lathao, New Mohong	District Hospital, Gyati Takka General Hospital
4	HWC: Manmow, Dharampur, Empong, Solungto	CHC: Old Ziro, Yazali
5	Asha Interactions	PHC: Yachuli
6	Households Visits & FGD	HWC/SC: Siiro, Manipolyang
7	Community Interactions	Asha Interactions, AWC-SIIRO
8		Households Visit, key Informant Interviews
9		Community Interactions

### Achievements

- Arunachal Pradesh is a state allocating 4.2% of its GSDP to health.
- As part of Ayushman Bharat state has operationalized 86% of HWCs with clean and well-maintained buildings, appropriate signages and in place.
- For COVID-19, state has operationalized 2 DCHs, 39 DCHCs & 59 CCCs, established PSA plants, 11 pediatric care units and 1 Pediatric Centre of Excellence in TRIHMS under ECRP II.
- The state has been successful in vaccinating 79% of population for first dose and 59% for second dose, with only 44 active cases as on 12<sup>th</sup> November, 2021.

- The state has taken efforts in mainstreaming AYUSH services with doctors, pharmacists and medicines in place; organized in such a way that there is no mismatch in the deployed human resource and medicines. Patients are also referred between allopathic and AYUSH systems depending upon type of morbidity.
- Under the National AYUSH Mission, AYUSH HWCs are also established. The AYUSH HWCs have the mandate to provide 12 packages of comprehensive primary care services as envisaged in AB-HWCS and also provide AYUSH treatment.
- Arunachal Pradesh is one of the states that have implemented Clinical Establishment Act. The act in the state has done temporary registration of hospitals and data is available for category and type of facility.

### Challenges/ Scope for Improvement

- Strengthen comprehensive primary care through expanded set of services in Health and Wellness Centers.
- Strengthen secondary care services with focus on emergency care services e.g., Blood bank, OT, ICU, referral transport.
- Initiate steps to ensure compliance to the Biomedical Waste Management Guidelines, 2016 with the focus on establishment of common biomedical waste treatment facilities.
- Initiate implementation of IPHS and NQAS on priority for all facilities.
- Capacity building for program management, financial management and integrated District Health Action Plan.
- RMNCAH+N services need strengthening and follow the continuum of care approach by providing all the components- FP services to Eligible couples, Antenatal, intrapartum and post-partum services during pregnancies, essential and emergency newborn care, care for the small and sick newborn and their follow up, immunization for children, screening and management of sick children through Paediatric care, RBSK, RKSK and Nutritional care across the spectrum with competent and trained providers.
- Engagement of local self-government and civil society for health planning, priority setting, mobilization of resources and monitoring.
- Leverage capacities available with the development partners to undertake need assessments, identify gaps, design, rectification plans, evolve locally implementable solutions and solicit technical assistance for further strengthening service delivery.

## Assam

### Team Composition

1. Dr. MA Balasubramanya, NHSRC (Lead)	1. Dr. Megha Khobragade, MoHFW
2. Dr. Vishesh Kumar, WHO	2. Smt. Malti Rawat, MoPR
3. Dr. Bhumika Talwar, MoHFW	3. Dr. Kirti Udayai, IIHMR
4. Mr. Amit Raj Roy, RRC-NE	4. Ms. Seema Pati, MoHFW
5. Dr. Hafsa Ahmad, NITI Aayog	5. Dr. Asif Shafie, MoHFW
6. Mr. Koustav Ghosh, PRC	6. Dr. Vaibhav Rastogi, MoHFW
7. Dr. Srishti Gulati, NHSRC	7. Dr. Ashutosh Kothari, NHSRC
	8. Ms. Vijaya Shekhar Salkar, NHSRC
1. Ms. Priyanka Grover, MoHFW	
2. Dr. Mukut Bhowmik, PHFI	
3. Dr. Urya Nag, WHO	
4. Ms. Banashri Haloi, JHPIEGO	

### Facilities Visited

Districts & Facilities Visited in Assam

District	Block	Primary Care				Secondary Care		Tertiary Care	Other Facilities Visited:
		Public			PPP	Public	PPP	Public	
		SHC	PHC	UPHC					
<b>Kamrup Metro</b>				1					1. Drug Warehouse, Hailakandi 2. MMUs 3. School Visits 4. GNM Training Centre, Hailakandi 5. B.Sc Nursing College, Cachar 6. Community Interactions 7. VHSNCs 8. MAS/RKS 9. Private Pharmacies (Schedule I Implementation) 10. Cachar Cancer Institute
<b>Cachar</b>	Dholai		1						
	Sonai	1							
	Harinagar	1	1		1	1	1		
	Lakhipur	1							
	Bikrampur	1							
	Jalalpur					2			
	Borkhola	1				1			
	Silchar HQ			1		1		1	
	<b>Sub Total (1)</b>		<b>10</b>			<b>6</b>		<b>1</b>	
<b>Hailakandi</b>	Lala	3	1						
	Katlicherra	1	2			1			
	Algapur	1				2			
	Hailakandi HQ					1			
	<b>Sub Total (2)</b>		<b>8</b>			<b>4</b>		<b>0</b>	
	<b>Total (1+2)</b>		<b>18</b>			<b>10</b>		<b>1</b>	

### Achievements

- Despite human resource being inadequate, the primary healthcare team was motivated enough to deliver better services.
- The ambulance services are running in a PPP mode (GVK) with one EMT and one driver and runs as a basic life support ambulance. It carries on an average around 50-60 patients per month and about 2-3 trips per month which is optimal.
- There was a provision of a separate entry for emergency area which was quite accessible.
- All staff nurses at the labour room and the MOs were well versed with all quality protocol and treatment procedures.
- The X-ray diagnostics service and even CT scan is being provided in a PPP mode with a turnaround time of 6-24 hours. Approximately 190-200/month X-rays are being conducted in the CHC, out of this 43 were Chest X-rays.

- Good IEC material regarding management of bio medical waste including liquid waste management was displayed at some facilities.
- Good sanitation practices were observed at a PHC-HWC with a deep burial pit in place and the date of last cleaning of the septic tank also mentioned.
- State, district and facility level committees was in place for Prevention, Prohibition and Redressal Act 2013, Rights of Persons with Disability Act 2016, Registration of Births and Deaths Act 1969.
- Establishment of the Mental Health Review Board was under process.
- HMIS data is widely used for planning, review, and monitoring purpose.
- Analysis of HMIS data is done every month and feedback provided to districts.
- Funds are adequate, no delay in releases and subsequent receipts reported, Districts' ROPs are in place.
- Single Nodal Agency (SNA) account has been opened.
- ASHAs and the ASHA Supervisor were seen to have a good rapport with the community.
- In some AB-HWCs, the community considered the SHC-HWCs as their own and were also involved in resolving any issues that the service providers might be facing.
- Support structure of ASHA at the block and district level were providing good hand holding support. The District Community Mobilizer of Hailakandi was fondly addressed to as 'ASHA ki mummy' by the community.
- Herbal garden was seen at every facility visited across different levels of care, displaying their medicinal as well as local names.
- Branding was completed in all facilities visited.
- Monthly review meetings were also used for capacity building of ASHAs by the MOs.
- Good handholding support was being provided by the MOs to the SHC-HWC team but mostly at Block PHC level.
- The state has its own insurance scheme for all APL and BPL families namely Atal Amrit Abhiyaan for identified six chronic conditions.
- RBSK program was found to be well established.
- Trainings and reorientation about IHIP have been completed in the district level.
- Community awareness on importance of ANC and PNC check-ups and availability of antenatal, intra-natal and post-natal services, breast-feeding practices and complementary feeding practices were adequate.
- There were no stock-outs for IFA and other drugs in the facilities visited all the essential lab tests were available.
- Beneficiaries were aware about JSY entitlements and had received due amount in their accounts through DBT.
- The episiotomy rate of both the DHs in Cachar and Hailakandi was approximately 80%.
- Samahar (dry food provided to lactating women) had been adequately provided to all lactating women.
- Almost all the visited L2 & L3 facilities were found to have dedicated area for new born care corners (NBCC) inside the labour room and OT with functional new born care equipment.
- Kangaroo Mother Care (KMC) was observed as an integral component of LBWs in all the facilities visited.
- There was good follow up of SNCU graduates/ SNCU discharged babies through SMS follow up mechanism (all visits) till 42 days of birth, both in community as well as health facility.
- State is running Mukhbir Yojna to unearth offenders who are involved in sex selection.
- Malaria Control programme is effective in both districts.
- District has trained DSO, Epidemiologist and Data Entry Operator. Integrated Health Information Platform is operational in the district.
- Trainings and reorientation about IHIP have been completed in the district level.
- Implementation of the universal screening, prevention, and management of common NCDs initiative was observed to be at different stages across the blocks visited.



- District NCD cell and NCD clinics have been established in both the districts.
- Population based screening for NCDs such as HT, Diabetes and cancer have been rolled out in the facility which is in its early stage.
- Cataract surgery, eye banking, and school eye screening are the key services provided under NPCBVI. Outreach camps were also being conducted for eye screening (especially in tea garden villages).
- A suicide prevention helpline is operational in the district (Toll-free number 104). Total 118 people were treated through epilepsy, substance use, and severe mental disorders patient in the last three months at the DH Hospital Cachar.
- In Assam, Dialysis services is free for both the APL and BPL Category patients

## Challenges

- HR Roll maintained designation wise and hence qualification not known. District and facility not aware of sanctioned posts. No specialist cadre. Hence mal-distribution of specialists noted.
- None of the facility visited were NQAS/LaQshya certified.
- District Quality Consultant posts are vacant.
- BMW segregation, treatment, and disposal were not as per BMW Guidelines, 2016.
- Poor internet connectivity & IT infrastructure
- Clinical establishment act 2010, PCPNDT, MTP Act, COPTA notified but not publicized.
- Separate toilets for males and females were not present.
- Unavailability of uninterrupted electricity and potable water supply which affects services like teleconsultation.
- Social security schemes for ASHAs have not been rolled out.
- Grievance redressal mechanism not set up.
- Only a few VHSNCs/MAS were functioning as per norms.
- Limited convergence between MAS/ VHSNC and ULB/ PRI was seen.
- State needs to ensure formation and functioning of JAS/RKS.
- List of Essential drugs and diagnostics at both PHC and SHC less than CPHC norms.
- Inadequate training and mentoring of Primary Health Care team. PHC team role clarity and delegated authority for CHOs needs to be established.
- Ayushman Bharat Health and Wellness Ambassador initiative yet to be implemented.
- Ill-defined mechanism for upward and downward referral and poor documentation and tracking of the same.
- In urban area, capacity of ASHAs and functioning of Community platforms is limited.
- 15<sup>th</sup> FC and PM-ABHIM grant utilization was yet to be planned.
- Regarding medicines and diagnostics, limited understanding on ADR and its established protocols was seen. Norms for Essential Drug List was not implemented.
- Limited awareness and coverage of PMJAY amongst the eligible population.
- Both number and usage of 108 ambulance is limited and the response time for ambulance is more than one hour.
- Limited community participation and utilization of funds for RKS.
- Absence of mechanism for Sample transportation from field to DMC/CBNAAT/TrueNAT site.
- Non availability of **ANMOL** tablet for health workers is an impediment for filling up of S reporting.
- Cold chain and logistics management at FRU & below are inadequate.
- No AEFI reporting and suboptimal monitoring was observed.
- No Family Planning counselling done in the antenatal period.
- Referral rate to medical hospital was seen to be high.
- SNCU are congested and NBSU are underutilized.
- Inadequate Comprehensive Newborn Screening (CNS) was seen.

