



स्वास्थ्य एवं
परिवार कल्याण मंत्रालय
MINISTRY OF
HEALTH AND
FAMILY WELFARE



16th

COMMON REVIEW MISSION REPORT

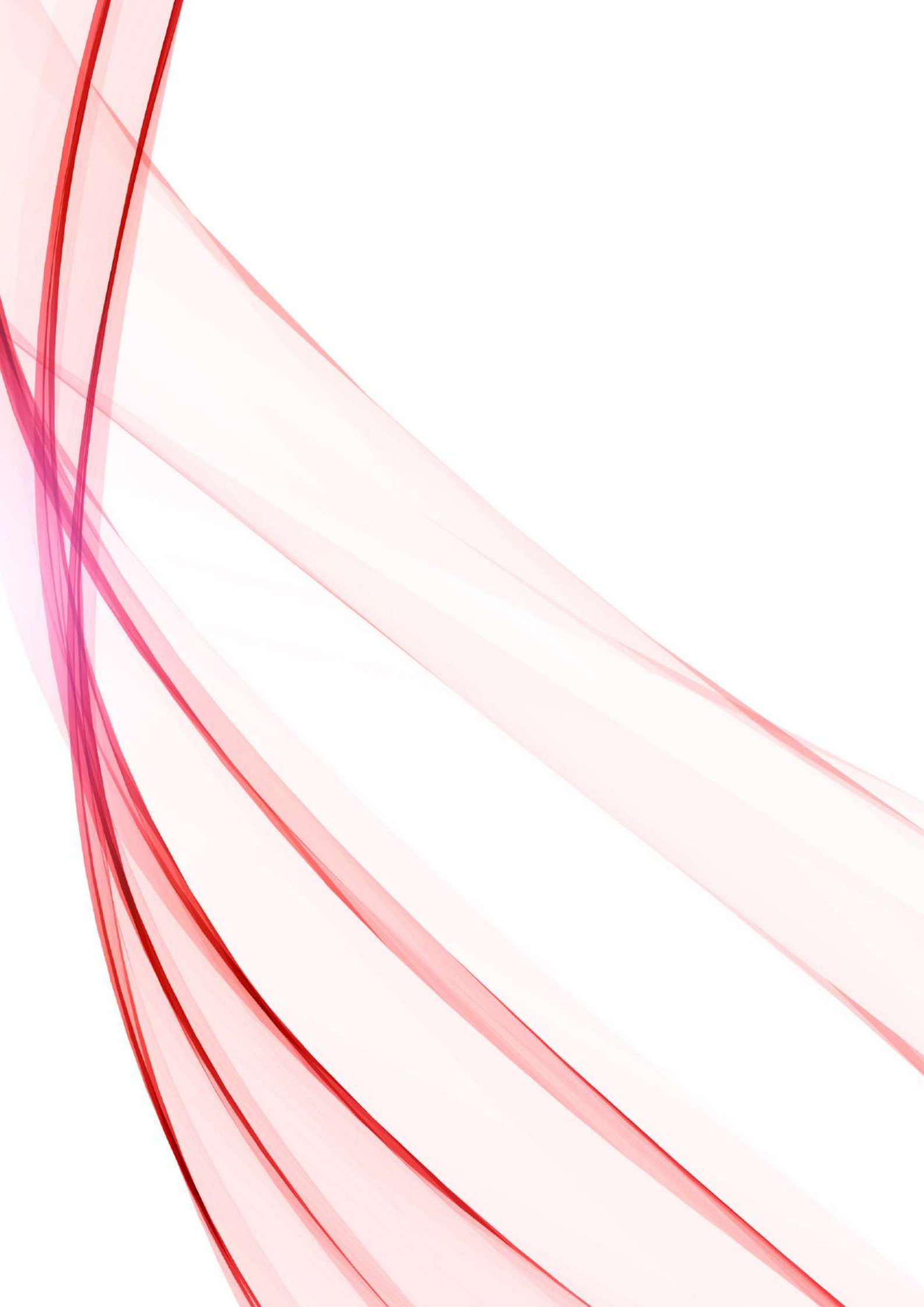


2024

16th

COMMON REVIEW MISSION REPORT

2024





जगत प्रकाश नड्डा
JAGAT PRAKASH NADDA



मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

Minister
Health & Family Welfare
and Chemicals & Fertilizers
Government of India



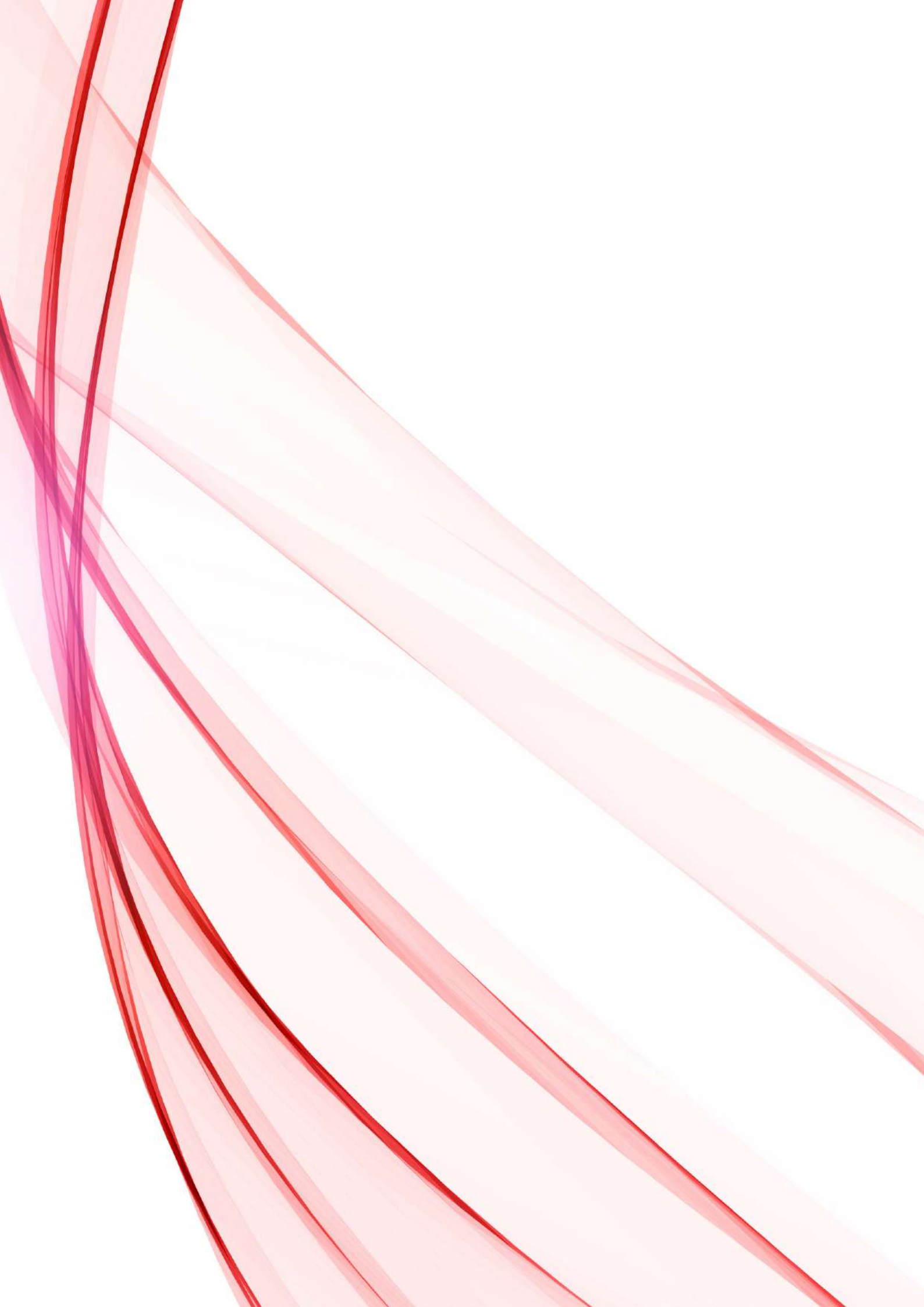
Foreword

The Ministry of Health & Family Welfare is steadfast in its commitment to strengthening India's healthcare system through initiatives like the Common Review Mission (CRM). Over the years, CRM has played an instrumental role in providing objective insights into the functioning of health programs, identifying gaps, and highlighting best practices that drive meaningful improvements in service delivery. These reviews serve as a vital mechanism for evaluating and enhancing health programs, ensuring that policies are not only well-designed, but also effectively implemented across the nation.

2. Regular on-field monitoring is the cornerstone of a responsive and accountable health system. Understanding the realities at the grassroot level allows us to make informed decisions that truly reflect the needs of the people. The Government of India remains dedicated to ensure that every intervention is contextually relevant and equity-driven, with a particular focus on vulnerable populations in hard-to-reach areas. We are committed to translate policy into tangible, life-changing outcomes, ensuring that no one is left behind in the pursuit of health and well-being.

3. As we move forward, we will continue to embrace innovation, digital health solutions, and community-driven initiatives to make healthcare accessible, inclusive, and impactful. Together, we are building a stronger, healthier, and more resilient India, where quality healthcare reaches every citizen, regardless of geography or circumstance. Aligned with the vision of Viksit Bharat, we are committed to ensure that healthcare serves as a pillar of national progress, uplifting every citizen and embodying the spirit of Antyodaya—reaching the last person in need.

(Jagat Prakash Nadda)





सत्यमेव जयते



राज्य मंत्री (स्वतंत्र प्रभार)

आयुष मंत्रालय

व

राज्य मंत्री

स्वास्थ्य एवं परिवार कल्याण मंत्रालय
भारत सरकार

MINISTER OF STATE
(INDEPENDENT CHARGE) OF

MINISTRY OF AYUSH AND

MINISTER OF STATE OF

MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

प्रतापराव जाधव
PRATAPRAO JADHAV



MESSAGE

I am honoured to affirm the Ministry of Health & Family Welfare's commitment to prioritizing the monitoring and evaluation of its healthcare initiatives and programs at both the national and state level through the 16th Common Review Mission (CRM). This approach is essential for identifying key enablers and barriers to the last-mile implementation of quality healthcare, ensuring that the intended health outcomes are effectively achieved.

The Government of India, under its vision of Viksit Bharat 2047, is dedicated to ensuring Universal Health Coverage through equity, accessibility, and affordability for all citizens. Over the years, CRMs have served as a guiding framework, enabling us to navigate the dynamic and evolving healthcare landscape in the country. Like all previous missions, this CRM too has been a significant milestone in assessing national programs and initiatives under the National Health Mission (NHM), providing valuable insights to guide strategic planning and necessary mid-course corrections for improved implementation.

It is pertinent to emphasize that the Government of India under the visionary leadership of Hon'ble Prime Minister Shri Narendra Modi ji and able guidance of Hon'ble Union Minister of Health and Family Welfare, Shri Jagat Prakash Nadda ji, is taking new initiatives to meet the healthcare needs of the people of India.

I extend my sincere gratitude to the CRM teams for their relentless efforts in driving this monitoring mission, which plays a crucial role in accelerating the growth of India's healthcare system. I hope that States and Union Territories will continue their efforts to meet the targets envisioned in the National Health Policy 2017, by addressing challenges and barriers to equitable and affordable healthcare at the district and sub-district levels, paving the way for a golden era of public health in the years to come.

सर्वे भवन्तु सुखिनः। सर्वे सन्तु निरामयाः।

(Prataprao Jadhav)

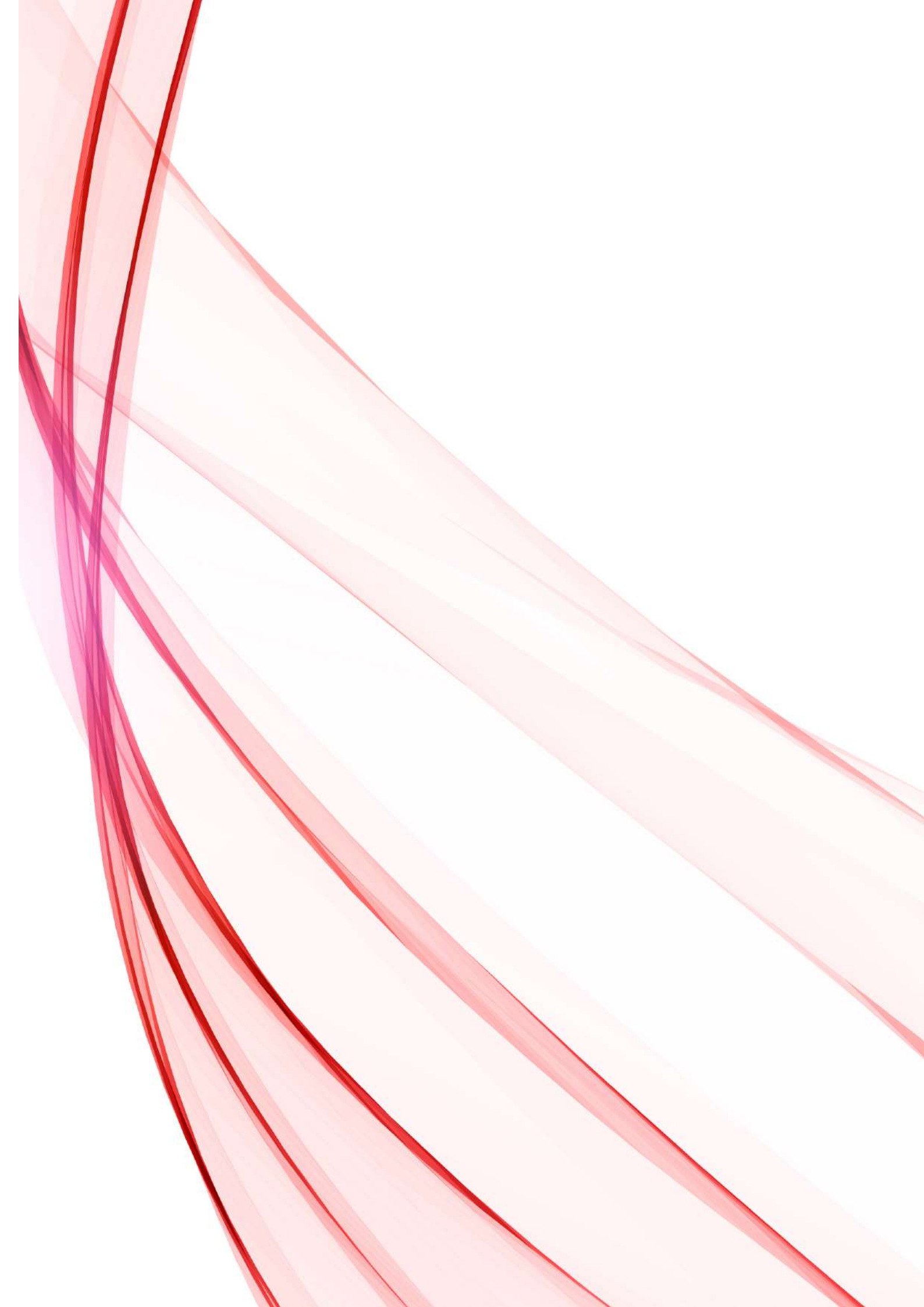
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राज्य मंत्री
स्वास्थ्य एवं परिवार कल्याण
व रसायन एवं उर्वरक
भारत सरकार

MINISTER OF STATE
HEALTH & FAMILY WELFARE
AND CHEMICALS & FERTILISERS
GOVERNMENT OF INDIA

अनुप्रिया पटेल
ANUPRIYA PATEL

Message



The Common Review Mission (CRM) is a pivotal mechanism undertaken by the Ministry of Health & Family Welfare (MoHFW) to assess the implementation National Health Mission (NHM) programs across India's States and Union Territories. Through extensive field visits and stakeholder consultations, the CRM provides a comprehensive and objective overview of how NHM initiatives are functioning in the country. It not only highlights notable achievements but also identifies areas requiring further improvement, ensuring that our strategies remain people-centric and responsive to the evolving healthcare needs of the population.