## Bihar

### Team Composition

Team Lead: Dr Bina Sawhney	
Team 1 (Jamui)	Team 2 (Lakhisarai)
Dr. Bina Sawhney, Addl. DDG, Dte. GHS, Ministry of Health and Family Welfare	Dr. Pankaj Bhardwaj, Additional Professor, AIIMS Jodhpur
Mr. Anjaney, Senior Consultant, Healthcare Technology Division, NHSRC (WHO Collaborating Centre for Priority Medical Devices & Health Technology Policy), NHSRC	Dr. Pushpanjali Swain, Professor, National Institute of Health and Family Welfare, Government of India
Dr. Annapurna Kaul, Health Specialist, UNICEF	Mr. Raghunath Prasad Saini, Senior Consultant-RCH, Ministry of Health and Family Welfare, Delhi
Dr. Ashok Kumar Meena, Chief Medical Officer, Dte. GHS, Ministry of Health and Family Welfare	Dr. Neha Singhal, Senior Consultant, Community process and Comprehensive Primary Healthcare, NHSRC
Dr. Jyoti Rai, Consultant, Ministry of Health and Family Welfare	Dr. Pankaj Talreja, Associate professor, IIHMR, Delhi
Dr. Ashwini Kumar, Senior programme officer, Jhpiego	Ms. Manisha Sharma, Consultant, NHSRC
Dr. Gursimran Kaur, Senior programme officer, School and Wellness, Jhpiego	Dr. Aditya Joshi, Fellow, Community process and Comprehensive Primary Healthcare, NHSRC
Mr. Arun Bhat, Consultant-Finance, Ministry of Health and Family Welfare	

### Facilities Visited

Health Facility Visited	Jamui	Lakhisari
District Hospital	• District Hospital Jamui	• District Hospital, Lakhisarai
Sub divisional hospital	• Referral Hospital Chakai	• FRU/RF/SDH, Barahiya
Community Health Centre	• Block PHC-Jhajha, CHC Sikandra, CHC-Khaira	• CHC: Halsi, Surajgarh, Barahiya
Primary Health Center – Health and Wellness Center	• APHC-HWC-Simultula, APHC-HWC Batiya, APHC- HWC Kewal	• PHC: Pipariay, Ramgarh, APHC: Gureau perasanda
Urban Primary Health Center	• UPHC, Patna	• UPHC. Patna
Sub Health Center - Health and Wellness Center and Community	• SHC-Telva	• SC/HWC: Tetarhat
Others	• Community Visit-Khaira, Jhajha, Sono	• Community visits

### Achievements

- Branding of HWC-PHCs is done as per CPHC guidelines, NHM and Ayushman Bharat logos are displayed on the walls.
- The IT equipment with internet facility for data reporting was available at the visited AB-

HWCs. MOs, Staff Nurses, Lab Technicians, Pharmacists and MPW-M/F have been trained in using IT-Based applications.

- COVID-19 vaccination and testing facility was available up to DHs level. Tika Express : Mobile Vans to decrease travel distance and

Tika Wali Naav : Vaccination at boats in flood affected districts.

- Digital X-ray Machine is functional at DH Lakhisarai and RH Barhiya. Tele-radiology services for tele-reporting of X-ray from specialists is available in PPP mode.
- Semi auto analysers & Haematology analysers were available at most of the facilities like RH Barhiya, DH Lakhisarai, PHC Ramgarh Chowk, CHC Surajagarha, HWC Tetarhat, APHC Geruau Pursunda, and PHC Halsi.
- Pradhan Mantri National Dialysis programme has been operational in State at DH level in PPP-mode and BPL beneficiaries are availing free dialysis sessions. The drugs are also being provided free to beneficiaries by private service providers.
- PSA plants were installed at District hospitals in Jamui and Lakhisarai, yet to be made operational.
- Functional ALS & BLS with critical equipment and essential emergency medicines. Transportation is free of cost available to all patients including roadside accidents, facility to facility transportation of critical cases including Pregnant Women for complicated delivery and New-born as well as Children.
- IEC material is well displayed in the facilities (RH Barhiya, DH Lakhisarai, PHC Ramgarh Chowk, CHC Surajagarha, HWC Tetarhat, APHC Geruau Pursunda, CHC Halsi).
- All Labour rooms were well equipped with adequately trained and motivated HR. Initiatives like AMANAT program is rolled out across and is enhancing knowledge and skill of Labour Room staff.
- The RBSK Mobile Health Team was well versed with screening protocol and were conducting regular screening visits. Uptake of the Bal Hridyay initiative of the State was found quite satisfactory and appreciated by the community.
- School Health and Wellness initiative have been implemented in 14 districts. Aspirational district jamui is also covered under the same.
- With the use of PFMS the beneficiaries under various programmes like JSY, JSSK, ASHA,

NTEP etc. are getting their money through DBT. Implementation of ASHWIN Portal from November 2020 has significantly reduced the delays in ASHA payments. This has led to increase in motivation level of ASHA.

- The initiative of providing free food through Didi ki Rasoi, at a few health facilities was appreciated by the patients and attendants alike.

## Challenges

- Inadequate HR at HWCs-A-PHC, UPHCs and HSCs- State has deployed MBBS Medical Officers and CHOs through a rotational roster of postings to operationalize HWCs.
- There is shortfall of MO-MBBS and Lab technicians in the State. 963 MOs are in position against 1147 APHC/UPHC- HWCs.
- Lack of awareness amongst the primary health care team members especially ASHAs, ANM, Staff Nurse about the concept of Ayushman Bharat- Health and Wellness Centres.
- The quality of ASHA training may be improved, and handholding and supportive supervision needs to be strengthened for AAA.
- None of the labs providing diagnostics as per the essential/free diagnostics services initiative.
- Referral and follow-up of patients with poorly controlled hypertension and diabetes to the district hospital was not being recorded at either the HWCs or the PHCs.
- The capacity of the RKS to be strengthened beyond the utilization of Untied fund and aim to include quality improvement, grievance redressal, ensuring quality service delivery at the facility, community mobilization etc.
- Planning of new construction of health facilities, a standard design and layout plans of infrastructure, critical service areas (esp. OT), support services etc need to be prepared as per the GoI Layouts.
- Need/Gap assessment of health facilities, mapping with existing HR, Geographical access and future road upgradation were not done analysed and planned.

- Availability of Laboratory Technician (LT) is a key challenge in expanding the range of diagnostics as NHM Free Diagnostic service initiative.
- Mapping of equipment inventory was not in place, Biomedical equipment management and maintenance programme needs to be rolled out to ensure upkeep of critical equipment in all health facilities.
- Quality Assurance program are limited to certain facilities and institutions like NQAS committee, District Coaching team and Facility Quality Circles needs to reinstate.
- Immunisation Sessions were missed due to COVID-19 Vaccination as same HR were engaged in the COVID -19 vaccination.
- Screening of NCDs need to be streamlined starting with filling up of CBAC forms by ASHAs at the community level and subsequent screening, diagnosis, treatment & follow up of at-risk population.
- The implementation of N-FAMS has not been taken up and should be a priority.



## Haryana

### Team Composition

Observer: Dr Sanjay Roy, Director, MoHFW	
Team Lead: Dr G Kausalya, Director, CHEB	
Team 1 (Nuh)	Team 2 (Fatehabad)
Dr. G. Kausalya, Director, CHEB	Sh. SN Mishra, DS, Plan., Policy and Monitoring, MoRD
Ms. Leena Goyal, NHM	Dr. Ananth Kumar, CP NHSRC
Dr. Vishal Dogra, Program Officer BMGF	Diksha, HCT, NHSRC
Dr. Sitanshu Sekhar Kar, Prof & HoD, JIPMER	Dr. Harsh Sharma, Jt Director, Communicable Diseases, UPTSU
Dr. Shipra Verma, Cons, Immunization	Dr. Gaurav Thukral State Technical Officer - Immunisation USAID-RISE Jhpiego
Dr. Bhavin Vadera, Health Officer, USAID	Dr. M Jayaram, PHFI
Dr. Pankaj, RRCNE	Dr. Piyusha Majumdar, Assistant Professor, IIHMR,
Mr. Nitesh, Fellow, NHSRC	Dr. Manju Chhugani, Former Dean, School of Nursing Sciences, Jamia
Mrs. Astha Saksena, Fin Assistant, NHM	Ms. Devyani Shelke, Fellow, NHSRC
	Mr. Basavaraj I. Pundappanavar, Research Investigator

### Facilities Visited

	District	
Health Facility Visited	Nuh (Mewat)	Fatehabad
District Level	<ul style="list-style-type: none"> <li>GH Mandikhera &amp;</li> <li>O/o Civil Surgeon</li> </ul>	<ul style="list-style-type: none"> <li>DH Fatehabad</li> <li>SDH Tohana</li> </ul>
Community Health Center	Punanaha	CHC Bhuna
Primary Health Center – Health and Wellness Center	<ul style="list-style-type: none"> <li>Tigaon</li> <li>Sudaka</li> <li>Singar</li> </ul>	<ul style="list-style-type: none"> <li>UPHC Ashok Nagar-Polyclinic</li> <li>PHC Jhalania</li> </ul>
Sub Health Center - Health and Wellness Center and Community	<ul style="list-style-type: none"> <li>Kurthla</li> <li>Tigaon</li> <li>Bubblheri</li> </ul>	SC Dhingsra
Camp site	<ul style="list-style-type: none"> <li>Singar</li> <li>Sudaka (also observed VHND)</li> </ul>	Rattakheri Village: Observed VHND
Community Interaction; FGDs	HWC Kurthula	Aharwa Village
Office of DC	Office of DC, Nuh (Mewat) and Fatehabad	

## Achievements

- State has operationalized 1114 AB-HWC. Fatehabad has operationalized all (18) PHCs into AB-HWC while Nuh (Mewat) has operationalized 17 out of 18 PHCs.
- AB-HWCs have rolled out maternal, neonatal & infant care, childhood health care, family planning, NCD, communicable disease and OPD services well.
- About NCD screening, HWC team has been carrying out the Community Based Assessment Checklist (CBAC) Form for Early Detection of NCDs, Tuberculosis (TB) and Leprosy.
- Samples of each batch of the drugs were being tested at the duly certified laboratory and if found not fit, all the drugs received from pharmacy were returned with the recommendation of blacklisting of the pharmacy.
- Selection of ASHAs was carried out through Gram Sabha's after nominations from Gram Panchayat & ANM and a screening test.
- District hospital had a dedicated Yoga room and full-time trainer/instructor for wellness interventions in functional post COVID Care Centre – UMANG.
- IT system was used for procurement of essential drugs and consumables through a dedicated portal ODSCMS.
- The AB-HWCs had the availability of 14 diagnostic tests and PHCs had medicines for ATT and NCD so that needy people could replenish medicines periodically.
- ASHA/ANM have been trained to look for patch /skin lesions of leprosy. Identified suspected case is referred to the DH directly for dermatology or district leprosy officers' opinion.
- The State Government has another software named "e-upchar" which maintains inhouse drugs inventory and monitors use of drugs at various facilities including the pharmacy.
- Ambulances are well equipped with essential equipment and medicines. Average response time approximately 15 minutes and drop off time is 30–45 minutes.

- The State has launched a centralized mechanism to gather information regarding maternal deaths, infant deaths, and stillbirths from the health facilities at various levels of the health system and accordingly, an on-line "Maternal & Infant Death Reporting System (MIDRS) has been developed and used.
- The State of Haryana has 22 District Training Centres and 4 Skill Laboratories, although none were situated in Nuh (Mewat) District. To ensure effective dissemination of the information imparted during the trainings, pre and post tests are conducted during the training process.
- The districts have constituted the District Regulation Authorities (DRA) under Clinical Establishment Act (CEA) and there is a provision of conducting monthly meetings.
- A 38 bedded paediatrics ward was created in the District Hospital, Fatehabad oxygen supply plants (10 litres/minute) was installed, and eight ventilator beds were made available for care of COVID-19 patients.
- The HWCs are following the Central Government (NACO) SOPs/ Guidelines under Human Immune Deficiency Virus and Acquired Immune Deficiency Syndrome (Prevention & Control) Bill, 2017.

## Challenges

- Adolescent services, Eye, ENT care, Oral health care, Care for elderly and palliative care, and mental health care services need substantial improvement and capacity building of concerned staff.
- Nuh (Mewat) needs to improve ANC and PNC check-ups. It has 40% children under 5 years with underweight. Full immunization coverage is 13%. 30% IUCD are removed after a short duration of insertion and efforts are required for sustenance. Adolescent registration and counselling coverage are low.
- HWC lacked a planned system for follow-up of chronic diseases like NCDs, HIV, Mental Health disorders and thereby affecting continuum of care.
- ASHAs predominantly focussed on RMNCHA+ programme components with

limited engagement in other programmes, particularly in NCD care.

- Community based planning and monitoring through VHSNCs was not in place. The CHOs are not aware about the significance of JAS and VHSNC committee.
- There is absence of an inter-sectoral convergence of HWC with other allied departments.
- The HWC-SHC organises limited number of health and wellness activities which includes health education talks as per the annual health calendar days.
- At SHC-HWC, there was a lack of synergy and cooperation between the CHOs and ANMs. This resulted in poor completion of CBAC and family folders at the community level and regular screening of NCDs.
- There is need of provision of X-ray facilities at CHCs.
- Coverage of PM-JAY is low at around 25% in Nuh (Mewat).
- A monthly plan of supervisory officers to review data from various portals and to draw evidence-based conclusions and actions.

- Adequate supply of TB drug susceptibility testing kits and availability of Isoniazid tablets for TB preventive treatment.
- Post discharge follow-up of elderly people in the community is not happening if they come to the clinic, counselling services are provided.
- The implementation of the scheme of 'You Quote We Pay' for postings of MOs/ Specialists in difficult areas has been widely publicized by the NHM, Haryana, but the actual implementation of the scheme has been found to be lacking especially in context to the postings in the Districts of Fatehabad and Nuh (Mewat). Even though there are provisions for performance incentives for the healthcare staff there was a lack of initiative to offer hard areas allowance.
- POSH Act, 2013: A 5 member ICC has been constituted at the DH Nuh (Mewat) in the year 2018. But none of the members have received any training on the guidelines of POSH act though cases are being handled based on national guidelines.

## Karnataka

### Team Composition

Team Lead: Dr Himanshu Bhushan	
Team 1 (Davangere)	Team 2 (Yadagiri)
Dr. Himanshu Bhushan, Advisor, Public Health Administration, National Health System Resource Center, New Delhi.	Dr. C. M. Singh, Professor & Head, AIIMS Patna.
Dr. Mahesh Bhagwat Dale, Deputy Sec, MoAyush, New Delhi.	Dr. Mayank Dwivedi, Public Health Specialist & Laboratory Advisor, CDC, New Delhi.
Dr. Marion Jane Cros, Senior Economist World Bank, New Delhi.	Dr. Sukhbir Singh, Research Investigator, PRC, Punjab University, Chandigarh
Dr. Pranav Bhushan, Senior Technical Officer, ADU, Ministry of Health and Family Welfare, New Delhi.	Mr. Vivek Singhal, Senior Consultant, CH Division, MoHFW, New Delhi
Dr. B Mohammed Asheel, Former Executive Director, Kerala Social Security Mission, Kerala	Ms. Nisha Kadyan, Sr. Consultant (NUHM), MoHFW, New Delhi.
Dr. Poonam, Consultant, Public Health Administration, NHSRC, New Delhi.	Dr. Saurav Basu, Assistant Professor Indian Institute of Public Health, New Delhi.
Ms. Phibansuk Lyngdo, Senior Research Officer, Indian Institute of Public Health, Shillong	Mr. Santosh Pujari, Program Officer, Jhpiego
Dr. Diksha Dhupar, Senior Research Associate, iHAT	Mr. Hari Krishnan, Junior Consultant, NHM, MoHFW, New Delhi. xxxxxxxx
Ch. Stella Grace, Fellow, Quality Improvement, NHSRC, New Delhi.	Ms. Neelam Tirkey, consultant, Public Health Administration, NHSRC, New Delhi.
	Dr. Syeda Tahseen Kulsum, Fellow, PHA, NHSRC.

### Facilities Visited

Health Facility Visited	Davangere	Yadagiri
District Hospital	District Hospital, Davanagere	District Hospital, Yadagiri
Sub divisional hospital	<ul style="list-style-type: none"> <li>Taluka Hospital, Harihara</li> <li>Taluka Hospital, Honnali</li> </ul>	Taluka Hospital Shorapur
Community Health Center		<ul style="list-style-type: none"> <li>Community Health Centre, Hunasagi</li> <li>Community Health Centre, Gurmatkal</li> </ul>
Primary Health Center – Health and Wellness Center	<ul style="list-style-type: none"> <li>Primary Health Centre, Belludi</li> <li>Primary Health Centre, Kondajji</li> <li>Primary Health Centre, Kondadahalli</li> <li>Primary Health Centre, Shamihipnea</li> </ul>	<ul style="list-style-type: none"> <li>Primary Health Centre, Rajan Kollur</li> <li>Primary Health Centre, Yergol</li> </ul>
Urban Primary Health Center	Urban Primary Health Centre, SMK Nagar	Urban Primary Health Centre, Surpur
Sub Health Center - Health and Wellness Center and Community	<ul style="list-style-type: none"> <li>Sub Centre, Kukanur</li> <li>Sub Centre, Gutturu</li> </ul>	<ul style="list-style-type: none"> <li>Sub Centre- HWC, Bailkunti</li> <li>Sub Centre- HWC, Wadenhalli</li> </ul>



Health Facility Visited	Davanagere	Yadagiri
Others	<ul style="list-style-type: none"> <li>Govt School of Nursing, CGH</li> <li>Women &amp; Child Hospital, Davanagere</li> <li>Drug Warehouse, Davanagere</li> <li>District Training Centre, Davanagere</li> <li>Anganwadi Centre, Gutturu D-centre</li> <li>Sarkari Utkrusht Hiriya Prathamika Shala, Belludi</li> <li>Community interactions- villages &amp; slums</li> </ul>	<ul style="list-style-type: none"> <li>Community interactions- villages &amp; slums</li> <li>Patient interviews at the facilities visited</li> </ul>

## Achievements

- Branding of HWC-SHC and PHC are done as per CPHC guidelines, NHM and Ayushman Bharat logos are displayed on the walls.
- PHCs were manned by Medical Officer, Staff Nurses, Lab Technician, etc as per IPHS.
- COVID-19 vaccination and testing facility was available up to PHCs level.
- Growth monitoring of the children at the AWCs in Davanagere and early identification and referral of SAM/MAM children by the ASHAs in both the districts.
- Fixed day services such as counselling, provision of IFA tablets for adolescent health are being provided at **SNEHA clinic**.
- Ambu bags and radiant warmers have been provided to all primary healthcare facilities where deliveries are being conducted.
- VVM status is regularly checked and e-VIN functional except in a few PHCs (Belludi and Kondadhahalli). The new ILR supplied to UPHC SMK Nagar were not yet installed.
- Nikshay Poshan Yojana is being effectively implemented in the field with a coverage of above of 80% of eligible beneficiaries.
- ARV is included and exhibited as part of EDL in the PHCs and were available in both districts.
- Continuum of care in terms of frequency of follow-up, regular monitoring of blood pressure and blood glucose levels, and dispensing of medications was observed under NCD program.
- In Davanagere Mobile ophthalmic unit from District Hospital visits the PHCs once in a month.
- As of the “nalli-keli” (learning through playing) program, school children are taught about the harmful effects of passive smoking.
- Convergence between health and Panchayati Raj Institution at department level and below district level is excellent.
- All ASHAs receive a minimum monthly wage of more than Rs. 6000 out of which the state grants a fixed sum of Rs. 4000/month.
- Provision of safe drinking RO water at the rate Rs. 3/20 litre in each village.
- Availability of functional critical equipment in emergency, OT, HDU/ICU & Labour room.
- The staff was found adhering to proper dress code in all facilities visited.
- Critical equipment, emergency medicines, PSA plants, oxygen concentrators and cylinders were available in both the districts at every level of facility.
- Well maintained OT with clearly demarcated clean, buffer, and sterile zones in all facilities of Davanagere and modular OT observed at Taluka Hospital, Shahpur (Yadagiri).
- All emergency departments visited had separate entry with provision of ramps, stretchers, and wheelchairs at the entrance.
- Support services like CSSD, laundry and dietary/Kitchen available at the level of DHs/ Taluka Hospitals in both districts however,

laundry was not mechanised, and kitchen utensils being used were obsolete.

- Both the districts have SNCU with adequate bed occupancy, 30-bedded SNCU at DH Davanagere had more than 80% BOR.
- Newborn Hearing Screening is done exclusively in the District Hospital using the OAE provided under the NPPCD program, all the children suspected to have hearing impairment in the periphery are referred to the DH,
- Free drug entitlements are displayed at the facility in the local language. Drugs are prescribed by their generic names in most visited facilities. Well maintained drug store and availability of near expiry drug list.
- Recruitment of specialists was done once in 2017–18 through 'You Quote We Pay' to implement initiative
- DH Davanagere utilized the KAYAKALP incentives for IEC display for cleanliness, needle stick injuries and BMW management, buying toilet cleaning equipment and for implementing 3 bucket cleaning system
- CHCs (CHC Nyamathi, CHC Kerebilachi, CHC Santhebennur) received a support of 10 lakhs under SSS and all the three facilities utilized those funds in a proper way and won KAYAKALP award.