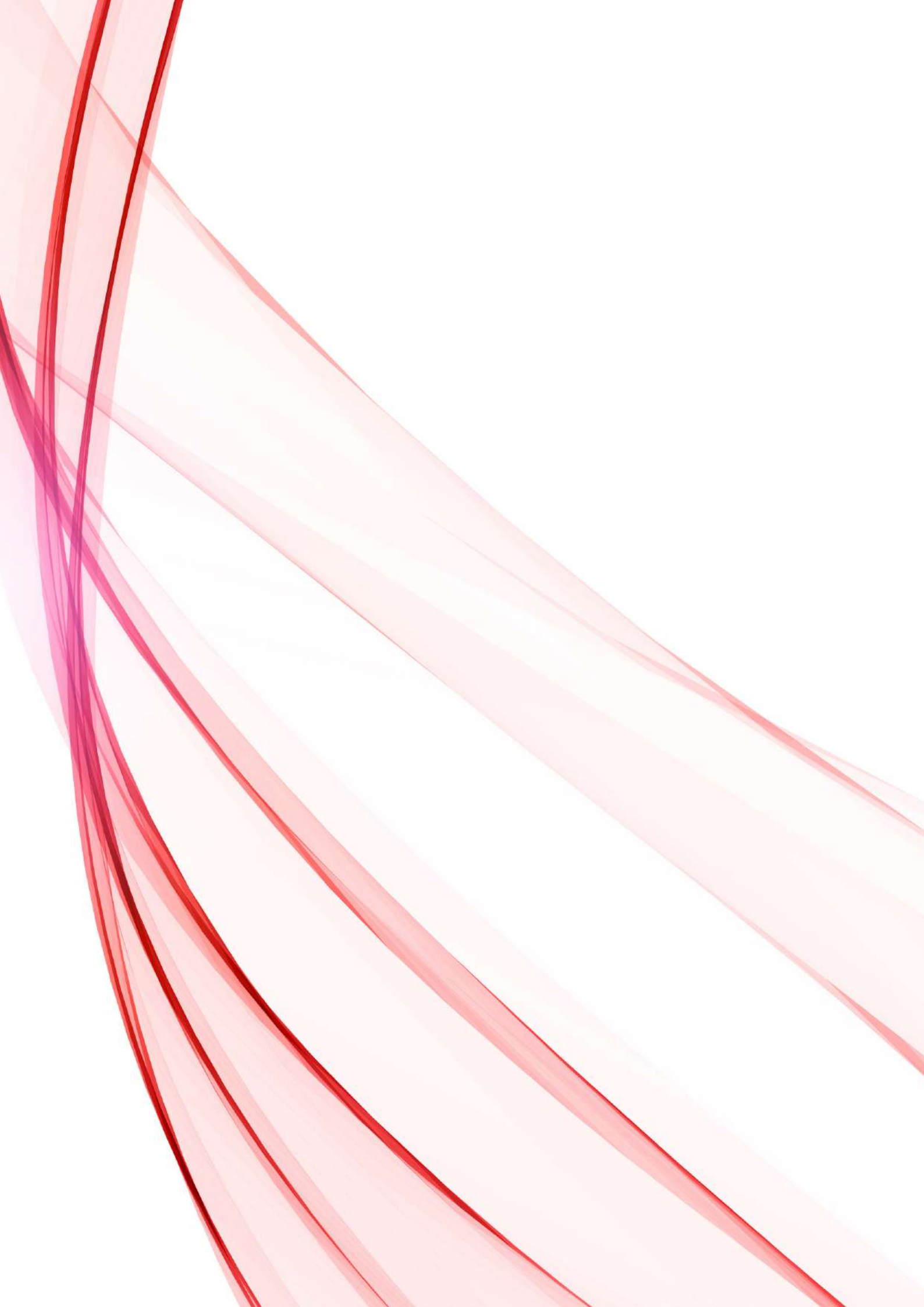
Bringing together a diverse mix of stakeholders, including policymakers, senior program officials, public health experts, researchers, government representatives, PRCs, NGOs, technical partners, and civil society organizations, the CRM facilitates a holistic and in-depth understanding of the ground realities in health systems across the country. This collaborative approach provides a thorough and nuanced perspective, strengthening our systems and guiding us toward a more efficient, equitable, and resilient healthcare framework.

The 16th CRM comes at a crucial juncture as India strives to achieve the Hon'ble Prime Minister, Shri Narendra Modi ji's vision of Viksit Bharat@2047. Government efforts have continuously improved the quality, scale, and cost-effectiveness of healthcare, and regular monitoring, coupled with timely interventions, remains essential in addressing grassroots challenges in program implementation.

I extend my heartfelt gratitude to MoHFW officials, State Governments, healthcare workers, and NHM teams for their dedication in making this mission a remarkable success. I sincerely hope that such robust monitoring practices will continue, serving as a source of motivation and guidance for the public health fraternity as we work towards a stronger, healthier India.

(Anupriya Patel)

February 24, 2025
New Delhi





पुण्य सलिला श्रीवास्तव, भा.प्र.से.
सचिव

PUNYA SALILA SRIVASTAVA, IAS
Secretary



सत्यमेव जयते



भारत सरकार

स्वास्थ्य एवं परिवार कल्याण विभाग

स्वास्थ्य एवं परिवार कल्याण मंत्रालय

Government of India

Department of Health and Family Welfare

Ministry of Health and Family Welfare



FOREWORD

It is with pleasure that I present the 16th Common Review Mission (CRM) Report of the National Health Mission (NHM). This Report provides a comprehensive and insightful assessment of the progress and performance of NHM in 19 States of the country.

NHM has been instrumental in strengthening our health systems and improving key health indicators over the years. The 16th CRM offers a valuable opportunity to reflect on our achievements, identify persistent challenges, and chart a course for future action. The rigorous review conducted by the multi-disciplinary teams has provided us with invaluable feedback on the ground realities, highlighting both the successes and the areas that require our focused attention.

The CRM has focused on the delivery of comprehensive primary and secondary healthcare services, including availability of free medicines and diagnostic services, quality of care; and the progress in leveraging provisions under centrally sponsored schemes like PMABHIM, and XVth Finance Commission - Health Sector Grant. The findings presented in this Report underscore the importance of strengthening the public healthcare infrastructure and services as per the IPHS and National Quality Assurance Standards; addressing human resource gaps; reflecting the cost-benefits of forging strategic partnerships in closing service delivery gaps, and fostering local innovations to meet service delivery goals. They also emphasize the need for greater inter-sectoral coordination, improved accountability mechanisms, routine monitoring and evaluation, and responsive financing practices.

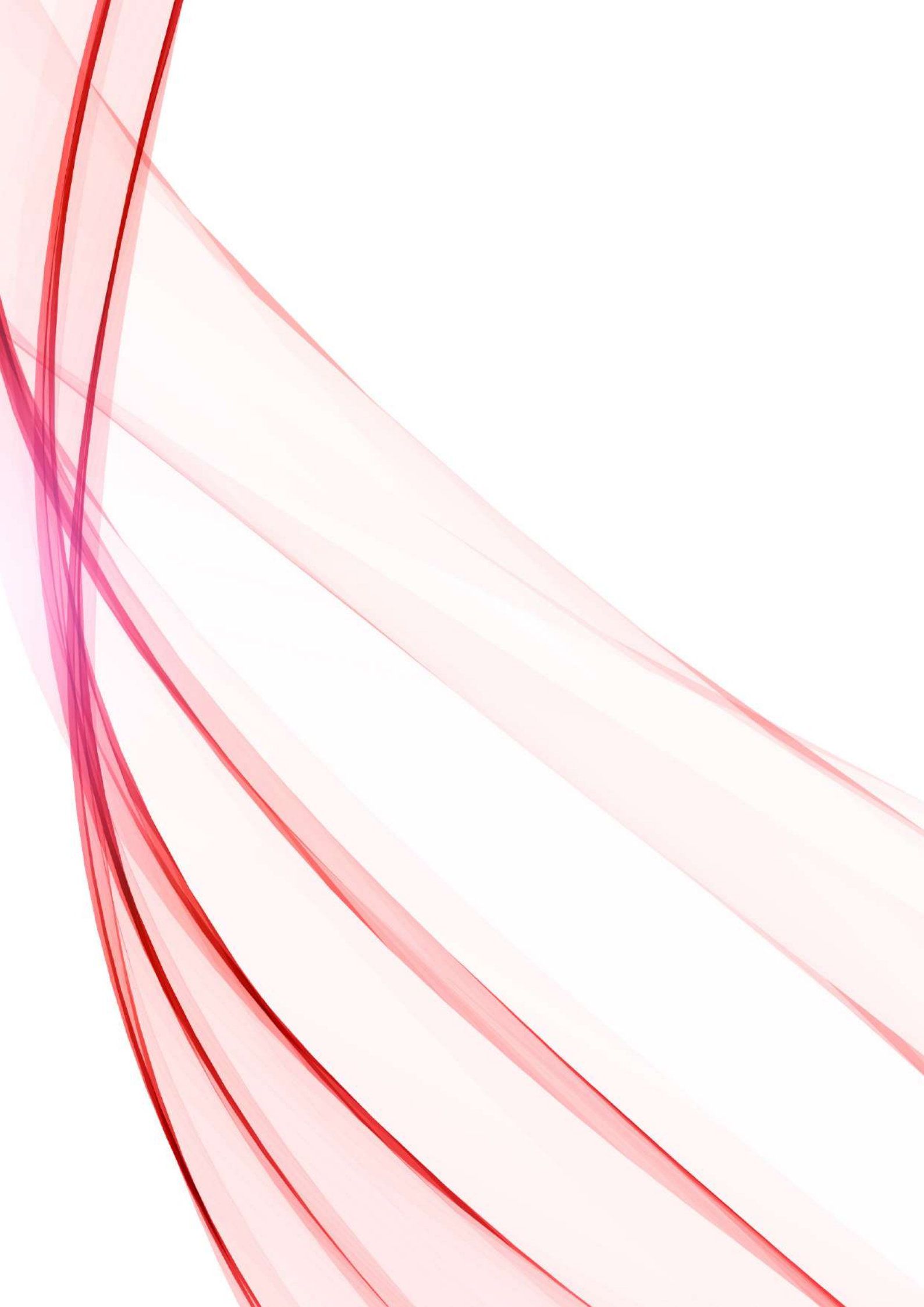
I commend the CRM teams for their diligence in conducting this comprehensive review. I also extend my sincere appreciation to the State Governments, health officials, service providers, and community members for their active participation and cooperation throughout the CRM process.

The recommendations in this Report will be useful to inform our strategies and action plans for strengthening NHM. We are committed to working closely with the States and all stakeholders to address the identified challenges and accelerate our progress towards providing quality and accessible healthcare for all. I am confident that the insights and recommendations presented in this 16th CRM Report will serve as a catalyst for positive change and contribute significantly to our journey towards achieving "Health for All."

Punya Salila
(Punya Salila Srivastava)

Date : 25.02.2025
Place : New Delhi

टीबी हारेगा देश जीतेगा / TB Harega Desh Jeetega





आराधना पटनायक, मा.प्र.से.
अपर सचिव एवं मिशन निदेशक (रा.स्वा.मि.)

Aradhana Patnaik, IAS
Additional Secretary & Mission Director (NHM)



सत्यमेव जयते



आज़ादी का
अमृत महोत्सव

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
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Government of India
Ministry of Health and Family Welfare
Nirman Bhawan, New Delhi-110011



FOREWORD

The Ministry of Health & Family Welfare (MoHFW) prioritizes program monitoring and review as a crucial exercise to assess enablers and barriers in the effective implementation of national health programs. Strengthening healthcare systems remains central to this vision, with the National Health Mission (NHM) driving improvements in service delivery, accessibility, and quality of care.