## Challenges

- In Davanagere, the gap analysis for upgradation/conversion of sub-centres into AB-Health and Wellness Centres yet to be undertaken.
- At Yadagiri, although the Sub-centres were converted into HWCs yet adequate space for wellness and other such activities is non-existent. Health and wellness rooms are available only in a few newly constructed buildings.
- In both the districts, the PHCs do not have proper health and wellness rooms along with teleconsultation.
- There are huge gaps in the availability of drugs against EML. Drugs available at the PHCs vary from 20–25 and 5–7 at the HSCs.
- None of the labs providing diagnostics as per the essential/free diagnostics services initiative.
- The postings of CHOs in Davanagere was under process and the trainings of health workers on 12 packages of CPHC services were yet to be completed in both the districts.
- RBSK focus was not adequate as in Davanagere approx. 50% of children were screened out of the total target 2020–21. RBSK teams were also involved in COVID activities, knowledge of nurses on screening at birth was found to be inadequate.
- Due lists available with ASHAs, ANC registration is being done, however, first ANC registration is only 53% in Davanagere and the high-risk pregnancies are being referred to secondary care facilities.
- Referral and follow-up of patients with poorly controlled hypertension and diabetes to the district hospital was not being recorded at either the HWCs or the PHCs.
- VHSNC meetings are being organized monthly at the community in both districts. however, record keeping, and proceedings in Yadagiri were inadequate
- People were incurring the out-of-pocket expenditure as patients were seeking treatment from the private sector.
- Specialists like ENT & Ophthalmologists (only 1–2 surgeries in a month) were not optimally utilised in comparison to young Orthopaedic Surgeon who is performing 4–5 surgeries per day. One of the major reasons for a smaller number of surgeries were lack of some equipment.
- In Yadagiri, PICU and NICU services were not established, and HDU/ ICU are not available at any level except at Taluka hospital however, not being used despite availability of intensivist for last 4 months. So, all the

patients requiring critical care services are being referred to other districts.

- The concept of LDR was not implemented by the State in any district so, labour beds were not available and alternate birthing positions not being practiced
- Maternal deaths are under reported and even facility based maternal death has not been conducted for last one year.
- AFHC was available in Yadagiri but not in Davanagere as RKSK program implemented only in selected districts of the state
- The dialysis Centers are functional in the District Hospitals and in a taluk hospital in the Yadagiri District. However, the dialysis machines not being used optimally as per day utilization of the dialysis machine was less than 2 times/machine/24 hours.

- Despite the availability of EMTs, the transportation of the patient was done without any first aid services. Timely maintenance of equipment is required in ambulance.
- Karnataka has 60 Medical Colleges that is 10 Medical Colleges per 1 Crore population, despite this the vacancies of 39% specialists and 45% MBBS doctors is hampering the range of services available in the secondary care facilities
- Many facilities in the districts started implementing NQAS from 2017 and started internal assessments in 2018 but failed to achieve the satisfactory results due to lack of orientation, proper team and training. So, till now no facility in the Davanagere and Yadagiri district is NQAS nation certified.

## Mizoram

### Team Composition

Observer: Ms. Roli Khare, Director, MoHFW	
Team Lead: Dr. Sila Deb	
Team 1 (Champhai)	Team 2 (Mamit)
Dr. Sila Deb, Addl. Com. (Child Health)- Team Leader	Dr. Jyoti Rawat, Joint Comm (NUHM) – Team Leader
Sh. Nehjamang Symte, DS, DoNER	Ms. Sweta Roy, NHSRC
Prof. Nanthini Subbiah, NIHFW	Dr. Pankaja Raghav, CoE (AIIMS- Jodhpur)
Dr. Nikhilesh Parchure, PRC Sagar	Mr. Ankur Nair, NHSRC
Mr. Saurabh Raj, AGCA Secretariat	Mr. Sahil Kapoor, UNFPA
Ms. Sneha Mutreja, NHM	Dr. Atul Rairker, NHSRC
Ms. Isha Sharma, NHSRC	Dr. Subin Subramanian, ITSU
Dr. Priyanka Bharti, Maternal Health	
Ms. Divya Shrivastava, NFAMS	

### Facilities Visited

Health Facility Visited	Champai	Mamit
District Hospital	• Champhai DH	• Mamit DH
Community Health Center	• Ngopa	• Kawrthah
Primary Health Center – Health and Wellness Center	• Bungzung Khawbung Hnahlan	• West Phaeling Zawluam
Urban Primary Health Center	• Champhai	
Sub Health Center - Health and Wellness Center and Community	• Dungleang Vanzau Zokhawthar Vaikhawtlang	• Bungthuam Darlak

### Achievements

- Strong community participation: Pastor / local priest/Village council member actively participate in health-related activities
- Some facilities have strong linkages with local community & youth groups like Young Mizo Association (YMA) for conducting sanitation drive on volunteer basis
- CSR fund utilized for improving health service delivery
- Doctor-Patient Relationship: Direct access to MOs and Specialists at the DH through phone and WhatsApp

- District Hospital (DH) Labour Room in Mamit is State and National level Laqshya certified. DH at Champai is State certified.
- MO being self-trained on data analytics has designed systems on excel reporting using macros for OPD, identification of risk pregnancy and immunization.

### Challenges

- **Out of Pocket Expenditure (OOPE)** above 60% observed at DH, CHC and PHC: User charges on lab tests and diagnostics, short supply of medicine



- DVDMS is implemented up to PHC, but is widely used **ONLY** for updating stock and not for indenting purpose
- **Referral Transport:** No centralized tollfree number available for ambulances. Non availability of Public Transport in the State. Families mostly rely on the private taxis; high OOPE
- **e-Sanjeevani:** Low utilization of telemedicine largely due to network issues. WhatsApp and phone calls used as alternate mode of teleconsultation
- Irregular disbursement of incentives to the ASHAs and ASHA mobilizers (Last released was made in March 2021 and since April 2021, it is due)
- Irrational Distribution - No vacancy as per sanctioned post. In Mamit, 18 areas ASHAs are serving more population ranging from 1203 to 4652 while in 16 areas are not being served by ASHAs.
- Recruitment and management HRH was completely centralized. Lack of clear recruitment process and job descriptions leading to mismatch in the qualification/skills and actual responsibilities of the HRH
- Irrational deployment and poor service provision. (e.g. 6 LTs posted in DH Mamit. Average caseload per LT per day is 3)
- Family Planning: Health workers have not been trained in provision of FP (IUCD insertion). Non availability of condom facilities in most of the health facilities visited
- Provision of full PMSMA service package is limited to District Hospital only
- No mechanism for High-risk Pregnancy identification and tracking was found
- Availability of IFA and Calcium was not seen at some sub-centres
- Infant Milk Formula – procured and widely practiced in health facilities (PNC wards, SNCU) and Community. Bottle feeding – prevalent in communities
- Infrastructure of SNCU Champhai – poorly maintained (seepage)
- **DEIC** is located in Aizawl and Lunglei districts. Children referred by RBSK team find it difficult to reach the district hospital as majority of their parents are daily wagers and they lose their income during their visit to DEIC, leading to high out of pocket expenditure.
- **Immunization:** Variations in the practice of open vial policy across Cold Chain points. Storage of different medicines and testing kits was done in the ILR along with the vaccines. E.g. used COVID Vaccine vial, Anti rabies vaccines, Rickettsia Testing Kits, Unused Oxytocin Vials, Old Samples of COVID Patients.

## Odisha

### Team Composition

Team Leader – Dr. Raghuram Rao, Joint Director, MoHFW	
District Sundargarh	District Rayagada
Dr. Raghuram Rao, Joint Director, MoHFW	Dr. Padmini Kashyap, Asst Commissioner, MoHFW
Dr. Ram Chahar, WHO	Dr. A. C. Mallick, Dy Secy, D/o Water Resources
Mr. Mandar Randive, NHM, MoHFW	Dr. Vimlesh Purohit, WHO
Ms. Suchi Khanna, NHM, MoHFW	Dr. Santosh Ojha, NHM, MoHFW
Ms. Haifa Thaha, NHSRC	Dr. Debajit Bora, NHSRC
Ms. Rishita Mukherjee, NITI Aayog	Ms. T Ankitha, NHSRC
Dr. Anil M H, PATH	Dr. Vipin Garg, CARE India
Dr. Shweta Singh, WHO	Dr. Shailey Gokhale, Jhpiego
Dr. Debasis Swain, Jhpiego	Dr. Subrat Panda, WHO

### Facilities Visited

Facilities	District Sundargarh	District Rayagada
Subcentre	Kharalchhapa	
Subcentre – Health & Wellness Centre	Jhariapali Kurga Kiralaga	Regada Jalatar Elangalpadu Dukum Singari Gadiseskhal Matikona Dudukabahal Sikarpai Akhusing
PHC – Health & Wellness Centre	Tangrapali Malidhi Gundiadihi Taragaon Kadobahal Suarijore Jarangloi	Minajhola Sikarpai Rugudubai Puttasing Kumbhar Dhamuni Majhiguda
CHC/ SDH	Mangaspur Sargipali Rajgunpur Bargaon	Muniguda Ramanaguda Kashipur Padmapur Gunupur
Regional Government Hospital (RGH)	Rourkela	
District Headquarter Hospital	Sundargarh DHH DPMU	Rayagada DHH DHS
Other facilities	Tribal Residential Welfare School NRC	School NRC

## Achievements

- **Matrujyoti scheme – ensured quality antenatal care including Ultrasonography for mothers**

As a step towards curbing IMR and MMR, in District Sundergarh, Antenatal Care Services are being facilitated under a specially designed “Matrujyoti” scheme. It aims to provide 4 free ultrasound and other basic investigations like Hemoglobin, BP, Blood Sugar, Urine, etc. to all women during pregnancy.

- **Advanced Rehabilitation centre and Integrated Physiotherapy Unit**

A state-of-the-art facility, established in the campus of Sundargarh District Headquarters Hospital (DHH). The key objective of this centre is to facilitate a life of dignity and empower People living with Disabilities, Advanced Rehabilitation and Integrated Physiotherapy Unit.

- **Focus on service support (HR, referral and infrastructure upgradation) through DMF**

The District Collectors leveraged the District Mineral Fund (DMF) as an additional resource and invested in the HR, strengthening referral services and infrastructure. If the specialists and other HR could not be availed from NHM resources, then recruitments were carried out by supplementing funds from DMF.

- **Daman initiative for combating Malaria**

DAMaN was undertaken since 2017. The camp-based approach conducted were successful in detecting most of the asymptomatic cases and providing treatment.

## Challenges

- Among the available IT Applications under the NHM, Nikshay and IHIP were not fully operational at AB-HWC in PHC / SHC levels. Challenge of internet connectivity in hard-to-reach areas and application limitations. Nikshay and IHIP portal not operationalized.
- NCD screening is limited to Hypertension and DM in most of the facilities. Referrals for Continuum of Care directly to DH/SDH level. Limited post treatment follow-up for

downward referrals of CBAC. High LAMA and referral rate for all cases was observed.

- Emergency services and critical care services were largely available at DH level due to lack of specialists at CHC/SDC level facilities.
- Stock outs of drugs were observed in multiple facilities. Expired drugs were kept in the same racks as non-expired drugs.
- The radiology facility is currently available at the DH/SDH & RH level only. No Teleradiology services were available for X-ray (available for CT scans).
- DH Rayagada is LaQshya certified but maintaining standards post certification was a challenge. Lack of strategic planning for LaQshya and NQAS certification of all the facilities.
- Infection control practices sub-optimal in health facilities, ambulances and at community levels.
- Single Nodal account is yet to be implemented at all levels. Statutory Audit report for F.Y 2020–21 was not submitted.
- Identification of High-risk pregnancy is low. Lack of adequate knowledge among service providers towards newer initiatives like-SUMAN, SAANS etc.
- Availability and orientation of staff on Non-Pneumatic anti-shock garments. However, this is a relatively new initiative supported by State Government SAMPURNA Scheme and has not been used since one and half month of its availability.
- Instead of free drop back service, patients are provided Rs. 500 under JSSK, however only 50% beneficiaries could avail the scheme (as they could not fulfil the criteria of 48 hours of minimum admission).
- Use of Inj. Tramadol in most of the cases during labour was found in SDH-Gunupur of Rayagada District and C-Section rate was high during daytime and was only 22% during nighttime.
- Although MCP cards are being filled in, but its correctness remains a challenge with underlying reason being capacity building of

ANMs and nurses. Also, HRP red cards that are being attached to the MCP cards were not filled properly.

- Birth companions are being registered but still not allowed in labour room in few of the facilities at Rayagada.
- There is limited utilization of RCH portal, ANMOL, by the service providers due to lack of connectivity and handwritten registers and records are used more.
- Sub optimal utilization of peripheral facilities for labour services: Delivery load is less at periphery level (CHCs/PHCs), labour cases referred to DHH & RGH and few opt for private nursing homes at Sundargarh.
- Overcrowding at RGH Rourkela MCH center – the 100 bedded hospital is unable to cater to the patient load and there is an urgent need to create more space for ensuring respectful care for laboring mothers at hospital. RGH Rourkela hospital is catering to the nearby districts of Jharkhand (20% of admissions in MCH unit).
- The Basket of choice for Family Planning is available across all facilities; however, the counselling on Family Planning awareness and uptake needs improvement in the districts, especially in post- partum period and among young eligible couples.
- Inborn admission of RGH Rourkela SNCU is 60%, indicating quality of new-born care and Labour Room protocols for new-born are likely to have been compromised.
- Vacancy of Doctors (03 MOs) are observed in SNCU-Rayagada.
- Mortality rate in SNCU is around 7% which is good, however the admission based on the defined criteria needs to be reviewed. At the same time in Rayagada the discharge rate is 76%. About 23% are either referred/ get LAMA or die. Referral and getting LAMA are near miss cases and chances of survival are less in such cases.
- High OOPE and dis-satisfaction with care services was reported by users for new-born

services including referral to tertiary centres. While there is a functional State health insurance scheme, there is limited private sector empanelment in the visited districts.

- At the Angawadis as well as NRC in Rayagada, weighing scales were not calibrated as well as technique of weighing the child and measuring the height lacked finesse.
- RBSK/MHT quality screenings at the field level needs improvement. There is lack of early identification and development delay was found in one missed out case.
- Vacancy of MHT doctors seen in Rayagada district. (19 MHT Doctors post are vacant).
- Sub optimal utilization of DEIC found in Rayagada. Pediatrician is not available.
- Delayed delivery of vaccines at DVS, due to availability of only one Vaccine Van at State Vaccine Store, affecting timely logistics and transport.
- e-VIN not fully functional - indent of vaccine, logistics and temperature monitoring gaps observed across the facilities.
- Linkages with the AYUSH department for wellness and quality care in geriatric patients should be strengthened.
- The community was seen to be suffering from oral health problems without awareness / orientation on preventive care or availability of oral health care services.
- Persistent trend in detection of Malarial Parasites and HBsAg among the voluntary blood donations in the blood banks over last 3 years was observed including a spike in detection of Syphilis in 2021. This indicates a persistent presence of sub-clinical / asymptomatic infection in general population.
- Low cross - referral from other national programmes (like HWCs, NCD clinics, ICTC, ART, RBSK/RKSK, NRC, tobacco cessation units, etc) for TB testing is less than 1%.
- Less than 50% of Health Centres (CHCs+ PHCs) have functional DMCs (21 out of 49). One CBNAAT and one TruNAT machine is in the DTC Rayagada, however due to lack

of CBNAAT cartridge and non-functional of Tru NAAT machine, molecular diagnostic is temporarily stopped.

- Testing was not happening except for pregnant women for hepatitis B. The staff at PHC and CHC were not aware of guidelines/SOP on referrals and management of hepatitis B infected pregnant women and newborn.
- The ART centre (Rayagada) has a high non retention with cumulative loss to follow up rate around 20% and deaths around 15%. These are however lower for new cases in this financial year.
- PEP drugs were not available at some centers below the district hospital. Moreover, at almost all facilities (except at one CHC) the health care workers were not aware of the correct post exposure prophylaxis steps and regimes. Some nurses and doctors even quoted wrong ARV to be used (mentioned Syp Nevirapine for PEP for health care workers).
- In Raygada District, there have been issue with the point of care CD4 machine, including supply of CD4 test reagents and breakdown of machine for a month during which CD4 testing was not done.



## Puducherry

### Team Composition

Team Lead: Dr. Kanwar Sen, Principal Advisor, DGHS	
Team 1 (Puducherry)	Team 2 (Karaikal)
Dr. Kanwar Sen, Principal Advisor, DGHS-Team Leader	Dr. Ashok Roy, Director RRC-NE – Team Leader
Mr. Vigneshwaran PS, Technical Officer-CTD, MoHFW	Mr. Tapas Chatterjee, Lead Consultant, MoHFW, Gol
Mr. Daman Ahuja, Program Manager, AGCA Secretariat	Prof. R Nagarajan, IIPS
Dr. Kapil Joshi, CH Division, MoHFW	Ms. Nistha Lahoti, BMGF
Dr. Shayoni Sen, Consultant, NHSRC	Dr. Pratiksha Pal, JHPIEGO
Ms. Ritu, Consultant, NHSRC	Ms. Sunita, RRC-NE
Dr. Monika Saini, Asst Prof, NIHF	

### Facilities Visited

Health Facilities	Puducherry	Karaikal
Medical College and Super Speciality Hospital	<ul style="list-style-type: none"> <li>Indira Gandhi Medical College</li> <li>Rajiv Gandhi Women and Child Hospital</li> </ul>	-
District Hospital	Indira Gandhi Govt. General Hospital	GH Karaikal
Community Health Center	<ul style="list-style-type: none"> <li>CHC Mannadipet</li> <li>Karikalampakkam</li> </ul>	CHC Thirunallar
Primary Health Center – Health and Wellness Center	PHC-HWC Mettupalayam	<ul style="list-style-type: none"> <li>UG PHC Nedungadu</li> <li>PHC Neravy</li> <li>PHC T.R Pattinam</li> <li>PHC Kovilpathu</li> </ul>
Urban Primary Health Center	<ul style="list-style-type: none"> <li>UHC Dubrayapet</li> <li>UPHC Puducherry</li> </ul>	<ul style="list-style-type: none"> <li>U-PHC Karaikal Medu</li> <li>Urban H&amp;FW Centre, Karaikal</li> </ul>
Sub Health Center - Health and Wellness Center	<ul style="list-style-type: none"> <li>North Venjore</li> <li>Akkraivattam</li> <li>Dubrayapet</li> <li>Veerampattinam</li> </ul>	<ul style="list-style-type: none"> <li>North Vanjore Subcentre</li> <li>Akkraivattam SubCentre</li> </ul>
Community	<ul style="list-style-type: none"> <li>Karikalampakkam</li> <li>Sompet Village</li> </ul>	<ul style="list-style-type: none"> <li>Puthuthurai Village</li> <li>Kinjalmedu Village</li> <li>Thiruvettakudi Village</li> <li>Kinjalmedu Village</li> </ul>

### Achievements

- PHC and CHCs have good infrastructure in most places having 24\*7 electricity and drinking water supply.
- Branding of the AB-HWCs were completed in most of the facilities. All the facilities visited have herbal gardens.
- Well displayed IEC materials in vernacular language were observed across all the AB-HWCs visited in district Puducherry with all priority areas of the population covered.
- ASHAs are energetic, pro-active, having good connects with the community. Field functionaries (ANMs) are having commendable rapport with the ASHAs, AWWs and community members.
- Dedicated pharmacist at all PHC-HWCs. Maintaining and displaying of expiry calendar of drugs at the pharmacy of PHC-HWC.
- Alert system for staff about drugs that “look alike and sound alike” at RGW&CH.
- Birth dose of vaccination to all newborns before discharge.

- A decision was passed under the leadership of District collector, Puducherry to include an amount of 30 lakhs in RKS from the collection of the Hundi (from a temple inside the campus). Revenue generated from the parking was also included in the RKS fund.
- Due to well connectivity and close proximity of the district hospital to the community, it is able to cater all the Karaikal region population as well as certain catchment areas of neighbouring state for the critical care services such as deliveries, dialysis services, cardiac arrest emergencies, accidental cases etc.
- SNCU bed occupancy rate is more than 80%. All protocols including death audits are being conducted at SNCU Rajiv Gandhi Medical College and gap identification and action plans were accordingly prepared
- Zoning was observed in all Operation Theatres at IGMC, IGGGMC, RGMC and DH Karaikal
- Screening of newborns at birth are being done by the SNCU staff
- Significant demand of Injectable Contraceptives at community level
- PMNDP has been implemented through in-house mode in two districts- Puducherry and Karaikal with 24 dialysis machines. Dialysis services are provided free of cost to all the patients
- District has sufficient no of 108/ PTV/ALS as per the population norms. 24\*7 Call Centre is functional (three shifts-one operator per shift) and well-maintained records.
- No structured mechanism to support/analyse ASHA's monthly performance and address their grievances
- Community forums like Village Health Sanitization and Nutrition Committee (VHSNC), Mahila Arogya Samiti (MAS) and Jan Arogya Samiti (JAS) are either inactive or have not been constituted
- More than 50% deliveries are C-section. During community visit it was observed that out of 10 women, 7-8 mothers have pre-C-Section history (Karaikal district)
- Institutional deliveries are conducted only at the DH Level, no delivery at Sub-District level facilities though they are equipped with structured labour room, equipment, HR etc.
- Though district have good ambulance services but the drop-back mechanism after delivery not found satisfactory due to lack of awareness/willingness in the community.
- Mother and Child Protection Card (MCP) is not available, information is being taken in fragments (not universal).
- Biomedical Equipment Management and Maintenance Program (BMMP): Some of the key equipment like microscope, auto analyser were non-functional and downtime is high. Lack of awareness about the program among staff at some facilities in Karaikal region.
- PMNDP: Average waiting list of around 30 patients was observed at DH Karaikal with an average waiting time of 1 year. There is demand of Dialysis Technician in Karaikal, the state has the vacancy of approved post of Dialysis Technician; however, the post is not yet being filled up
- The constitution of Panchayat Raj Institutions (PRIs) has not been in place since last 10 years
- Delay in release of State share from State treasury. Delayed for up to 7 months for the FY 2020-21.
- The activities of the FY 2021-22 are being managed through the unspent balance.
- The expenditure of ECRP-II is only Rs. 90 lakhs out of the RE of Rs. 9.03 Cr. UT received Rs. 4.52 Cr under ECRP-II.