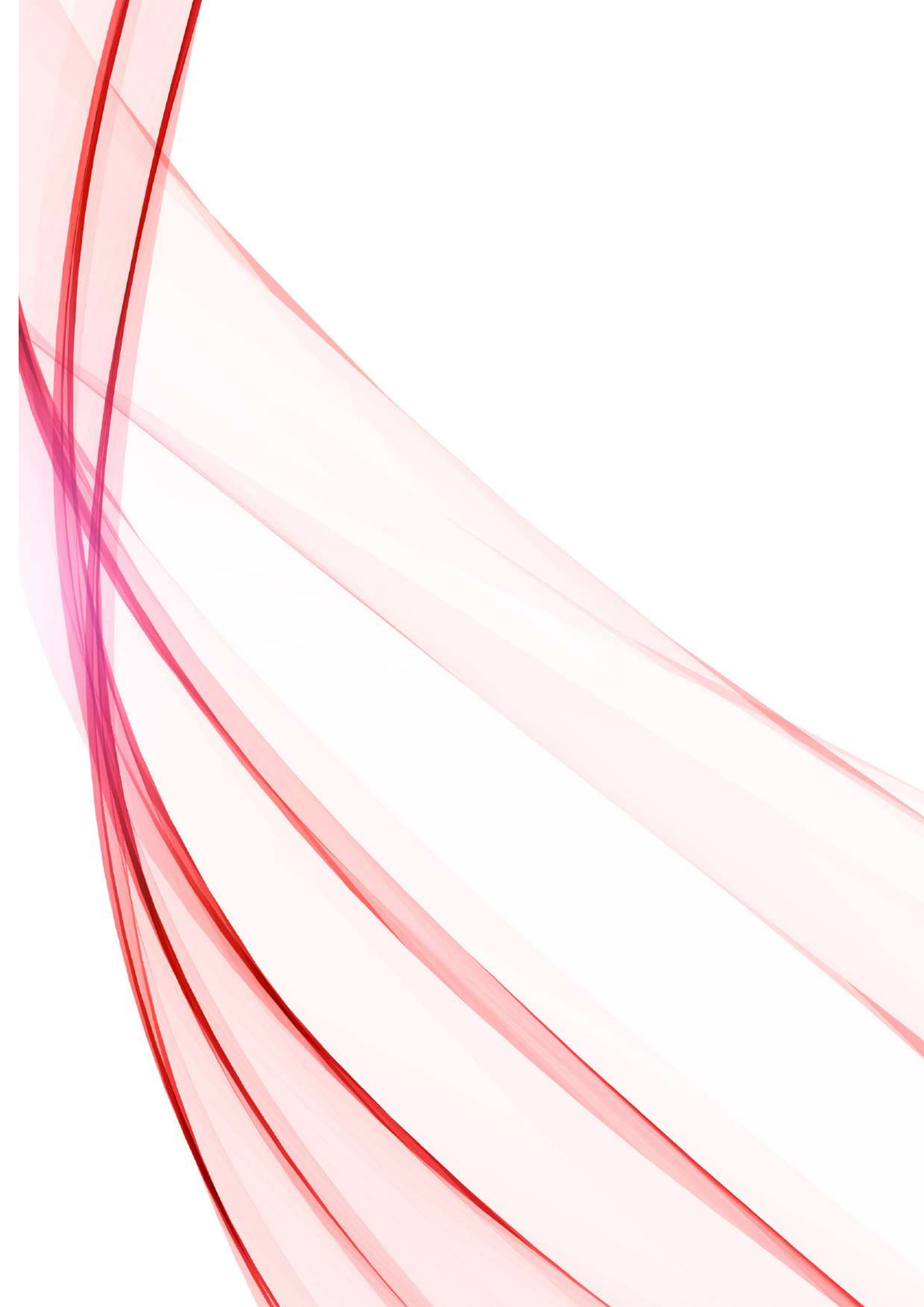
The Common Review Mission (CRM), conducted by the MoHFW and supported by NHSRC, serves as a key mechanism to evaluate and strengthen NHM implementation. The CRM teams, constituted by officials from MoHFW, NHSRC, NITI Aayog, public health experts, and representatives from other ministries, visited 18 States and 1 Union Territory to critically evaluate healthcare services at the primary and secondary levels, including various components of the Ayushman Bharat program. The findings from the CRM play a pivotal role in enhancing the effectiveness of health interventions, reflecting field insights and system preparedness.

The 16th CRM report highlights progress and barriers in Universal Health Coverage, Comprehensive Primary Health Care, digital health interventions, and infrastructural strengthening for service delivery through the Ayushman Arogya Mandir, PM-ABHIM, and XV-FC Health Sector Grant. The report showcases states' commitment to transforming public healthcare institutions to meet the public health and quality assurance standards. Its findings will support evidence-based policy making, helping states and UTs strengthen public health systems across levels.

I extend my sincere appreciation to all stakeholders for their dedication, and unwavering commitment towards ensuring a resilient, inclusive, and efficient healthcare system for India. The findings will help states and UTs strengthen national health programs and Ayushman Bharat, leveraging NHM to enhance public health.

Dated: 25 Feb, 2025


(Aradhana Patnaik)



सौरभ जैन, भा.प्र.से.
संयुक्त सचिव

SAURABH JAIN, IAS
JOINT SECRETARY



Foreword

The Ministry of Health and Family Welfare in coordination with the National Health Systems Resource Centre (NHSRC) undertakes the annual Common Review Mission (CRM) to assess the implementation of the National Health Mission (NHM) across the country. As one of the key monitoring exercises, CRM enables a comprehensive review of health system performance, identifying achievements, challenges, and best practices that contribute to strengthening India's healthcare landscape.

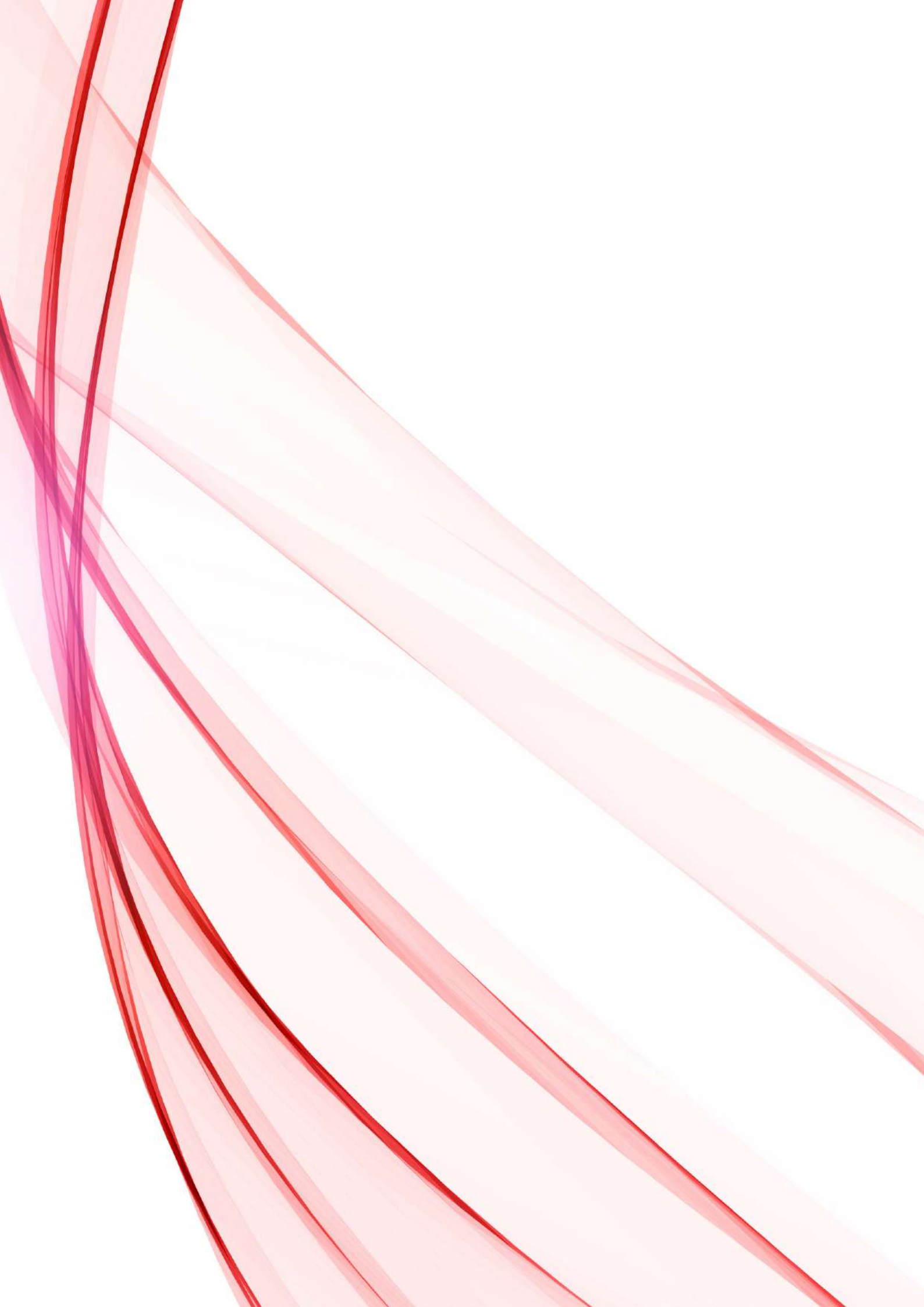
The CRM findings reveal both our achievements and areas needing further attention to make our health systems responsive to our population needs. These insights are vital for shaping our policies and driving continuous improvements in healthcare service delivery. The evidence-based recommendations derived from the CRM reports have been instrumental in guiding our efforts to strengthen public health systems across all levels. By incorporating these findings into our policy framework, we can ensure a resilient, and efficient healthcare system that meets the needs of every citizen.

It is heartening to know the availability of expanded range of services at Ayushman Arogya Mandirs (AAMs), ensuring healthcare closer to communities. The role of ASHAs, ANMs, and Community Health Officers remains central in strengthening service delivery and enhancing community participation. 16th CRM also highlights the achievements and efforts made by States/UTs in strengthening the health systems by implementing newer initiatives like PMABHIM, and XV-FC.

I commend the efforts of all stakeholders from MoHFW, NHSRC and Public Health Experts and state health teams involved in this extensive exercise. Their dedication and commitment to assessing and improving healthcare services have been instrumental in shaping this report.

I believe findings and recommendations of the 16th CRM will serve as valuable inputs for policy planning, enabling data-driven decision-making and further strengthening India's healthcare system.


(Saurabh Jain)



Maj Gen (Prof) Atul Kotwal, SM, VSM

MBBS, MD (PSM), PDF (Epidemiology),
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राष्ट्रीय स्वास्थ्य प्रणाली संसाधन केंद्र
Ministry of Health and Family Welfare
Government of India



Foreword

Common Review Mission (CRM) is a well-established monitoring mechanism under National Health Mission (NHM) undertaken by MoHFW & NHSRC to review the progress made by States & UTs in the implementation of NHM initiatives. The key strategies and priority areas of CRM are to analyse challenges with respect to strengthening health systems and identify trends in the progress of key indicators. By adopting a proactive approach to monitoring, we can drive continuous improvement, foster accountability, and ultimately enhance the access and quality of care provided to all citizens.

Through this rigorous exercise involving stakeholder engagement, and evidence-based evaluation, CRM aims to provide an objective overview of the current state of implementation of Various National Health Programmes and their impact on health outcomes and health systems performance. The 16th CRM report presents a comprehensive analysis of the initiatives implemented within NHM highlighting key learnings, achievements towards enhancing access and quality of care, and also identifying areas for further improvement.

I would like to extend my gratitude to each and everyone who contributed to this herculean task of generating evidence towards effective service delivery in NHM. The commitment of State teams in the field have been invaluable in bringing this important work to fruition.

I believe, that the findings and recommendations outlined in this report would help the States/UTs in planning and further improving the implementation of NHM initiatives to build, a more resilient healthcare system that delivers on the promise of quality healthcare for all.



Maj Gen (Prof) Atul Kotwal

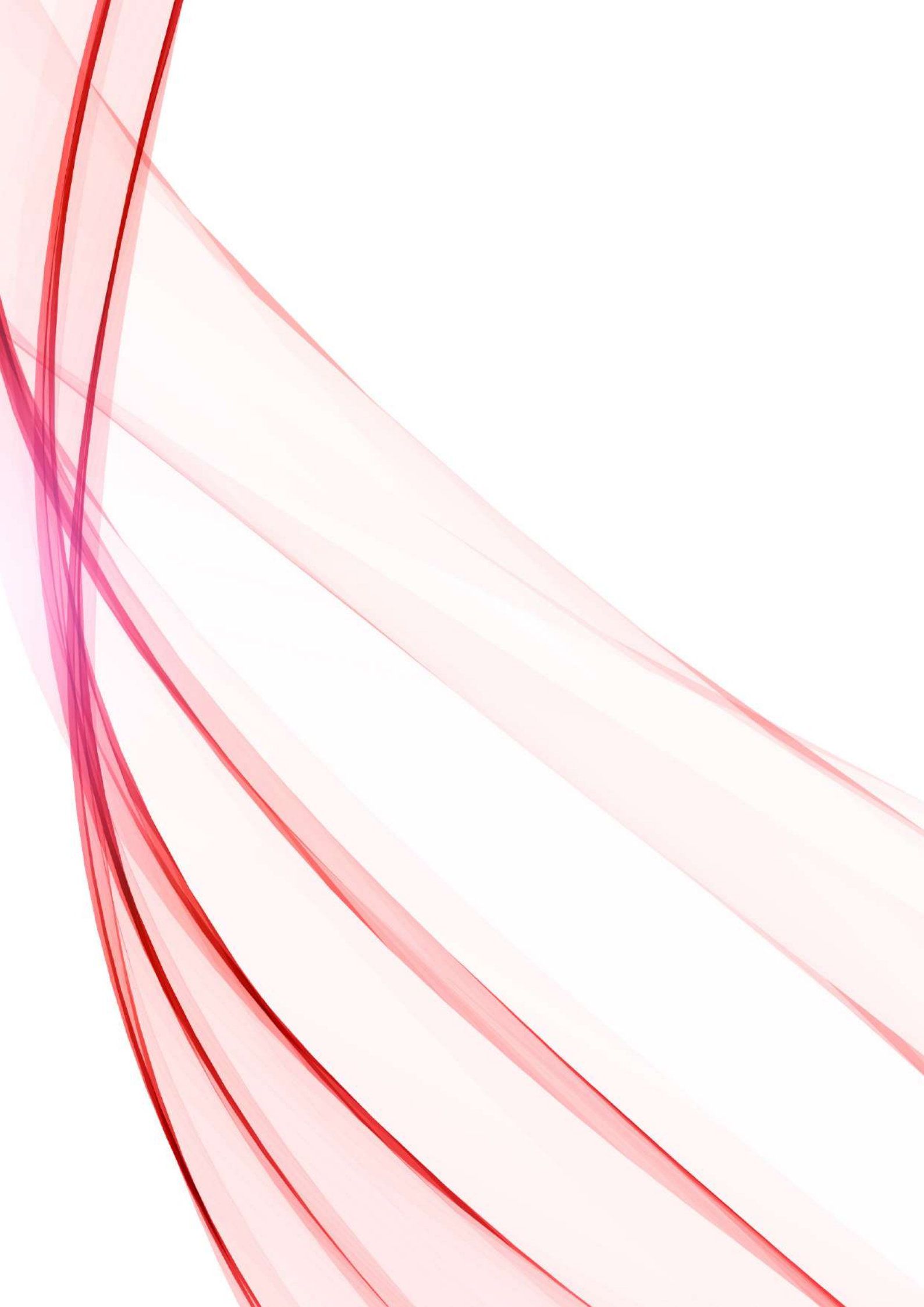


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CRM ABBREVIATIONS

A	
AAM	Ayushman Arogya Mandir
ABHA	Ayushman Bharat Health Account
AB-HWCs	Ayushman Bharat Health and Wellness Centres
AB-SHWP	Ayushman Bharat- School Health & Wellness Programme
AEFI	Adverse Effect Following Immunization
AERB	Atomic Energy Regulatory Board
AFHC	Adolescent Friendly Health Clinic
AIIMS	All India Institute of Medical Sciences
ALS	Advance Life Support
AMC	Annual Maintenance Contract
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
ANM-OL	Auxiliary Nurse Midwife Online
APAR	Annual Performance Appraisal report
APHC	Additional Primary Health Centre
ARS	Anti Rabies Serum
ASHA	Accredited Social Health Activist
ASV	Anti Snake Venom
AWC	Aanganwadi Centre
AWW	Aanganwadi Worker
B	
BCC	Behavioural Change Communication
BCM	Block Community Mobiliser
BCSU	Blood Component Separation Unit
BEMMP	Biomedical Equipment Maintenance and Management Program
BLS	Basic Life Support
BMW	Bio Medical Waste
BPHU	Block Public Health Unit
BPL	Below Poverty Line
C	
CBAC	Community Based Assessment Checklist
CBNAAT	Cartridge Based Nucleic Acid Amplification Test
CBWTF	Common Biomedical Waste Treatment Facility
CDR	Child Death Review
CDSR	Child Death Surveillance and Response
CEA	Clinical Establishment ACT
CHC	Community Health Centre
CHO	Community Health Officer
CLMC	Comprehensive Lactataion Management Centre