## Challenges

- The services at SHC-HWCs are limited to Maternal & Child Health with minimal laboratory ANC services
- MOs appointed as CHOs but not available at the SHC-HWC, the rate of attrition of CHOs (MBBS) posted under NHM is high no dedicated team leader at the SHC-HWCs especially in Karaikal region
- ASHAs have not received the ASHA kits and no regular training plan.
- ASHAs have not received the performance-based incentives for the last 1 year

## Rajasthan

### Team Composition

Observer: Dr. Harmeet Singh, Joint Secretary, MoHFW	
Team Lead: Ms Mona Gupta	
Team 1 (Karauli)	Team 2 (Jalore)
Ms. Mona Gupta (Advisor, NHSRC)	Prof. Usha Ram, IIPS
Dr. Ashwini Kumar Nanda, PRC, CRRID	Dr. Suresh Shapeti, IIPH
Dr. Ashish Chakraborty, MoHFW	Mr. Sanjeev Gupta, NHM
Dr. Arvind Srivastava, NHSRC	Mr. Harish Iyer, BMGF
Dr. Abhishek Raut, MGIMS	Ms. Sumitra Dhal Samanta, NHM
Dr. Aniket Chowdhary, NHM	Ms. Sonali Bhardwaj, NHM
Mr. Jaidev Anand, WHO	Dr. Mithun Dutta, NHM
Dr. Priyanka Kumari, NHSRC	Dr. Jaidev Khatri, Jhpiego
Ms. Charu Rai, NHSRC	Dr. Surabhi Sethi, NHSRC
Ms. Vaishnavi Akanksha N, NHSRC	Ms. Falguni Bhosale, NHSRC

### Facilities Visited

Health Facility Visited	Karauli	Jalore
District Hospital	Karauli	Jalore
Sub-Divisional Hospital	Hindaun	-
Community Health Center	Gudhachandraji, Mandrayal	Ahore, Bhinmal
Primary Health Center – Health and Wellness Center	Langra, Rhodhai	Bagra, Malwada
Urban Primary Health Center	Ganesh Gate	Jalore
Sub Health Center - Health and Wellness Center and Community	Dargama, Gadhika Gaon, Kunjela	Akhrad, Deegaon

### Achievements

- Dialysis services are being delivered under PMNDP which has been implemented in PPP Mode in all 33 Districts.
- Branding of HWCs has been done as per guidelines.
- ANC registration and check-up (incl. HIV tests) are being done regularly. Birth companion and respectful maternity care are being practised.
- Regular activities under VHND, PMSMA, MPV, RI, and supplementary immunisation for left-out children are being conducted.
- State's efforts for countering sex-selective abortion include wide-scale IEC activities,

registration of USG centres, and surveillance of women who have already had 2 girl children. The basket of choice of contraceptives was displayed in all the facilities.

- Developmental disabilities have been included in the *Mamta* card to create awareness.
- Labour rooms of both MCH hospitals are LaQshya Certified. The SNCU in both districts had good equipment and optimal bed utilisation.
- Senior citizens were assured of separate registration lines, no user charges, and reservation of beds in the DH.
- HIV-TB cross referrals and screening of TB patients for Diabetes were being adequately

practised. Partnership with NGO, Vihaan for HIV/AIDS defaulter retrieval was observed.

- The state has an adequate number of posts in the four main service delivery cadres (Staff Nurses, Lab technicians, Pharmacists, and Doctors).
- Rajasthan has engaged nurses as COVID Health Assistants (CHA) from its own resources, adding a helping hand at the SC level.
- Many highly motivated and dedicated staff at the field level. Good coordination among ASHAs, Anganwadi Workers and ANMs.
- For the training of counsellors, an online certificate course on counselling skills has been initiated under NHM with the support of collaborating organizations.
- Assurance of free drugs and diagnostic facilities was observed. Additional investigations and teleradiology services are made available free of cost through PPP engagement with Krsnaa Diagnostics. The Essential Drug List (EDL) was displayed in most health facilities.
- Quality check of all the drugs received at the warehouse is being done.
- Integration of IT for health and financial management was seen. Examples include disbursement of payments through ASHA Soft and Ojas software, inventory management through the e-Aushadhi system, utilisation of e-Upkaran for BMMP, and HRIS for salary disbursement.
- Good practices under COVID include the utilization of ECRP-1 funds (80%), the creation of an Oxygen Bank, ensuring availability of oxygen concentrators, the establishment of RTPCR labs and PSA plants, and inter-sectoral convergence through Corona Core committees.

## Challenges

- Upgradation of more than 90% of sanctioned sub-centres to HWC is pending.
- High number of vacancies across service delivery and program management staff, no recruitment under NHM for last 3 years, absence of Specialist cadre, lack of transfer

policy and no incentivization for difficult geographical areas.

- Poor infrastructure and lack of amenities like water and electricity supply at the SCs were noted.
- ASHA recruitment via ICDS led to duplication of reporting channels, heavy workload and also underserved pockets; as wherever an AWC does not exist, ASHAs are not deputed.
- Blue colour uniforms of ASHAs in Jalore deemed culturally inappropriate, as it is a colour of mourning. Need to be changed to improve community acceptance of ASHAs.
- Participation of community members, PRIs and VHSNC in health activities was minimal.
- Wellness activities, counselling activities, and IEC for health promotion were limited.
- Lack of trust in public health facilities was noticed. Reasons range from lack of awareness about healthcare workers' availability and service provision, long waiting times, to the rough behaviour of the male staff nurses and doctors.
- Poor governance and supervision, doctors and nurses forcibly divert patients to private facilities. Poor behavioural standards of healthcare workers were observed as some patients were subjected to verbal and physical violence.
- Line-listing, record-keeping and tracking of high-risk pregnant women are not adequate.
- ASHA home visits are nominal in nature and actual assessment of newborns as per HBNC guidelines is not being done. No HBNC Kit was available with the ASHA.
- Non-adherence to proper cold chain maintenance and vaccine stock management was noticed e.g., heat-sensitive vaccine vials with unusable Vaccine Vial Monitor (VVM) and no temperature loggers for the deep freezer.
- The Hospital Maternal Death Review (MDR) committees and Child Death Review (CDR) committees were not formed. MDR and CDR are not being done regularly.
- Counselling services on family planning methods were inadequate. Cases of PPIUCD insertions without consent were observed.

- Low awareness of the WIFS scheme along with a lack of visibility of adolescent health services was observed in the community.
  - DEICs and NRCs were underutilised or not operational. Referral linkages from the field were absent.
  - Gaps in coverage, quality and data entry of Population-Based Screening and CBAC forms were seen. Opportunistic screening of Hypertension and Diabetes was poor and screening of cancers was not being undertaken. Diagnostic services for common cancers are not available at the DH level also. Services under other NCD programmes are not being delivered at the primary level.
  - Transport and quality of samples for testing were not as per protocol (COVID-19, TB, Hepatitis B, HIV, Malaria).
  - Poor TB treatment record maintenance at the PHC level was observed. Some peripheral facilities were unable to use Nikshay Aushadhi despite the training of staff.
  - Several lacunae were noticed in IDSP data quality, functioning of Rapid Response Teams, and use of Integrated Health Information Platform.
  - The services of 104/ 108 ambulances for pick up and drop back of ANC to the delivery points were found to be non-existent in both districts. Response time and availability of ambulances for emergencies were very poor.
- MMU maintenance and outreach plans were inadequate.
- Gaps were noted in critical care emergency services and OT functionality at the DH level.
  - Lack of training and refresher training on a regular basis and consequent skill gaps was an observed gap. Lack of supportive supervision at all levels was seen, especially for ASHAs and ANMs.
  - Lack of processes for storing, monitoring and disposal of expiry drugs in the health facilities was observed. Near-expiry drugs were found in both districts.
  - Most of the facilities' X-ray emitting equipment including CT-Scan was not AERB approved.
  - Staff was unaware and untrained in infection control protocols, NQAS, *Mera Aspataal*, Kayakalp program, and Bio-Medical Waste Management. Only the DH and SDH are integrated with the *Mera Aspataal* portal (Response rate ~ 5%).
  - BMW practices including liquid waste management and infection control practices were poor.
  - PM JAY (Chiranjeevi Scheme) utilisation was low due to the high claim rejection rate.
  - The *e-Sanjeevani* OPD has not started at the level of SDH/CHC/PHC level.
  - A delay in the payment of JSY beneficiaries at all levels was found.