CMC	Comprehensive Maintenance Contract
CMHO	Chief Medical and Health Officer
CMO	Chief Medical Officer
COPD	Chronic Obstructive Pulmonary Disorder
COTPA	Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act
COVID	Coronavirus Disease
CPAP	Continuous Positive Airway Pressure
CP	Community Process
CPHC	Comprehensive Primary Health Care
CPR	Cardio Pulmonary Resuscitation
CRM	Common Review Mission
CSR	Corporate Social Responsibility
D	
DBT	Direct Benefit Transfer
DEIC	District Early Intervention Centre
DEO	Data Entry Operator
DH	District Hospital
DLSA	District Legal Service Authority
DMC	Designated Microscopic Centre
DMHP	District Mental Health Programme
DNB	Diplomat of National Board
DOTS	Directly Observed Treatment Short Course
DPHL	District Public Health Laboratory
DQAC	District Quality Assurance Committee
DQAU	District Quality Assurance Unit
DTC	District Tuberculosis Centre
DTFI	District Task Force for Immunization
DVDMS	Drug Vaccine Distribution & Management System
E	
ECD	Early Childhood Development
ECPs	Emergency Contraceptive Pills
ECRP	Emergency Covid Response Package
EDL	Essential Drug List
ELISA	Enzyme Linked Immunosorbent Assay
EML	Essential Medicine List
EMR	Electronic Medical Record
EPFO	Employee Provident Fund Organisation
e-VIN	Electronic Vaccine Intelligence Network

F	
FBNC	Facility Based Newborn Care
FPLMIS	Family Planning Logistics Management Information System
FRU	First Referral Unit
FSSAI	Food Safety and Standards Authority of India
FY	Financial Year
G	
GAD	General Anxiety Disorder
GDMO	General Duty Medical Officer
GDP	Gross Domestic Product
GNM	General Nurse Midwife
GPS	Global Positioning System
GSDP	Gross State Domestic Product
GGE	General Government Expenditure
GoI	Government of India
H	
Hb	Haemoglobin
HbIg	Hepatitis B immunoglobulin
HBNC	Home Based Newborn Care
HBsAg	Hepatitis B Surface Antigen
HYBC	Home Based Care for Young Children
HCV	Hepatitis C Virus
HDU	High Dependency Unit
Hep.B	Hepatitis B
HIV	Human Immuno Deficiency Virus
HMIS	Health Management Information System
HPV	Human Papilloma Virus
HR	Human Resources
HRH	Human Resources for Health
HRMIS	Human Resource Management Information System
HRP	High Risk Pregnancy
HTN	Hypertension
HVAC	Heating Ventilation Air Conditioning
HWCs	Health & Wellness Centres
I	
ICC	Internal Complaint Committee
ICDS	Integrated Child Development Scheme
ICTC	Integrated Counselling and Testing Centre
ICU	Intensive Care Unit
IDCC	Interdepartmental Coordination Committee
IDSP	Integrated Disease Surveillance Programme
IEC	Information Education Communication
IFA	Iron & Folic Acid

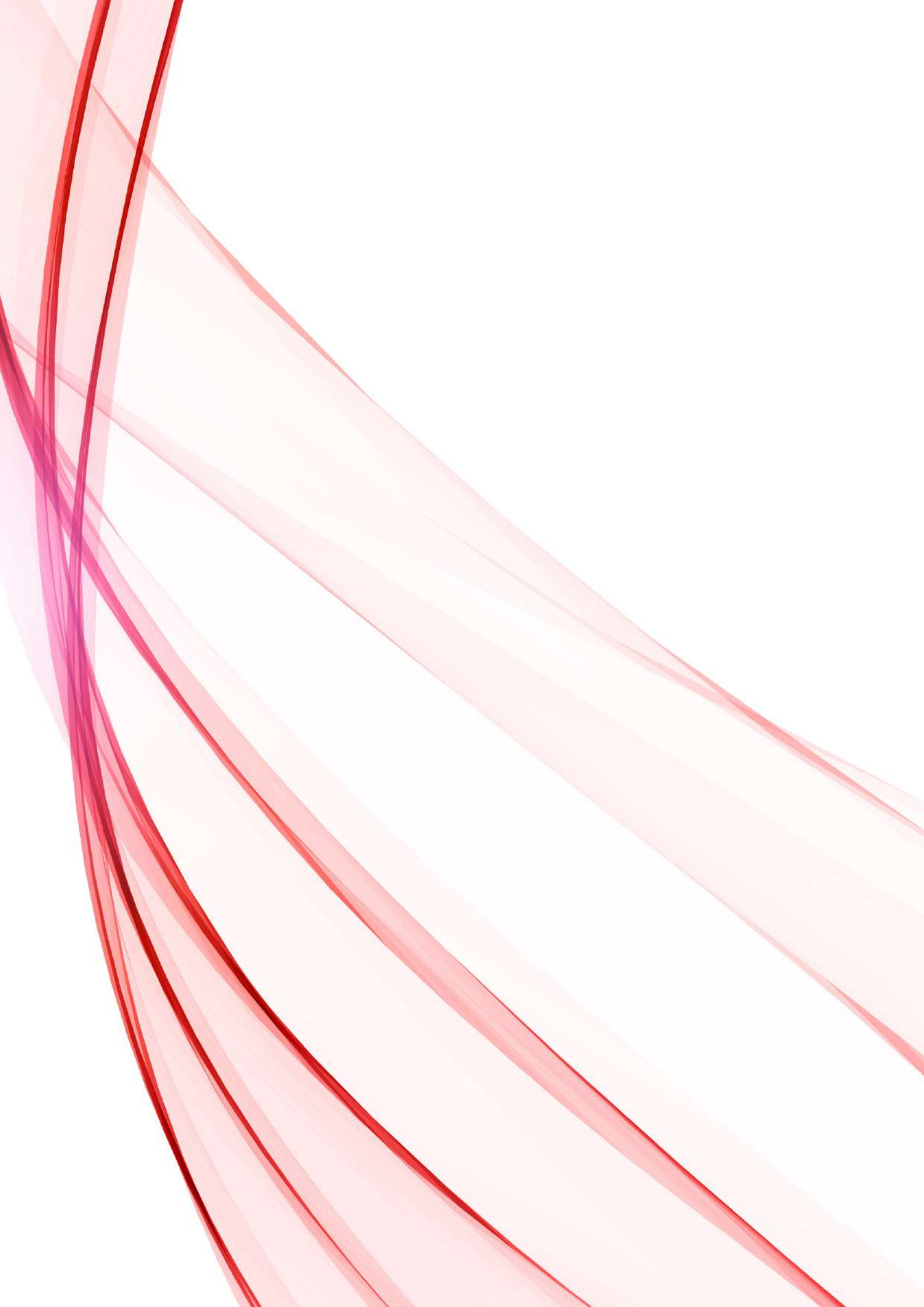
IHIP-	Integrated Health Information Portal
IIPH	Indiana Institute of Public Health
ILR	Ice Lined Refrigerator
IPC	Infection Prevention and Control
IPD	In Patient Department
IPHL	Integrated Public Health Laboratory
IPHS	Indian Public Health Standards
IT	Information Technology
IUCD	Intrauterine Contraceptive Devices
IYCF	Infant and Young Child feeding
J	
JAS	Jan Arogya Samiti
JSSK	Janani Shishu Suraksha Karyakaram
JSY	Janani Suraksha Yojana
KMC	Kangaroo Mother Care
LAMA	Left Against Medical Advice
LBW	Low Birth Weight
LCDC	Leprosy Case Detection Campaign
LDR	Labour Delivery Recovery
LLINs	Long Lasting Insecticidal Nets
LT	Laboratory Technician
M	
MAA	Mother's Absolute Affection
MAS	Mahila Arogya Samiti
MBBS	Bachelor of Medicine, Bachelor of Surgery
MCH	Maternal and Child Health
MCP	Mother and Child Tracking
MCR	Microcellular Rubber
MDSR	Maternal Death Surveillance and Response
MDT	Multi Drug Therapy
MGPS	Medical Gas Pipeline System
MHCA	Mental Health Care Act
MHT	Mobile Health Team
MLC	Medico Legal Case
MLHP	Mid Level Healthcare Provider
MMA	Medical Methods of Abortion
MMUs	Mobile Medical Units
MO	Medical Officer
MoHFW	Ministry of Health and Family Welfare
MPCDSR	Maternal, Perinatal, Child Death Surveillance and Response
MPWs	Multipurpose Workers
MRI	Magnetic Resonance Imaging
MR	Measles Rubella

MTP	Medical Termination of Pregnancy
MVA	Manual Vacuum Aspiration
N	
NBCC	Newborn Care Corner
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organisation
NHA	National Health Accounts
NHM	National Health Mission
NICU	Neonatal Intensive Care Unit
NIDDCP	National Iodine Deficiency Control Programme
NIHFW	National Institute of Health and Family Welfare
NIMHANS	National Institute of Mental Health and Neuro Sciences
NLEP	National Leprosy Eradication Programme
NMHP	National Mental Health Programme
NMTI	National Midwife Training Institute
NOHP	National Oral Health Programme
NPA	Non-Practicing Allowance
NPCBVI	National Programme for Control of Blindness and Vision Impairment
NP-NCD	National Programme for Control of Cardiovascular diseases, Cancer and Stroke
NPHCE	National Programme for Healthcare of Elderly
NPPC	National Programme for Palliative Care
NPPCF	National Programme for prevention and Control of Fluorosis
NPS	New Pension Scheme
NPY	Nikshay Poshan Yojana
NQAP	National Quality Assurance Programme
NQAS	National Quality Assurance Standards
NRC	Nutritional Rehabilitation Centre
NRCP	National Rabies Control Programme
NSSK	Navjat Shishu Suraksha Karyakaram
NSV	Non-Scalpel Vasectomy
NTEP	National Tuberculosis Elimination Programme
NUHM	National Urban Health Mission
NVBDCP	National Vector-borne Disease Control Programme
NVHCP	National Viral Hepatitis Control Programme
O	
OBGYN	Obstetrician Gynaecologist
OCPs	Oral Contraceptive Pills
OGTT	Oral Glucose Tolerance test
OOPE	Out of Pocket Expenditure
OPD	Out Patient Department
OSC	One Stop Centre
OT	Operation Theatre

P	
PBI	Performance Based Incentive
PCPNDT	Pre-Conception Pre Natal Diagnostic Test
PCTS	Pregnant Women & Child Tracking System
PECA	Prohibition of Electronic Cigarettes Act, 2019
PEP	Post Exposure Prophylaxis
PFMS	Public Fund Management System
PG Portal	Public Grievance Portal
PG	Post Graduation
PGIMER	Post Graduate Institute of Medical Education and Research
PGMO	Post Graduate Medical Officer
PHC	Primary Health Centre
PHMC	Public Health Management Cadre
PHN	Public Health Nurse
PHQ	Public Health Questionnaire
PICU	Paediatric Intensive Care Unit
PIP	Programme Implementation Plan
PLP	Performance Linked Payment
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PM-CARES	Prime Minister's Citizen Assistance and Relief in Emergency Situations
PMJAY	Pradhan Mantri Jan Arogya Yojana
PMJJBY	PM Jeevan Jyoti Bima Yojna
PMNDP	Pradhan Mantri National Dialysis Programme
PMS	Progress Management System
PMSBY	Pradhan Mantri Suraksha Bima Yojana
PMSMA	Pradhan Mantri Surakshit Matritav Aashwasan
PMSYMY	Pradhan Mantri Shram Yogi Maan Dhan Yojna
PMU	Programme Management Unit
PNC	Post Natal Care
POC	Point of Care
POCSO	Prevention of Children from Sexual Offenses
POSH	Prevention of Sexual Harassment
POSHAN	Prime Minister Overarching scheme for Nourishment
PPE	Personal Protective Equipment
PPIUCD	Post Partum Intra Uterine Contraceptive Device
PPP	Public Private Partnership
PR&RD	Panchayati Raj & Rural Development
PRCs	Population Research Centres
PRI	Panchayati Raj Institutions
PSA	Pressure Swing Adsorption Plant
R	
RBD	Registration of Births and Deaths

RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
RDK	Rapid Diagnostic Kit
RHFWTC	Regional Health and Family Welfare Training Centre
RI	Routine Immunisation
RKS	Rogi Klayan Samiti
RKSK	Rashtriya Kishor Swasthya Karyakram
RMC	Respectful Maternity Care
RMDs	Rural Medical Dispensaries
RMNCH	Reproductive Maternal Newborn Child Health
RTI	Reproductive Tract Infection
S	
SAM	Severe Acute Malnutrition
SBA	Skilled Birth Attendant
SDH	Sub District Hospital
SHCs	Sub Health Centres
SHP	School Health Programme
SHS	State Health Society
SHSRCs	State Health Systems Resource Centres
SIHFW	State Institute of Health and Family Welfare
SIHMC	State Institute of Health Management and Communication
SMTI	State Midwifery Training Institute
SN	Staff Nurse
SNA	Single Nodal Agency
SNCU	Special Newborn Care Unit
SOP	Standard Operating Procedure
SQAC	State Quality Assurance Committee
SRS	Sample Registration System
STEMI	ST Elevated Myocardial Infarction
STG	Standard Treatment Guidelines
STP	Sewage Treatment Plant
SUMAN	Surakshit Matritva Aashwaswan
T	
TAT	Turn Around Time
TB	Tuberculosis
TCC	Tobacco cessation center
TeCHO	Technology Enabled Community health Operations
TISS	Tata Institute of Social Sciences
TLD	Thermoluminescence Dosimeter
T-MANAS	Tele Mental Health Assistance and Networking Across States
TMIS	Training Management Information System
TNA	Training Needs Assessments

ToR	Terms of Reference
TPT	Tuberculosis Preventive Treatment
TU	Tuberculosis Unit
U	
UCHC	Urban Community Health Centre
UHID	Unique Health Identification
UHND	Urban Health and Nutrition Day
UHCW	Urban Health and Wellness Centre
UIP	Universal Immunisation Programme
ULB	-Upper Local Body
UPHC	Urban Primary Health Centres
USG	Ultrasonography
UT	Union Territory
V	
VHC	Village Health Council
VHN	Village Health Nurse
VHND	Village Health and Nutrition Day
VHSNC	Village Health Sanitation and Nutrition Committee
VIA	Visual Inspection with Acetic Acid
VVM	Vaccine vial Monitor
W	
WCD	Women and Child Development
WIFS	Weekly Iron and Folic Acid Supplementation





**MANDATE &
METHODOLOGY OF
16TH CRM**

16th

OVERVIEW

The National Health Mission (NHM) denotes a coordinated effort towards health systems' reforms in the country. Every year, the Common Review Mission (CRM) is organized by the Ministry of Health & Family Welfare (MoHFW) in various states to evaluate the effectiveness of several National programmes within the National Health Mission (NHM). Common Review Mission undertaken so far has provided valuable insights and understanding of the strategies which were successful and have led to several significant mid-course adjustments.