## Sikkim

### Team Composition

Team Lead: Dr. J.N Srivastava	
Team 1 (North Sikkim)	Team 2 (West Sikkim)
Dr. J.N Srivastava, Advisor NHSRC, MOHFW	Dr. S.K Singh, Professor, KGMU
Ms. Asmita Jyoti Singh, Senior Consultant, NHM, MoHFW	Dr. Arpita Agrawal, Consultant, QPS
Dr. Ashish Bhatt, Senior Consultant, RCH, MOHFW	Ms. Diksha Rathee, Junior Consultant, PHA, NHSRC
Mr. Anand Yadav, QPS	Dr. T.R. Dileep, IIPS
Dr. Abhishek Kunwar, NPO, WHO	Dr. Mayank Sharma, SPO, PATH
	Mr. Javeed A Golandaj, PRC
Ms. Charu, NFAMS, MOHFW	

### Facilities Visited

Health Facility Visited	West Sikkim	North Sikkim
District Hospital	District Hospital Gyalshing	District Hospital Mangan
Community Health Center	CHC Soreng	-
Primary Health Center – Health and Wellness Center	PHC Dantum, Sombria, Rinchenpong	PHC Passingdong, Chungthang, Dikschu
Sub Health Center - Health and Wellness Center and Community	Nayabazaar, Bermiok, Bongten	Linthem, Singik, Naga, Lachung
Focus Group Discussion	ASHAs, Community Members	ASHA, PRI members
AWC/Schools		Primary School Singik, ICDS Chungthang, Sr. Secondary School Chungthang
Drug warehouse	District Drug Warehouse	
Others at State Capital	Sir Thutob Namgyal Memorial (STNM) Hospital, DEIC, Call Centre, UPHC Gangtok, State Drug warehouse	

### Achievements

- The State has deployed Community Health Officers (CHOs) in all the 147 Sub health centres in the State.
  - ASHAs were very active in facilitation to provide services for immunization, institutional delivery, counselling services, screening, referral, and follow-up of beneficiaries.
  - Grievance's redressal boxes were kept in the district hospital and PHCs visited.
  - IHCI was initiated under NPCDCS program in Sikkim state from April 2021 starting with East and South districts. Later it was expanded to North district in Aug 2021 and
- West district in Oct 2021. State has initiated the registration of registered Hypertension and Diabetes patients under IHCI program.
- Regular meeting of JAS on monthly basis were held.
  - Rogi Kalyan Samitis are formed and running in all the facilities in the districts visited, majority of the RKS money was being utilized for facility maintenance. Some facilities had also purchased sphygmomanometer, sanitizer, and pulse oximeter from the RKS fund.
  - Population enumeration was largely most of the HWCs visited, however, significant

disruptions in planned activities happened due to COVID-19. During the visits, the team observed that screening for diabetes and hypertension was taking place and most of the people put on treatment in the catchment areas.

## Challenges

- District hospital in north Sikkim district is under construction and is not providing services as per defined scope.
- Availability of HR at District hospital is a major issue, there is no resident gynaecology at District hospital in north Sikkim which make pregnant women to travel capital for the treatment.
- None of the facility in the state is IPHS compliant due to lack of human resources at some facilities while some facilities have more HR against the IPHS norms.
- Unavailability of essential medicines, diagnostics, and ambulance services lead to high out of pocket expenditure. A robust supply mechanism for essential medicines and diagnostics (Scrub Typhus Kit, Anti-snake venom, Rabies, etc.) need to be established in the State to address the OOPE.
- MCH services are not provided at primary level, beneficiaries are supposed to travel District Hospital or STNM hospital in the capital.
- State is facing challenges in conducting regular program review at Block/District and State level.
- Lack of awareness regarding Quality programmes like NQAS, MusQan, LaQshya Mera-Aspataal at ground level.
- Utilization of IT based systems, portals are very less in the State. Trainings of health care workers and ASHAs, ANMs needs to be initiated for various IT applications.
- All facilities were found to be lacking in the necessary hardware equipment to implement and monitor the programs through the various IT applications under the National Health programs except availability of tablets with CHOs.
- PMJAY: The District Authorities informed implementation of PMJAY is a challenge as those really needing those benefits were not in the eligibility list. According to national criteria all SC & ST population are entitled while many of them from this State are well off and do not come forward for such benefits. The district is only able to enroll 8000 out of the 30,000 targets. Many of those in the target group are unwilling to enroll while others who are poorer are out from national eligibility criteria. There is a plan at the state level to prepare a new list, which is again delayed due to COVID-19.
- CRM team observed that all high-risk cases were referred to District Hospital as there was no linkage to ensure shortage of blood and blood products at PHCs. Referred cases were not being followed back at PHCs thereby, disrupting the continuum of care.
- Annual maintenance of medical equipment is a major concern in the State as most of the critical care equipment at District Hospital & CHC are dysfunctional or not functioning properly.
- The Direct Beneficiary Transfer (DBT) under JSY was found delayed for more than 6 months due to the poor internet connectivity and non-linkage of beneficiary with PFMS in North District Mangan.
- Orientation of pharmacists on handling LASA drugs, CMS should also include the tender condition that “labelling of drugs should be distinct for each drug if a suppliers have rate contract for multiple drugs”.
- Non-compliance to the statutory requirements viz. Authorization for BMW, AERB authorization for radiology set-up, NOC for fire safety, etc. was a common observation across the state.
- The time taken in receiving funds from State Treasury to Single Nodal Account is 1–2 months. This delay leads to delay in salary of employees at all the level, delay in programme implementation and delays in training, monitoring, and supervision.

## Tripura

### Team Composition

Team Lead: Maj Gen (Prof.) Dr. Atul Kotwal, SM, VSM	
Team 1 (Khowai)	Team 2 (North)
Maj Gen (Prof) Dr. Atul Kotwal, SM, VSM; ED NHSRC – Team Leader	Dr. Antony Kollanur, Ex ED SHSRC Chhattisgarh – Team Leader
Dr. Sushil K Vimal - DC NUHM	Dr. Deepika Sharma, NHSRC
Dr. Neha Dumka, NHSRC	Dr. Moiz Uddin Ahmad, NHM
Dr. Sandeep Mishra, CTD	Dr. Amrita Sekhar, BMGF
Mr. Sutirtha Mazumder, NHM	Dr. Ankur Yadav, NIHFV
Dr. Rakesh Sharma, HMIS	Dr. Gudakesh, PRC Delhi
Dr. Sanjay Pandey, AIIMS Patna	Dr. Tarannum Ahmed, NHSRC
Dr. Deepak Bhagat, NHSRC	Ms. Tejal Varekar, NHSRC
Dr. Erin Hannah, NHSRC	

### Facilities Visited

Health Facility Visited	Khowai	North
District Hospital	Khowai DH	Dharmanagar DH
Sub District Hospital	Teliamura	Kanchanpur
Community Health Center	Kalyanpur	Kadamtala
Primary Health Center – Health and Wellness Center	Hemanta Debbarma Smriti (HDS) Mungiakami	Jampui
Sub Health Center - Health and Wellness Center and Community	West Karanghicharra Hazarepare	Fulbari Behliangcchip
Urban Primary Health Center	Padampur (West Tripura)	

### Achievements

- During the COVID-19 pandemic, the state conducted mass vaccination drives for hard-to-reach areas with active engagement of local influencers, community mobilizers and religious leaders addressing vaccine hesitancy and achieved 95.43% for 1st dose and 61.68% for the second dose coverage of COVID-19 vaccination.
- The Mayer Ghar initiative facilitates optimal intrapartum and post-partum care for pregnant women and mothers, and address issues of accessibility, acceptability, affordability and related socio-cultural factors.
- 'ASHA Varosha Diwas' effectively organizes monthly meetings with the ASHAs and ASHA facilitators to accelerate motivation, capacity building, skill development and knowledge update along with a platform for grievance redressal, performance monitoring and tracking of performance-based incentives.
- Rashtriya Bal Swasthya Karyakram (RBSK) activities in the state are well organized. Under RBSK, the state has successfully treated 257 cases of congenital heart diseases, 210 cases of cleft lip and cleft palate, 198 cases of club foot, 209 cases of hearing impairment, and 9 cases of hydrocephalus (2019–21).
- The Mukhya Mantri Sustho Shaishab, Sustho Kaishore Abhiyan (MSSSKA) implemented by the Government of Tripura successfully organizes special drives to implement four

programmes including de-worming and diarrhoea control, for target children and adolescents (1–19 years).

- In addition to the NIKSHAY Poshan Yojana, the Government of Tripura offers one-time financial support of Rs. 900/- to each patient at the end of the treatment.
- The number of Kayakalp awarded facilities has increased. Under Kayakalp in FY 2020–21, 50% of DH, 33% of SDH, 43% of CHC, 38% of PHCs, 50% of UPHCs, and 10% of HWC were awarded.

## Challenges

- Operationalization of upgraded infrastructures across the levels of care is challenged by inadequate inputs and processes. Erratic power supply and poor network connectivity were widely reported as barriers for effective service delivery.
- In the absence of MPW-F, the sub-health centers are not designated as HWCs even though the CHOs are positioned in the facilities.
- The principle of care continuum is affected due to factors like the limited role of MO in CPHC, lack of robust referral linkages and follow-up mechanisms.
- Community processes needs strengthening to ensure service reach and access by socially disadvantaged groups and by the tribal population.
- Convergence with urban local bodies is differential. They were neither informed nor aware of their role in the FC-XV grants.
- Emergency and critical care services in secondary level facilities need attention. The facilities lacked distinct spaces for triaging and zoning, while co-existing shortage of manpower, equipment, and emergency medicines led to underutilization of the existing spaces.
- Emergency referral services needs further strengthening. Currently, the average referral time is high and critical equipment in ambulances need urgent redressal.
- Available specialists are not rationalized adequately- rather are overburdened, deputed across the facilities, or underutilized.
- Orientation of NMHP and related activities is an area of concern, given the high suicide rate among 15-39 years age group in the state.
- Inadequate availability of medicines is reported as an issue across the State. At the district level, the store reported receiving only 30% of its current annual demand.
- Most of the visited public facilities are not notified of the free drug initiative. The provisions under the scheme are yet to be implemented. Both the providers and patients expressed unawareness of their entitlements
- Even the primary level facilities are empaneled under AB-PMJAY, where the cost of services and medicines provided is linked to the beneficiaries' monetary entitlement of the scheme. The purchase of medicines by the DH for the patients under the scheme uses up the golden card limit allocated for tertiary services.

## Uttar Pradesh

### Team Composition

District Fatehpur	District Mahoba
Team Lead- Dr. Zoya Ali Rizvi, Deputy Commissioner (AH), MoHFW	
Dr. Zoya Ali Rizvi (Team Leader) - DC (AH)	Dr. Ravinder Kumar, NHM
Er Vikas Sheemar, NHM	Dr. Ranjeet Prasad, NHM
Dr. Agrima Raina, NHM	Ms. Nidhi Verma, NHM
Dr. Shivali Sisodia, NHSRC	Ms. Rupali Mhaskar, NHSRC
Dr. C M Lakshmana, ISEC	Dr. Dharmendra Kumar Yadav, NIHFV
Dr. Sravan Sai Kumar, PGI Chandigarh	Ms. Isha Rastogi, ADB
Dr. Nitish Dogra, IIHMR	Ms. Seema Upadhyay, PFI
Dr. Atreyi Ganguli, WHO	
Mr. Sumanta Kar, NHM Finance	

### Facilities Visited

Health Facility	District Fatehpur	District Mahoba
District Hospital	Male and Female District Hospital converting into Medical College	District Women's Hospital and District Hospital
Community Health Centre	CHC (FRU) Hathgam	CHC Kabrai
	CHC (FRU) Bindki	CHC Panwari
Primary Health Centre/ Health Wellness Centre	PHC, Khajuha (block PHC)	PHC Bharwara
	APHC-HWC, Mawai	PHC Srinagar, Kabrai
	B-PHC Bahua	
Urban – Primary Health Centre	UPHC, Ramganj, Pakka Talaab	UPHC – HWC Bajariya, Bhatipura
Sub- Health Centre/ Health and Wellness Centre	HSC Akbarpur Chorai, Block Hathgam,	Sub Health Center – Salarpur, Kabrai
	HSC-HWC Shah	Sub Health Center – Nakra, Panwari
	SC-HWC, Joniha, Block Khajuha	
Others	Mini Skill lab for GNM at DH	
<b>Community Interactions</b>		
VHSND	Village Purushottampur	Vill Salarpur, Kabrai,
		Vill Nakra, Panwari,
Schools	Upper Middle School Akbarpur Chorai, Block Hathgam,	Upper Primary School, Salarpur
	Girls JHS Jonihan, Block Khajuha	
	Primary School, Jonhan II, Block Khajuha	
Community Meetings attended	Triple A meeting	Mahila Arogya Samiti (UPHC Bajariya)
	ASHA-ASHA Sangini Cluster meeting	
	Mahila Arogya Samiti- Bakarganj	
Communities Visited	Brick kiln community	Vill Nakra, Panwari
Anganwadi Centres		Vill Nakra, Panwari



## Achievements

- SNA has been implemented as per the Guidelines.
- ASHA- ASHA Sangini support structures are well formed.
- e-Kawach App, which is being piloted at Bahua, Fatehpur shows good promise. The app is developed for the ASHAs to help them fill and access the details of their communities. At a click, she is able to know about the health status of the registered families, where all her visits are due, visits she has already conducted and much more. ASHAs seem to be comfortable with the App and eager to learn more. They are looking forward to a full implementation of this App for all the components.
- Accountability of service providers ensured by displaying names and contact details is better implemented at Fatehpur.
- Co-ordination with Education (WIFS)/ WCD (OSC/AAA) was seen in both districts.
- Selection and upgradation of CHCs in lines with ECRP II guidelines is better at Fatehpur.
- Complicated cases referral to DH- a WhatsApp group, consisting of doctors and nurses at the division level, has been created, to ensure quick referral and also follow-up of referred patients. The details of the patient are posted in the group, for early intimation to the DH. The Labour staff from the PHC also calls up the DH Labour Room to ensure that the patient is well-received.

## Challenges

- Issues of electricity supply (despite the availability sufficient funds) and internet availability adversely affect services.

- Storage, Identification and dispensing of drugs to be done in a more systematic manner. Training of Pharmacists for inventory management, IT support and DVDMS.
- Expansion of Telemedicine to all primary health facilities with adequate HR and trainings to support it.
- Regular validation of data entered in HMIS.
- HR rationalisation needed to prevent OOOPE (e.g.: to tackle patient overload on ultrasound).
- Referral mechanisms to the district hospitals are poor at UPHCs.
- Urban ASHA attrition rate is higher than rural.
- Proper filling of forms and training of health professional under IDSP programme. Further IHIP to be implemented at District and early warning signal (EWS) form to be reported on weekly basis for any early detection of outbreak at community level.
- Focused Active Case Finding (ACF) at District level considering the hot spot area for TB cases and best effort to be made from district to achieve 100% NPY on time.
- Teething issues during current DH Transition to MC-Competition between administrative and clinical authorities, Lack of DH, allied health cadre is not in place.
- Adherence to BMW Management guidelines and sterilisation protocols.
- Shortage of HR across all healthcare facilities. Recruitment has slowed down post- COVID-19.
- Intra-departmental coordination between maternal health and CP division for LaQshya, NQAS certifications.
- Utilization of untied funds at HWCs.
- Conducting regular audits- concurrent, Internal, RKS.

## West Bengal

### Team Composition

Team Lead: Dr. Sunil Gupta, DGHS	
Team 1 (North 24 Parganas)	Team 2 (Nadia)
Dr. Sunil Gupta, DGHS	Dr. Ranjan Choudhury, NHSRC
Dr. Arun Aggarwal, PGIMER, Chandigarh	Dr. Vidyadhar Bangal, RMC, Maharashtra
Dr. Veena Iyer, IIPH Gandhinagar	Dr. Soumitra Ghosh, TISS
Dr. Meghashish Sharma, Jhpiego	Dr. Dhruv, WHO
Dr. Surbhi Seth, MoHFW	Ms. Aastha Arora, World Bank
Shahid Ali Warsi, MoHFW	Dr. Arun Srivastava, NHSRC
Ms Vertika Agarwal, NHSRC	Dr. Aashima Bhatnagar, NHSRC
Dr. Swarupa Kshirsagar, NHSRC	Dr. Musarrat Siddiqui, NHSRC
Ms. Bhavya Chadha, MoHFW	Ms. Sakshi, NHSRC
Dr. Sitikantha Banerjee, Jhpiego	

### Facilities Visited

S. No.	Health Facility	North 24 Parganas	Nadia
1	District Hospital	Barasat, Basirhat	Nadia
2	Sub-district Hospital/State General Hospital	SHS- Barrackpore	Nabadwip
3	Rural Hospital	Taki	Karimpur Krishnaganj CHC
4	Block Primary Health Centre		Phulia, Karimpur-II
5	Primary Health Centre	Barunhat, Baberia	Badkulla, Duttaphulia, Shakirpur, Assanagar
6	Urban Primary Health Centre	Madhyagram III Habra- II	Nabadwip III
7	Health & Wellness Centre- Subcentre	Kamdevpur Murarishah	Milan Bagan, Ghola, Narayanpur
8	Other Facilities/Areas		
	CDC	Sandeshkhali II	
	MMU	Sandeshkhali II	
	Nutrition Rehabilitation Centre	Hathgachi	
	ASHA Training Centre		
	Anganwadi Centre		Ghola

## Achievements

- CHOs are being recruited from regular cadre of GNM. They have strong skills and knowledge. They are well versed with use of technology and also adaptive to changes.
- State specific teleconsultation portal “**Swasthya Ingit**” is well adapted across SHC-HWCs. The hubs and spokes are well connected through the user-friendly interface.
- Further, **Store Management Information System (SMIS)** is being regularly used for indenting drugs. It is facilitating timely procurement and assured availability of drugs.
- Daily reports and service delivery reporting in AB-HWC portal is being regularly filled at all AB-HWCs.
- Overall perception of community about AB-HWCs is positive where they mentioned improved availability of drugs and ability to talk to doctor immediately through teleconsultation.
- Convergence- Jan Swasthya Meeting - Monthly meeting on health and convergent action, conducted by Gram Panchayat, with ASHAs and AWCs of the area. VHSNCs are also involved.
- Robust infrastructure for ASHA training, engaging NGO partners -@ Rs. 623 / ASHA day. Good quality of training reflects in good knowledge, skills, and motivation levels of ASHAs. Some field mentoring visits are also done by the ASHA trainers.
- Remarkable decline in the out-of-pocket expenditure per delivery in public health facility is praiseworthy. Community interactions reveal minimal to zero OOPE during childbirth in public health facilities reflecting good implementation of JSSK.
- The line listing of pregnant women and children is well maintained with front line workers. The PHC team is well coordinated and capable of delivering coordinated care in the community.
- ANMs use mobiles/tablets for online entry on the **MatriMa portal** (State's RCH portal):

It is an mApp /Tablet based application is designed to capture the data from the field on real time by the ANMs directly. It includes user friendly FAQ and teaching learning materials developed in Bengali for ANMs

- Provision for privacy as per respectful maternity care was observed in most of the Labour Rooms visited.
- Community Delivery Centre (CDC-Borimani) is operational in a government building facilitated by Gram Panchayat where 2 doctors, 3 nurses and 1 cleaning staff are currently appointed, providing institutional delivery services to the population residing on riverine islands.
- New-born care corner is established as per norms at all visited delivery points. Essential new-born care is being provided by staff nurses. All high case load facilities have provision of Kangaroo mother care with reclining chairs.
- AFHC-**Anwasha clinics** were well established and functional at most places with equipment in places.
- The laboratory services are being provided through in-house mode for regular tests with its own state budget.
- The State has implemented Free Radiology Services (including MRI, CT scan and Digital Radiography) through PPP mode.
- Adherence to infection prevention and control practices despite infrastructural constraints.
- IEC posters, protocols were well displayed, and emergency supplies were adequate.
- Panchayat and rural development department is actively supporting and contributing to the environment and vector management part through vector control team and village level executor.
- Bengal chemist and drug association (BCDA) is actively notifying TB cases and around 25% of new TB cases are referred by private sector.
- Treatment adherence in TB cases is 98%, 48% samples are sent for molecular testing as against the target of 35%

- **Boat-based mobile medical units (MMU)** conduct fixed day clinics for population on riverine islands.
- The PMNDP services, being provided in service agreement model & PPP model, are free for all beneficiaries including drugs and diagnostic services.
- Blood Bank Services: Strong networking system for good communication with other Blood banks & BSUs with sharing of Google Sheet stock status and donor mobilization.
- The state has extended the **Swasthya Saathi programme** to the entire population, which is a significant step towards Universal Health Care which seems to have improved access to secondary and tertiary care in Nadia district.
- Regular collection of Patient Satisfaction Survey form for OPD & IPD patients starting from DH to RH/BPHC & UPHCs and analysis along with Corrective and Preventive Actions for improvement.
- The State had developed a web-portal for measurement of key performing indicators related to hospital operational data, doctors, nurses, patient days and Quality Assurance data which is updated monthly.
- **Fair price diagnostic and dialysis project** are run on PPP mode on various sites across the state. This allows access to free high end diagnostic services for patients at government facility itself and allows affordable prices for private patients as well.

## Challenges

- Population covered by SHC-HWCs is more against the population norms (about 10-12 thousand in some cases, PHCs in Nadia district cater to approx. 79000 population against the norms for 30000)
- Primary health care team – ASHA, ANM and CHOs are not trained in expanded package of services.
- AB-HWC team is less oriented for health promotion activities and observance of health calendar days. There is a limited focus on health promotion and wellness activities in service delivery.
- Currently no mentoring or supportive supervision mechanism is in place for CHOs. While the cadre is skilled and has good knowledge, the support from is still required for sustainability.
- There is lack of clarity on vacant ASHA positions (despite about 8% vacancies) while state has sanctioned additional 2500 new sanctioned positions in FY 2021-22. Comprehensive mapping of population under each block, and each SHC, needs to be undertaken, and uncovered pockets be identified.
- ASHA selection process has no community consultation and Panchayat/ULB involvement (desired as per the fundamental premises of ASHA programme).
- High incidence of teenage pregnancies needing interventions at community level.
- Most of the facilities visited had 50-60 years old infrastructure leading to compromised service delivery, specially at SDH Barrackpore where serious building faults were observed.
- Gross space crunch and inadequate triaging observed across most of the Emergency departments visited.
- No information about Integrated Health Information Platform (IHIP) exist anywhere in the districts
- Patient involvement in decision making regarding medical treatment seems to be lacking, which is an important reason for growing mistrust between patients and health care providers.
- Shortage of Specialists at secondary care facilities is concerning for both the districts visited. Similarly gaps in numbers of Medical Officers, Staff Nurses, LT and other staff at primary care facilities were also reported.
- NQAS and LaQshya certification (Target: 20; Certified: 9) were inadequate across both the districts.









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