This year the CRM field visits were undertaken from 18th to 23rd November 2024 in 17 States/UT namely Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu and Kashmir, Karnataka, Tripura, Mizoram, Odisha, Rajasthan, Madhya Pradesh, Uttarakhand, Uttar Pradesh, West Bengal and from 26th to 30th November 2024 in two states (Jharkhand, and Maharashtra).

OBJECTIVES

The objectives of the CRM is to undertake a rapid assessment of implementation status of NHM and its key strategies and priority areas, analyse strengths and challenges with respect to health system strengthening, identify trends in progress of key indicators, particularly relating to coverage, equity, quality and affordability at state, district/ sub-district, and community level, document innovations and best practices, evaluate readiness of states to undertake implementation of newer initiatives, review the progress and coordination mechanisms with various partners. Another focus of the CRM is to assess the implementation status of Ayushman Bharat-Ayushman Arogya Mandir (AAM) and availability of expanded package of comprehensive primary healthcare services at these upgraded AAM-PHCs and AAM-SHCs in the states.

TERMS OF REFERENCE OF THE 16TH CRM

The terms of reference (ToR) 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 16TH CRM

The 16th CRM covered 18 states and one Union Territory. The States were Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Karnataka, Tripura, Maharashtra, Mizoram, Odisha, Rajasthan, Madhya Pradesh, Uttar Pradesh, Uttarakhand, and West Bengal.

TEAM COMPOSITION

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

1. Government Officials
 - a. Officials of the MoHFW, GoI
 - b. Regional Directors of Health & Family Welfare
 - c. Officers from other Central Ministries and NITI Aayog
2. Public Health Experts
 - a. Non-official member of Mission Steering Group of NHM

- b. Non-official member of Empowered Programme Committee of NHM
3. Public Health Experts from the National Health Systems Resource Centre (NHSRC), National Institute of Health & Family Welfare (NIHFW), State Health Systems Resource Centres (SHSRCs), Public Health Foundation of India (PHFI), other credible academic institutions like Indian Institute of IIMR, Tata Institute of social sciences (TISS), Post Graduate Institute of Medical Education and Research (PGIMER), Public Health Experts (IAPSM) from Medical Colleges including AIIMS and School of Public Health.
4. Population Research Centres (PRCs)
5. Consultants from various divisions of the MoHFW and NHSRC

METHODS

To conduct the 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, latest 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 ToRs, and relevant findings from past CRM reports.

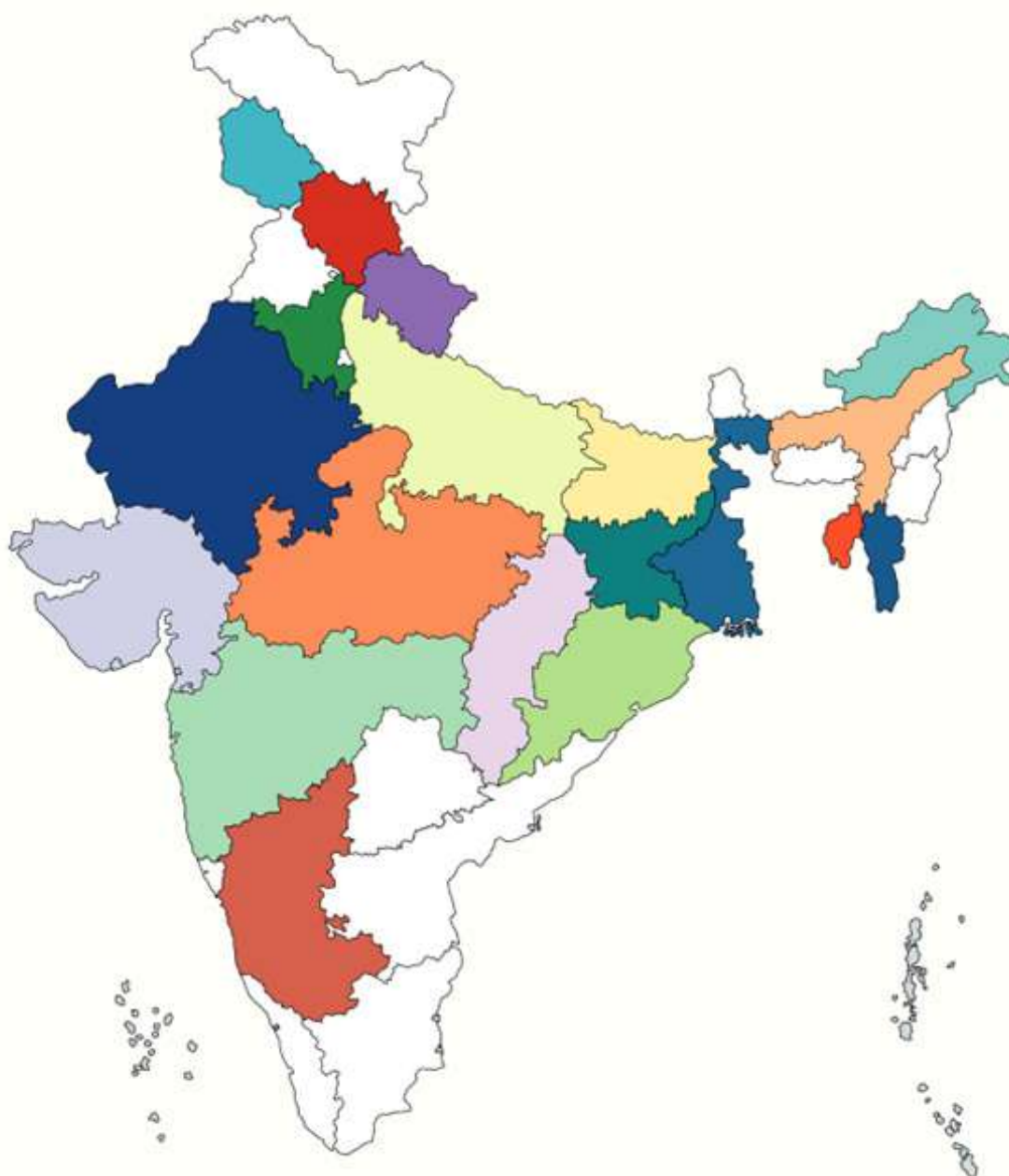
The CRM teams received briefings at the State and districts on the progress made by them on all NHM programmes. Subsequently, field visits were conducted in selected districts for next three to four days. The interactions were planned to begin with the community and continued to examine service provision from AAM onwards up to the district/state levels in rural and urban areas, on the principle of the continuum of care.

The facility visits were undertaken at DH/ SDH, CHCs/ UHCs, AAM-PHCs/UPHC, and AAM-SHC. Interviews were held with ASHAs, AWWs, ANMs, VHSNC/MAS/JAS members. Interactions were conducted with community representatives, including beneficiaries and community in two villages/slums. 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.

LIST OF STATES AND DISTRICTS VISITED IN 16TH CRM

Sr. No	Name of State	District-1	District 2
1	Arunachal Pradesh	West Siang	Longding
2	Assam	Morigaon	Baksa
3	Bihar	Kaimur	Gaya
4	Chhattisgarh	Jashpur	Gariyaband
5	Gujarat	Vadodara	Kachchh
6	Haryana	Panchkula	Rewari
7	Himachal Pradesh	Hamirpur	Shimla
8	Jammu and Kashmir	Baramulla	Reasi
9	Jharkhand	East Singhbhum	Sahebganj
10	Karnataka	Dakshin Kannada	Bellarri
11	Madhya Pradesh	Rewa	Balaghat
12	Maharashtra	Akola	Sindhudurg

13	Mizoram	Lunglei	Kolasib
14	Odisha	Koraput	Sambalpur
15	Rajasthan	Bharatpur	Sikar
16	Tripura	West Tripura	Dhalai
17	Uttar Pradesh	Agra	Kushinagar
18	Uttarakhand	Dehradun	Bageshwar
19	West Bengal	Malda	24 South Pargana



GEOGRAPHICAL COVERAGE OF 16TH CRM



**TOR 1:
COMPREHENSIVE PRIMARY
HEALTHCARE SERVICES**

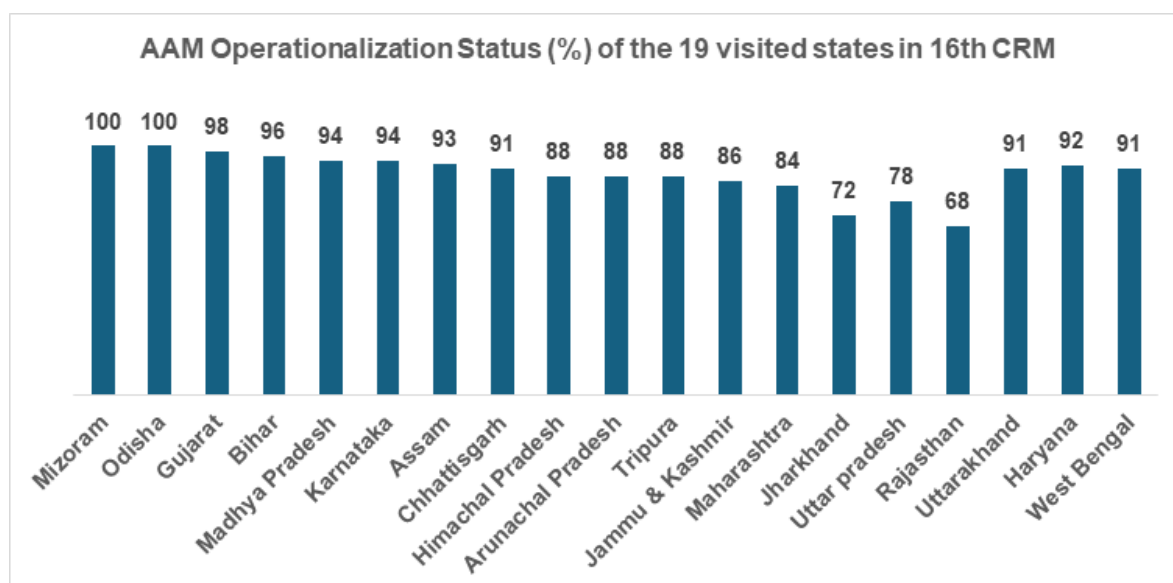
NATIONAL OVERVIEW

- Ayushman Bharat, a flagship initiative of the Government of India, was launched 2018 in tune with commitment of National Health Policy 2017. It aligns with the vision of Universal Health Coverage (UHC) and the commitment to “leave no one behind.” The Ayushman Arogya Mandir (AAM) facilities offer comprehensive primary healthcare services covering promotive, preventive, curative, rehabilitative, and palliative care, and ensuring free of cost quality services closer to the community.
- With the establishment of AAM closer to the community, comprehensive primary health care is being provided in a more citizen centric approach across the public health care system. As of February 2025, 176,500 AAM are operational across the country. An “Operationalized” AAM signifies that repairs, renovations, and branding of the infrastructure are complete; positioning of Community Health Officer (CHO) is ensured at SHC level ; the availability of drugs and diagnostics has been expanded as per the guidelines; health services have broadened from the previously limited maternal and child health services to include non-communicable diseases (NCDs) and expanded service packages, incorporating newer components like yoga and wellness. Along with this, financial reforms in the form of performance-based and team-based incentives, have been introduced. At the community level, over one million ASHAs are involved in raising awareness and mobilizing people to utilize these healthcare services. Consequently, functional AAM facilities have brought services closer to people’s homes, which is reflected through increased footfalls.

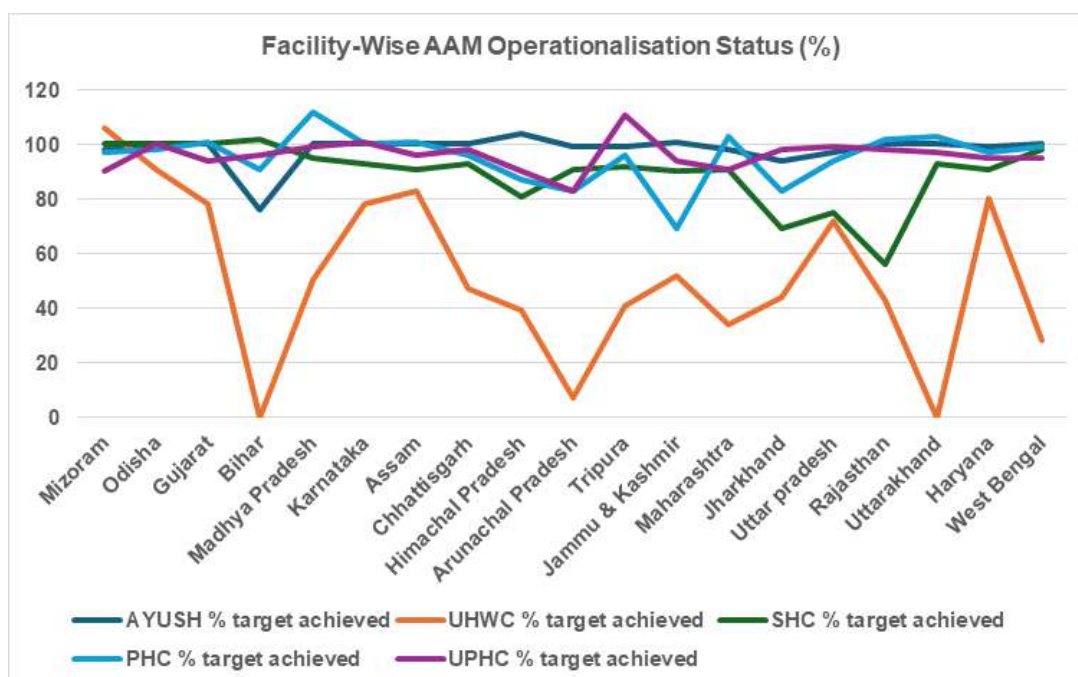
KEY OBSERVATIONS

A) Operationalization Of Ayushman Bharat- Ayushman Arogya Mandir and Delivery of 12 Packages of Comprehensive Primary Healthcare Services (CPHC) in Both Urban And Rural Areas

- The 16th CRM spanned 19 states/UTs including Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Mizoram, Odisha, Rajasthan, Tripura, Uttar Pradesh, Uttarakhand, and West Bengal. The progress of AAM operationalization against their approval and the facility-wise AAM operationalization status are depicted in the graphs below:



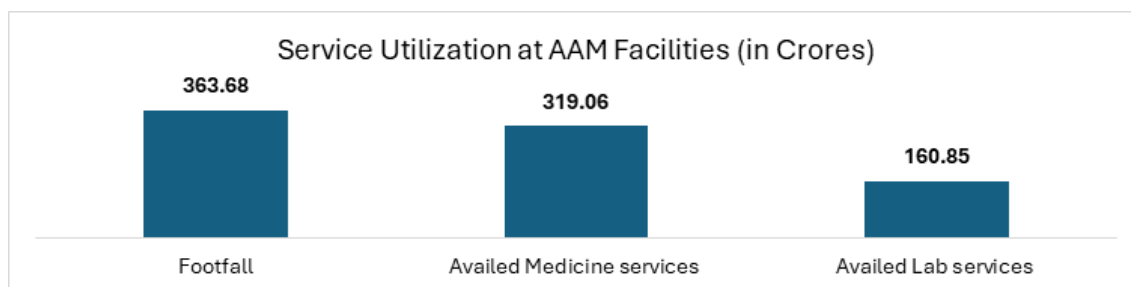
Source: Ayushman Arogya Mandir portal, Feb 2025



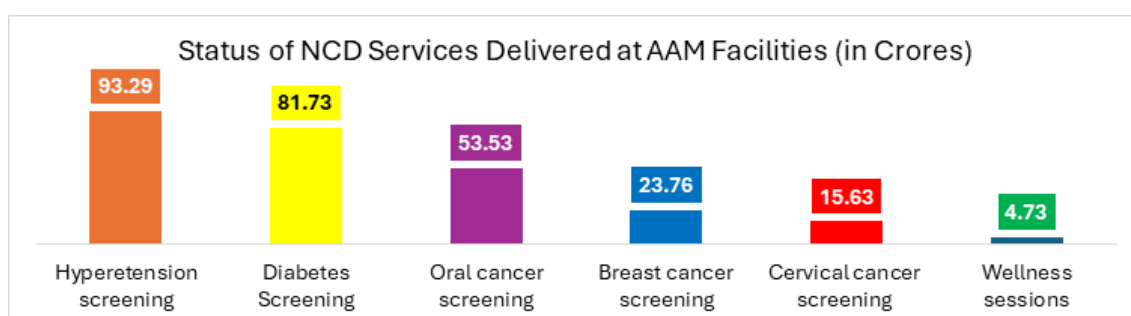
Source: Ayushman Arogya Mandir portal, Feb 2025

- Among the 19 states that were visited, operationalisation was high (90% and above) in Mizoram, Odisha, Gujarat, Bihar, Madhya Pradesh, Karnataka, Assam, Chhattisgarh, Uttarakhand, Haryana and West Bengal (11 states). These states have shown significant progress in AAM-SHCs and AAM-PHCs functionality. While AAM in rural areas are progressively implemented, U-AAM facilities remain a challenge even in some high-performing states, with lower operationalisation rates (e.g., West Bengal: Only 27.5% of U-AAM facilities functional).
- States with a moderate operationalisation status (70-90%) were Himachal Pradesh, Arunachal Pradesh, Tripura, Jammu and Kashmir, Maharashtra, Jharkhand and Uttar Pradesh (07 states). These states have achieved steady progress, and U-AAM facilities and AAM in remote areas still lag behind due to infrastructure gaps and human resource shortfall.
- Rajasthan had 70% operationalization reported as AAM implementation is still in the scaling-up phase, with challenges in branding, infrastructure, human resources, and service delivery expansion.
- States such as West Bengal, Chhattisgarh, and Rajasthan have reported significant delays in U-AAM operationalisation attributed to challenges in space constraints, staffing shortages, and limited financial allocations. U-AAM facilities in general reported challenges spanning lack of adequate infrastructure/wellness spaces, and laboratory services, affecting service delivery and patient engagement.
- One of the key factors for varied status of AAM implementation is the state level specific interventions. Variations in state-level planning, financial allocation, and governance capacity have played a significant role in the differing pace of operationalisation. States with strong political commitment and financial prioritisation (e.g., Gujarat, Madhya Pradesh, and West Bengal) have shown improved progress by ensuring timely infrastructure upgrades, workforce recruitment, and uninterrupted supply chains.
- Status of roll out of AAM also gets affected by geographical factors, wherein hilly and remote regions (e.g., Himachal Pradesh, Arunachal Pradesh, and Uttarakhand) suffer delays due to difficult terrain, poor road connectivity, and limited healthcare infrastructure.
- Even with these varied findings, overall, the operationalisation of AAM has significantly strengthened primary healthcare delivery across states, increasing access to essential services, NCD screening, maternal and child health programs, and improving access to specialist care

through teleconsultations at the grassroots level. The services provided by AAM facilities, including the NCD screening services as of February 2025, are illustrated in the graphs below:



Source: Ayushman Arogya Mandir portal, Feb 2025



Source: Ayushman Arogya Mandir portal, Feb 2025

INFRASTRUCTURE



- Significant progress has been made across most states in enhancing AAM facility infrastructure, including improvements in branding, reliable power and water supply, and the establishment of waiting areas. While some disparities remain regarding AAM-PHCs and AAM-SHCs, particularly in remote regions, ongoing efforts are helping bridge these gaps.

- Urban AAM (U-AAM) facilities are steadily expanding, with operationalization progressing well in many states. While some states, such as West Bengal, Rajasthan, and Chhattisgarh, are addressing challenges related to space constraints, wellness areas, and designated service zones, their commitment to infrastructure development is evident, and targeted improvements are underway to enhance functionality.
- Branding:** Most states have implemented branding as per National norms, with clear signages and facility names displayed prominently, but inconsistencies remain in some states. In Odisha, most AAM facilities show branding completed with clear identification and uniformity. In Uttar Pradesh, branding completion was reported at all visited AAM facilities, with AAM-UPHCs using billboards instead of painted signages. In Mizoram, facilities were still reflecting the “Health and Wellness Centre” name instead of AAM.



- Waiting areas:** Waiting areas were generally adequate in most states, but some still lack proper seating and ventilation for patients. Uttarakhand and Uttar Pradesh had inadequate waiting areas, requiring urgent improvements. Rajasthan and Odisha reported good waiting spaces in PHCs, while SHCs lacked sufficient space.
- Demarcated spaces (OPD, drug storage, laboratory):** Many states lack clearly demarcated spaces for OPD, drug storage, and laboratories, leading to operational inefficiencies. In Rajasthan, the



AAM at SHC level were observed to be functioning in one-two rooms with no dedicated space for screening, laboratory tests, or drug storage. However, AAM-PHCs generally had well-demarcated spaces as compared with AAM-SHCs.

- IEC materials and signages:** IEC materials and signages were displayed in most states but were

sometimes outdated, inconsistent, or not in the local language. Odisha had well-placed IEC materials in most AAM facilities, contributing to public awareness. Jammu & Kashmir and Uttar Pradesh lacked IEC displays in local languages in several facilities.

- **Power supply:** Power supply remains inconsistent, especially in remote SHCs, affecting service continuity. Tripura faced frequent power cuts, impacting service delivery and internet connectivity; however, Odisha had power backup systems in most AAM facilities, ensuring uninterrupted services.
- **Water supply:** Running water supply was available in most facilities. In Mizoram, rainwater harvesting system was implemented. Rajasthan reported inadequate potable water supply at several facilities.
- **Separate toilets:** Many states had separate functional toilets, but maintenance remains a concern. Rajasthan had functional toilets in AAM-PHCs, but not in AAM-SHCs. It was observed in Uttar Pradesh that most facilities did not have disabled-friendly toilets.
- **Disabled friendly structures:** Most AAM-PHCs had ramps, but additional facilities such as handrails, wheelchairs, and accessible toilets were often missing. Mizoram and Uttar Pradesh reported a lack of ramps and accessible infrastructure in some facilities.
- **Labor rooms:** While AAM-PHCs were conducting deliveries, hygiene remained a concern. Some states, such as Rajasthan and Uttarakhand, reported compromised infrastructure in labor rooms, with fungal growth on OT walls and inadequate zoning. Mizoram reported underutilized labor rooms.
- **Dedicated Wellness space:** Availability of dedicated spaces for wellness and yoga activities varied across the states. Uttarakhand reported no dedicated wellness space in some facilities; however, Odisha had clearly demarcated wellness spaces in some AAM-PHCs.
- **Boundary wall:** Availability of boundary was more of challenge for AAM-SHC facilities, while it was observed across most of AAM-PHC.
- **Complaint/Suggestion boxes:** Grievance redressal mechanisms was found to be lacking in most states. Complaint/suggestion boxes were available in some of the AAM facilities in Mizoram, but no action taken report was being maintained.

HUMAN RESOURCES

PRIMARY HEALTHCARE TEAM AT AAM

- One of the functionality criteria for AAM is availability of full-time dedicated CHO and MO-I/C at both SHC and PHC level to complement the efforts towards provision of Comprehensive primary care through expanded range of services. Most AAM facilities have successfully appointed primary healthcare teams, including CHOs, ANMs, and MPWs, ensuring effective service delivery. While some states continue to work on optimizing staffing and retention, and efforts are underway to strengthen workforce availability across all regions.



- Most of the states have achieved full recruitment of CHOs at AAM-SHCs, demonstrating strong progress in healthcare staffing. West Bengal, for instance, reported 100% CHO deployment at the visited facilities, while Jammu & Kashmir has effectively ensured a full healthcare team at most AAM facilities. Additionally, Uttar Pradesh and Odisha are nearing complete staffing levels, further reinforcing the capacity of primary healthcare teams.
- However, CHO vacancies persist in several states, impacting service delivery. Rajasthan and Himachal Pradesh reported a high number of unfilled CHO positions, leading to additional workload on existing staff. Uttarakhand and Mizoram highlighted shortages of MPWs and pharmacists at certain facilities.

TRAINING AND CAPACITY BUILDING

- Regular training programs, including those under SASHAKT, are actively being implemented across many states to enhance the skills of healthcare workers in CPHC service delivery. While variations in coverage and frequency exist, continuous efforts are being made to expand and streamline training initiatives.
- Several states have demonstrated strong commitment to refresher training, ensuring that healthcare workers remain updated on essential skills. Odisha and West Bengal have consistently conducted periodic training sessions for CHOs, ANMs, and MOs, with systematic tracking through the SASHAKT portal. Additionally, Jammu & Kashmir has prioritized frequent refresher training for CHOs, particularly in teleconsultation and NCD screening, strengthening service quality and delivery.
- Gaps in capacity building persist in states like Tripura and Arunachal Pradesh, where refresher training for CHOs and ANMs was not reported last year. Himachal Pradesh reported a lack of structured training schedules for AAM team. Additionally, Rajasthan and Karnataka reported inadequate practical training in emergency care and diagnostic procedures, thus limiting the skills of CHOs in emergency care.

PROGRAM IMPLEMENTATION AT PRIMARY LEVEL

MATERNAL HEALTH

The expansion of services at AAM facilities is progressing, with states gradually incorporating a broader range of healthcare services. Efforts are being made to ensure a more uniform and comprehensive integration of services across all regions.

- Maternal health services, including ANC, institutional deliveries, and PNC, continue to be available at SHC & PHC level with its upgradation to AAM. While the quality of care and tracking of high-risk pregnancies vary, ongoing improvements in infrastructure and service delivery have contributed to improved maternal health outcomes across states.
- States such as Odisha, Gujarat, and Madhya Pradesh have successfully established robust maternal health programs, serving as models for best practices. Meanwhile, other states are also actively making efforts to bridge service gaps and strengthen maternal healthcare including improving its accessibility and availability.
- Service delivery pertaining challenges in ANC services were reported in some remote areas in state of Himachal Pradesh and Jharkhand, where the states reported targeted interventions to address these gaps.
- Early registration of pregnancies was actively promoted in states like Odisha and Karnataka, leading to high ANC coverage.
- High-risk pregnancy tracking was inadequate in several states, including Tripura and Rajasthan, which was reported due to gaps in digital tracking and follow-up mechanisms.

- Iron and folic acid (IFA) supplementation for pregnant women was widely available, but stock-outs were reported in some states like Bihar and Jharkhand.
- In states like Odisha, Karnataka, and Rajasthan, where delivery points were well-equipped, institutional deliveries were reported across AAM-PHCs.
- It was observed in Assam and Uttar Pradesh that mothers were being discharged within 3-6 hours after delivery, impacting postnatal care counseling.
- Postnatal home visits by ASHAs and ANMs were regularly conducted in Odisha, Madhya Pradesh, and Gujarat but were reported to be weak in Tripura, Jharkhand, and Uttarakhand, where home-based care coverage was observed to be low.
- Maternal Death Surveillance & Response (MDSR) was operational in several states but lacked proper analysis and corrective action in Rajasthan and Uttar Pradesh.
- IV iron therapy for anemia was available in some states (Arunachal Pradesh, Assam) but lacked proper follow-up.
- In Rajasthan and Assam, delay was reported in JSY payments, which was negatively affecting the institutional deliveries.
- Stockouts of essential maternal health medicines (e.g., misoprostol, oxytocin) were reported, affecting the services in Jharkhand and Himachal Pradesh.
- Referral pathways were weak in Uttarakhand and Bihar, leading to delayed emergency obstetric care.

UNIVERSAL IMMUNIZATION PROGRAMME

- Routine immunization services are available across all states, with Odisha, Karnataka, and Madhya Pradesh reporting high coverage. While some states are addressing challenges related to stock availability, tracking zero-dose children, and cold chain maintenance, continuous improvements and targeted interventions are enhancing immunization efforts nationwide.
- Odisha and Gujarat have demonstrated exemplary performance in immunization, achieving nearly 100% child immunization completion. Strong community participation in routine vaccination drives has further reinforced these successes, serving as a model for other states.
- Efforts to improve immunization tracking are ongoing in Jharkhand and Himachal Pradesh, where focused strategies are being implemented to ensure better identification and coverage of unimmunized children, leading to an increase in full immunization rates.
- Zero-dose child tracking was actively conducted in Arunachal Pradesh and Assam, but low awareness and hesitancy persisted in tribal and remote areas, thus influencing its on ground implementation.
- Odisha, Gujarat, and Karnataka had well-maintained cold chain facilities with dedicated vaccine storage areas at AAM facilities. However, states such as Tripura, Uttarakhand, and Bihar faced intermittent power supply, affecting cold chain stability and vaccine storage conditions.
- eVIN was functional in most states, but staff training on cold chain monitoring was inadequate in Jharkhand, Tripura and Uttar Pradesh.
- Stock out related findings varied across states. States like Odisha and Madhya Pradesh reported strong vaccine supply chains, with minimal stockouts reported. However, Uttar Pradesh, Jharkhand, and Himachal Pradesh reported frequent vaccine stockouts, affecting routine immunization services.
- Mizoram and Arunachal Pradesh faced delays in vaccine supply due to difficult terrain, impacting timely immunization schedules.

- Role of community-based activities was also observed as an influencing factor for immunization. Odisha and Karnataka reported increase in uptake of immunization due to routinely conducted community awareness campaigns. Vaccine hesitancy was reported high in Arunachal Pradesh, Mizoram, and some districts of West Bengal, requiring targeted behavioural interventions.
- HPV and adolescent vaccination programs were reported partially implemented in states like Gujarat and Odisha. Limited adolescent immunization services were reported in Jharkhand and Rajasthan due to low prioritization in primary care.

CHILD HEALTH

- Child health services are well-established across all states, encompassing key areas such as growth monitoring, malnutrition management, ORS and zinc supplementation for diarrhoea, and routine immunization. Efforts are ongoing to further strengthen these services and ensure uniform access across the states/UT.
- States like Odisha, Gujarat, and Karnataka have implemented strong nutrition and child health programs, setting benchmarks for effective service delivery. Meanwhile, Jharkhand, Rajasthan, and Himachal Pradesh are actively working to enhance their child health initiatives and improve follow-up mechanisms.
- Regular growth monitoring of children is being effectively carried out in states such as Odisha, Karnataka, and Madhya Pradesh, with Anganwadi workers and ASHAs playing a key role in tracking child growth parameters, ensuring early identification of nutritional needs and timely interventions.
- Functionality and role of Nutritional Rehabilitation Centres (NRCs) in child health care varied across states. In states like Odisha and Karnataka, SAM and MAM cases were identified and referred to NRC for timely intervention. However, in states of Jharkhand and Tripura, NRCs were not found fully functional and thus identified as a priority area to act upon.
- Take-home rations for malnourished children were provided in most states, but uptake was reported low due to limited community awareness in Rajasthan and Himachal Pradesh.
- Odisha and Gujarat reported well-structured Infant and Young Child Feeding (IYCF) practices, promoting exclusive breastfeeding and complementary feeding through community-based programs.
- Lack of counselling services for mothers on breastfeeding and complementary feeding was noted in Jharkhand and Rajasthan, leading to poor nutrition indicators among children.
- ORS and zinc were available in most AAM facilities, but distribution gaps were reported in Jharkhand, Uttar Pradesh, and Himachal Pradesh, where stockouts were reportedly frequent. In Odisha and Karnataka, well-maintained ORS corners were observed, ensuring timely management of diarrhoea cases.
- The Integrated Management of Neonatal and Childhood Illnesses (IMNCI) approach was implemented in Odisha and Gujarat, ensuring early identification and treatment of pneumonia, diarrhoea, and malnutrition. However, states like Jharkhand, Rajasthan and Himachal Pradesh had challenges pertaining to IMNCI implementation, and ASHAs and ANMs lacked refresher training on childhood illness management.
- Neonatal care services, including screening for congenital disorders, were available in Gujarat and Karnataka but were absent in several primary-level facilities in Jharkhand and Himachal Pradesh.
- Referral mechanisms for sick newborns were weak in Uttarakhand and Bihar, leading to delays in emergency neonatal care.
- Vitamin A supplementation coverage was high in Odisha and Madhya Pradesh, ensuring protection against childhood blindness and immune deficiencies.
- Stockouts of Vitamin A supplements were reported in Tripura and Jharkhand, affecting the

continuity of supplementation programs.

- HBNC visits were actively conducted in Odisha and Karnataka, with ASHAs ensuring newborn care and follow-up. However, limited HBNC coverage was observed in Jharkhand and Himachal Pradesh, where ASHAs were inadequately trained on HBNC guidelines.

FAMILY PLANNING

- Family planning services are accessible across all 19 states, with varying levels of service coverage and contraceptive uptake. Continuous efforts are being made to enhance accessibility and awareness to ensure broader reach and effectiveness.
- States like Odisha, Gujarat, and Karnataka have established comprehensive family planning services, offering IUCD insertions, sterilization services, and access to emergency contraceptives. Meanwhile, states such as Jharkhand, Rajasthan, and Himachal Pradesh are focusing on improving stock availability, service access, and community awareness to further strengthen their family planning programs.
- IUCDs, oral contraceptive pills (OCPs), condoms, and Antara injections were available in most AAM facilities. However, stockouts were reported in Jharkhand, Uttar Pradesh, and Tripura.
- IUCD insertions were reported regularly at AAM-PHCs in Karnataka, Odisha, and Rajasthan; however, its uptake was low in Himachal Pradesh and Jharkhand, which was attributed mainly to limited trained personnel and community hesitancy.
- Antara injections were available in Odisha and West Bengal, but uptake was low due to lack of awareness and concerns related to its side effects. Lack of trained providers for IUCD insertions and Antara injections was reported in Tripura and Jharkhand.
- Male sterilization acceptance was low across all states, with most services focused on female sterilization at DHs rather than AAM-PHCs. Limited male participation in family planning services remained a common issue across all states.
- Gujarat and Karnataka had robust sterilization services, while Tripura and Jharkhand had limited access to sterilization at the primary level.



- Stockouts of condoms, IUCD kits, and oral contraceptive pills were reported in Jharkhand, Tripura, and Uttar Pradesh, leading to disruptions in service delivery. However, supply chain management was observed satisfactory in Odisha, Gujarat, and Karnataka, ensuring the availability of contraceptives across AAM facilities.
- ASHAs were actively engaged in family planning counselling and contraceptive distribution in most states, particularly in Odisha and Madhya Pradesh. Regardless, Jharkhand and Uttar Pradesh reported inadequate ASHA trainings on family planning, reported low community-level awareness and service uptake across the districts.
- Community awareness campaigns were being organized regularly in states of Odisha, Gujarat, and Madhya Pradesh, which led to increased contraceptive uptake. Himachal Pradesh and Rajasthan reported challenges in community acceptance of IUCDs and injectable contraceptives, which was mainly due to misinformation and social stigma.
- Jharkhand, Tripura, and Himachal Pradesh had high unmet family planning needs, particularly in rural and tribal areas.
- For family planning services, the key challenges reported were lack of awareness, cultural norms, limited service availability, and supply chain disruptions.

COMPREHENSIVE ABORTION CARE

- Comprehensive Abortion Care (CAC) services are expanding across AAM facilities, with several AAM-PHCs already offering Medical Termination of Pregnancy (MTP) services.
- States such as Odisha, Gujarat, and Karnataka have successfully implemented functional abortion care services, ensuring access to safe procedures. Meanwhile, Jharkhand, Himachal Pradesh, and Tripura reported working towards improving service reach, stock availability, and provider training to enhance access to CAC services.
- Odisha and Karnataka have made significant strides in ensuring abortion services at AAM-PHCs, where trained providers are equipped to handle both medical and surgical procedures, improving safe and accessible reproductive healthcare.
- Jharkhand and Uttar Pradesh reported limited access to MTP services at AAM-PHCs, with most referrals directed to higher facilities due to lack of trained providers.
- Himachal Pradesh and Rajasthan had no CAC services at the primary level, thus reporting high OOPE as beneficiaries were seeking care from private providers.
- Post-abortion care was integrated with maternal health services in Odisha and Gujarat, ensuring proper follow-up and contraceptive counselling. However, follow-up care for women post-abortion was weak in Jharkhand and Himachal Pradesh, with no structured tracking of post-abortion complications.
- MTP drug kits were adequately stocked in Odisha and Karnataka, ensuring access to safe medical abortion services. But frequent stockouts of MTP drugs were reported in Tripura, Jharkhand, and Uttar Pradesh, forcing women to purchase abortion medication from private pharmacies.
- Odisha and Karnataka had trained MOs and nurses on CAC guidelines, including medical and surgical abortion procedures. However, limited provider training was noted in Uttar Pradesh and Rajasthan, where many PHCs lacked staff trained in abortion procedures.
- Awareness campaigns on safe abortion services were conducted in Odisha and Gujarat, increasing acceptance of government-provided abortion services. However, misinformation about abortion was widespread in Himachal Pradesh and Rajasthan, which was also linked to unsafe abortions or delayed access to care.
- Stigma surrounding abortion was prevalent in Jharkhand, Himachal Pradesh, and Rajasthan, discouraging women from seeking services at AAM facilities.

- Lack of awareness on legal rights to abortion under the MTP Act was observed across most of the women in Uttar Pradesh and Jharkhand, which led to low utilization of public-sector abortion services.
- ASHAs engagement and awareness varied across states. In Odisha and Gujarat, ASHAs were actively involved in referral for CAC services and ensuring post-abortion follow-up. ASHAs in Tripura and Jharkhand had limited awareness of CAC services, resulting in low community outreach for safe abortion awareness.

RASHTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

- The implementation of the RBSK is progressing across states, with Odisha, Gujarat, and Karnataka demonstrating strong coverage through its Mobile Health Teams (MHT). Similarly, other states also reported efforts being underway to further streamline service delivery.
- MHTs are operational in most states, playing a crucial role in school and Anganwadi screenings. While some remote areas face staffing and logistical challenges, continuous improvements are being made to enhance their efficiency and coverage.
- Gujarat and Madhya Pradesh have successfully established fully functional MHTs, ensuring regular and systematic health screenings in schools and Anganwadi centres, contributing to improved child health monitoring and early intervention.
- Shortages of doctors and allied health workers in MHTs were noted in Jharkhand and Rajasthan, which affected overall service delivery.
- Odisha and Karnataka had well-established screening programs, covering birth defects, developmental delays, and nutritional deficiencies.
- Referral services for children with congenital conditions were weak in Jharkhand and Tripura, leading to delayed specialist care.
- Odisha and Gujarat effectively integrated RBSK with ICDS and school health programs, improving child health outcomes. However, lack of coordination between RBSK and school health services was reported in Jharkhand and Himachal Pradesh, leading to gaps in follow-up care.
- Limited availability of diagnostic tools and equipment across AAM facilities affected the effectiveness of RBSK screenings.
- Data reporting gaps were observed in Rajasthan and Jharkhand, where real-time tracking of screened children was not systematically maintained.



ADOLESCENT HEALTH

- Adolescent health services are being expanded across states, with Odisha, Gujarat, and Karnataka achieving strong coverage. In states like Jharkhand, Himachal Pradesh, and Rajasthan, targeted efforts are being made to enhance outreach and accessibility through improved service delivery, awareness, and programme uptake.
- ASHAs play a pivotal role in promoting adolescent health, actively engaging communities in awareness and preventive care. While the effectiveness of their training and outreach varies across states, ongoing capacity-building initiatives are strengthening their impact in ensuring better adolescent health outcomes.

A) RASHTRIYA KISHOR SWASTHYA KARYAKRAM (RKSK)

- RKSK was implemented in most states, but service delivery and uptake remained uneven. Odisha and Gujarat had active RKSK implementation, with functional adolescent health services and school-based awareness sessions. However, Jharkhand and Rajasthan lacked well-defined RKSK interventions, with low community participation and weak adolescent health outreach.
- Peer educator training under RKSK was functional in Odisha but limited in Himachal Pradesh and Jharkhand, which was primarily due to lack of trained facilitators.

B) ADOLESCENT FRIENDLY HEALTH CLINICS (AFHCs)

- AFHCs were established in Odisha, Gujarat, and Karnataka, offering counselling and reproductive health services for adolescents. However, Tripura, Himachal Pradesh, and Jharkhand had minimal AFHC coverage, leading to low adolescent engagement in healthcare services.
- Mental health services for adolescents were not well-integrated into AFHCs, affecting access to psychological support.

C) MENSTRUAL HYGIENE SCHEME (MHS)

- Sanitary napkins were distributed in Odisha, Gujarat, and West Bengal, ensuring access to menstrual hygiene products in schools and communities, while limited supply of sanitary napkins was reported in Jharkhand and Tripura, leading to inconsistent distribution in rural areas.
- Community stigma around menstrual hygiene persisted in Rajasthan and Himachal Pradesh, affecting adolescent girls' willingness to access services.

D) WEEKLY IRON AND FOLIC ACID SUPPLEMENTATION (WIFS)

- WIFS implementation was effective in Odisha and Karnataka, improving adolescent nutritional health while low adherence to WIFS supplementation was noted in Uttar Pradesh and Tripura, with supply chain gaps leading to irregular distribution.
- ASHAs played a key role in promoting WIFS adherence in Odisha, while challenges pertaining to outreach were reported in states of Jharkhand and Rajasthan.

E) SCHOOL HEALTH AND WELLNESS PROGRAMME (SHWP) UNDER AYUSHMAN BHARAT

- SHWP was integrated with adolescent health programs in Odisha and Gujarat, supporting health screenings, nutrition counselling, and mental health services. In Jharkhand and Tripura due to lack of a structured SHWP implementation, low awareness and engagement were reported in schools.
- Fragmented service delivery was observed in Rajasthan and Himachal Pradesh due to limited coordination between schools and health facilities.

NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME (NTEP)

- The NTEP is actively implemented across all states, with continuous efforts to enhance case detection, treatment adherence, and drug availability. Measures are being taken to strengthen program efficiency and ensure comprehensive coverage.

- Odisha, Gujarat, and Karnataka have established robust TB control programs, demonstrating effective management and intervention strategies. Meanwhile, states like Jharkhand, Himachal Pradesh, and Tripura are working towards enhancing program execution to improve TB detection and treatment outcomes.
- Active Case Finding (ACF) initiatives in Odisha and Gujarat have successfully facilitated early detection of TB cases, contributing to improved patient outcomes. Efforts are being intensified in states like Jharkhand and Tripura to expand systematic screening and enhance case reporting for timely diagnosis and treatment.
- Testing facilities were limited at AAM-SHCs, with TB diagnostics largely available at AAM-PHCs or higher facilities.
- TB medicines were consistently available in Gujarat and Odisha, ensuring uninterrupted treatment for notified patients and supporting effective TB management. These states have demonstrated strong supply chain mechanisms to maintain continuous drug availability.
- In Tripura and Himachal Pradesh, efforts are being made to address reported stockouts of TB drugs to ensure treatment continuity as it was identified as a major challenge in those states. Strengthening procurement and distribution systems will further enhance uninterrupted access to essential TB medications.
- Delayed case detection and underreporting were major challenges in Jharkhand, Tripura, and Himachal Pradesh while Uttar Pradesh and Rajasthan reported gaps in notification, with missing TB case records on the Nikshay portal.
- Limited DR-TB management services were available at AAM-PHCs, with most cases referred to tertiary hospitals. Additionally, Odisha and Gujarat had functional DR-TB centers, but Jharkhand and Rajasthan lacked specialized care at the primary level.
- Odisha and Karnataka ensured timely DBT payments under Nikshay Poshan Yojana, improving nutritional support for TB patients. However, Rajasthan and Jharkhand faced delays in DBT disbursements.
- Odisha and Gujarat had strong follow-up mechanisms for TB patients, improving treatment adherence. However, Tripura and Rajasthan reported high TB treatment dropout rates, with poor follow-up and weak counselling services.
- ASHAs were actively involved in case identification and treatment follow-ups in Odisha and Gujarat. While ASHAs in Himachal Pradesh and Jharkhand lacked training on TB referral pathways, limiting their effectiveness in patient tracking.
- Contact tracing was effectively conducted in Odisha and Gujarat, ensuring early identification of TB infections. Limited TB contact tracing was reported in Jharkhand and Rajasthan, leading to higher transmission risks.
- Private sector engagement for TB notification and treatment monitoring was observed in Gujarat and Karnataka, which also reported improved case detection.
- Odisha and Gujarat had well-equipped TB testing facilities at AAM-PHCs, ensuring faster diagnosis. While Tripura and Himachal Pradesh had gaps in diagnostic services, forcing patients to travel long distances for TB testing.
- Some key challenges reported in TB were inconsistencies in TB Preventive Therapy (TPT) administration in Tripura and Mizoram, inadequate follow-up for post-treatment TB patients in Himachal Pradesh, and issues with Direct Benefit Transfer (DBT) payments in Mizoram and Gujarat. Frequent patient migration in Gujarat was observed complicating treatment adherence, while in Bihar, the absence of TB diagnostic services at sub-health centres was observed as a main reason for patient referrals to higher facilities.
- Despite these challenges, states like Uttarakhand and Assam have achieved high TB notification rates and treatment success, with Uttarakhand documenting HIV and diabetic statuses for the

majority of cases and Assam surpassing notification targets in few districts. Collaborations with NGOs as seen in Karnataka, have bolstered patient support through initiatives like the Nikshay Poshan Yojana, although the effective utilization of disbursed funds remains uncertain in some regions.

- Efforts to enhance diagnostic capabilities are evident, with Chhattisgarh equipping all blocks with Nucleic Acid Amplification Test (NAAT) machines and Tamil Nadu implementing Universal Drug Sensitivity Testing (UDST) for a significant percentage of patients. Community engagement is reinforced through the active participation of TB Champions and Nikshay Mitras, contributing to awareness and patient support.

NATIONAL LEPROSY ERADICATION PROGRAMME (NLEP)

- Leprosy screening has been successfully integrated into primary healthcare across most states, ensuring broader access to early diagnosis and treatment. Efforts are ongoing to further strengthen early detection and enhanced follow-up mechanisms for improved patient outcomes.
- States such as Odisha, Gujarat, and Karnataka have implemented well-structured leprosy programs, contributing to effective surveillance and case management. Meanwhile, Jharkhand, Himachal Pradesh, and Tripura are focusing on enhancing their monitoring and response systems to improve service delivery.
- Active screening initiatives at AAM-PHCs in Odisha and Gujarat have significantly improved early leprosy detection, facilitating timely intervention and better disease management.
- Frequent stockouts of MDT drugs were reported in Tripura and Himachal Pradesh, disrupting treatment continuity.
- NLEP services were well-integrated with primary care in Odisha and Gujarat, ensuring timely screening and treatment initiation. However, Jharkhand and Rajasthan lacked structured integration, leading to delayed interventions.
- Rehabilitation services and disability management are another key concern. While Uttarakhand has ensured the distribution of self-care kits and MCR footwear in Dehradun, other areas like Bageshwar lack these essential resources. In Arunachal Pradesh, rehabilitation services are unavailable at the district hospital, and referral cases are directed to Assam Medical College. The situation is more critical in Chhattisgarh, where the state remains a leprosy hotspot, with a high prevalence of Multibacillary cases and Grade 2 Disabilities among new cases. The diminishing workforce of National Leprosy Mission (NMS) and National Medical Authority (NMA) cadres poses a long-term challenge, as they hold significant expertise in leprosy management. Additionally, disability prevention measures (protective footwear, physiotherapy) were in place in Odisha and Karnataka, but absent in Tripura and Jharkhand.
- Active surveillance and case detection campaigns have shown mixed results across states. In Jharkhand, the Leprosy Case Detection Campaign (LCDC) in 2024 led to the identification of a large number of cases, which were subsequently treated. Similarly, Odisha's campaigns have been successful in detecting thousands of new cases and performing reconstructive surgeries. In contrast, Gujarat recorded 139 suspected cases referred by ASHAs, but none were confirmed. Tripura, despite its low prevalence, detected five new cases in 2024.
- Odisha and Karnataka ran community awareness programs, reducing stigma and improving adherence. As well, high social stigma in Jharkhand and Rajasthan discouraged early health-seeking behaviour.
- Limited trained manpower for leprosy services in Tripura and Rajasthan, affected case detection.
- Weak follow-up mechanisms led to increased risk of disability among detected cases. Additionally, budget constraints in some states slowed down expansion of disability prevention and rehabilitation services.

NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME

- Vector-borne disease prevention and control measures are actively implemented across all states, with varying levels of coverage and effectiveness. Odisha, Gujarat, and Karnataka have demonstrated strong implementation under NVBDCP, while states like Jharkhand, Rajasthan, and Himachal Pradesh are working towards strengthening surveillance, vector control, and case detection mechanisms.
- Several states demonstrated proactive malaria control efforts, though challenges remain. In Madhya Pradesh, health facilities were well-equipped with Long-Lasting Insecticidal Nets (LLINs), essential medications, and diagnostic tools, but manpower shortages persisted outside malaria-endemic areas like Balaghat. In Bihar and Jharkhand, Rapid Diagnostic Kits (RDKs) were available at most facilities, but anti-malarial drug availability was inconsistent, and outreach activities in hard-to-reach endemic areas were limited. Jharkhand reported significant malaria burdens, yet no LLIN distribution had occurred in two years, and DDT stocks were depleted. In contrast, Mizoram and Arunachal Pradesh maintained strong malaria surveillance and prevention measures, with no recent cases reported and high LLIN coverage.
- Malaria Screening and Treatment at AAM facilities: These services are well-integrated into routine OPD services at AAM facilities in Odisha and Gujarat, ensuring early diagnosis and timely intervention. Arunachal Pradesh has successfully maintained a 100% malaria-free status for the past two years through proactive screening and vector control measures. While Jharkhand and Tripura are enhancing their malaria surveillance to prevent delays in case detection, Mizoram continues to conduct routine screenings, with efforts underway to improve diagnostic services in remote areas.
- Dengue Prevention and Vector Control Measures: Odisha and Gujarat ensured routine fogging, source reduction, and larval control activities, contributing to lower dengue incidence. In Rajasthan and Tripura, poor vector control measures led to persistent dengue outbreaks, particularly in urban areas. Mizoram and Karnataka implemented vector surveillance programs, but community awareness and participation needed strengthening.
- Filariasis Screening and Treatment Availability: Odisha and Karnataka conducted Mass Drug Administration (MDA) for filariasis, achieving good compliance. Jharkhand and Rajasthan had lower filariasis screening coverage, leading to underreported cases. Uttar Pradesh reported gaps in anti-filarial drug availability at some AAM-PHCs.
- Kala-azar Case Detection and Treatment: Odisha and Bihar actively tracked Kala-azar cases, integrating screenings at AAM facilities. Jharkhand and Rajasthan had inconsistent Kala-azar surveillance, leading to delayed treatment.
- Chikungunya Surveillance and Response: Odisha and Gujarat included chikungunya in their vector surveillance efforts, ensuring early case detection. However, limited chikungunya surveillance was reported in Jharkhand and Rajasthan, leading to low case reporting and weak outbreak response.
- ASHAs were involved in community education and case identification in Odisha and Gujarat, improving early detection. However, in Himachal Pradesh and Jharkhand due to inadequate training, their engagement was not observed effective in vector control measures.

NATIONAL RABIES CONTROL PROGRAMME

- Rabies prevention and post-exposure prophylaxis (PEP) services are widely available at AAM-PHCs across most states, ensuring timely intervention. Efforts are ongoing to further improve accessibility and enhance public awareness regarding rabies prevention and treatment.
- Odisha, Gujarat, and Karnataka have successfully implemented structured rabies control programs, strengthening vaccine availability and bite management protocols. Meanwhile, Jharkhand, Rajasthan, and Himachal Pradesh are actively working to address challenges in vaccine supply and streamline treatment services.

- Rabies surveillance has been effectively integrated into routine reporting systems in Odisha and Gujarat, enabling efficient case tracking. States like Jharkhand and Rajasthan are taking steps to enhance their reporting mechanisms to improve case detection and response.
- With regards to availability of Anti-Rabies Vaccine (ARV) and PEP, Odisha and Karnataka ensured the availability of ARV at AAM-PHCs, facilitating timely PEP while Jharkhand and Rajasthan reported frequent stockouts of ARV, forcing patients to seek vaccines from private facilities. Delayed initiation of PEP was a concern in some states due to poor awareness among frontline health workers.
- Odisha and Gujarat had defined referral pathways for managing severe animal bite cases. While Jharkhand and Rajasthan lacked clear bite management protocols at AAM facilities, leading to inconsistent treatment approaches.
- Low awareness about rabies prevention among frontline health workers and ASHAs was observed in Jharkhand and Tripura.
- Referral delays in severe rabies cases due to lack of emergency management at AAM-PHCs were reported across states.
- ASHAs were actively involved in rabies prevention education in Odisha and Karnataka, but training gaps remained a challenge in other states.
- Community awareness campaigns were implemented in Gujarat and Karnataka, increasing timely health-seeking behaviour post-animal bite while in Jharkhand and Rajasthan there was limited awareness programs, leading to delays in treatment initiation.

NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT

- Primary eye care services, including vision screening and refractive error correction, have been successfully integrated into AAM facilities across most states, improving access to essential eye health services. Efforts are ongoing to enhance consistency in service availability and ensure wider coverage.
- Odisha, Gujarat, and Karnataka have well-established NPCBVI activities, effectively delivering eye care services. Meanwhile, in states of Jharkhand, Rajasthan, and Himachal Pradesh efforts were being made towards strengthening screening programs, referral systems, and access to ophthalmic care to further improve eye health outcomes.
- Routine eye screening was available at AAM-PHCs in Odisha and Gujarat, supporting early detection of refractive errors and cataracts while Jharkhand and Rajasthan had limited eye screening services, with no systematic referral pathways to secondary or tertiary eye care centres.
- Gujarat and Karnataka had functional vision centres within select AAM-PHCs, improving access to ophthalmic care while Tripura and Rajasthan lacked ophthalmic equipment and trained personnel, affecting service delivery.
- Odisha and Karnataka distributed spectacles through their vision screening programs, improving access for school children and elderly patients. However, Jharkhand and Himachal Pradesh had gaps in spectacle distribution, with no structured mechanism in place.
- Odisha and Gujarat had referral mechanisms for cataract surgeries, ensuring timely intervention. However, Jharkhand and Rajasthan lacked clear referral linkages, resulting in delayed cataract management.
- School-based eye screening was successfully implemented in Odisha and Karnataka, ensuring early detection of vision impairments in children while Jharkhand and Rajasthan did not have dedicated school screening programs, leading to missed opportunities for early intervention.
- Key challenges reported in NPCBVI implementation were limited trained manpower for ophthalmic

services (especially in Jharkhand, Tripura, and Rajasthan), weak referral linkages between AAM facilities and secondary/tertiary eye care centres, leading to delayed management of cataracts and other visual impairments and lack of community awareness programs, affecting early detection and treatment-seeking behaviour.

NATIONAL TOBACCO CONTROL PROGRAMME

- Tobacco control and cessation services have been integrated into primary healthcare at AAM facilities in several states, with ongoing efforts to expand and standardize implementation across all regions.
- States like Odisha, Gujarat, and Karnataka have established structured awareness programs and tobacco cessation support services, helping individuals reduce tobacco use. Meanwhile, Jharkhand, Rajasthan, and Himachal Pradesh are working towards increasing service availability and accessibility.
- Odisha and Gujarat have successfully provided tobacco cessation counselling at AAM-PHCs, ensuring better access to quit support programs. While Jharkhand and Rajasthan are working on expanding dedicated cessation services, there is an opportunity to enhance pharmacological support such as nicotine replacement therapy at AAM facilities nationwide.
- Odisha and Karnataka conducted IEC campaigns at AAM facilities to raise awareness about the harmful effects of tobacco consumption. However low levels of IEC activity was observed in Jharkhand and Tripura, resulting in limited community engagement in tobacco cessation.
- Gujarat and Karnataka had strong enforcement of COTPA (Cigarettes and Other Tobacco Products Act), with visible “No Smoking” signage and tobacco-free zones across AAM facilities. Rajasthan and Jharkhand demonstrated poor enforcement, with tobacco products available in vicinity of public healthcare facilities.
- ASHAs in Odisha and Karnataka were trained to provide tobacco cessation counselling during home visits. However, Jharkhand and Rajasthan lacked ASHA-led tobacco awareness programs, limiting community-level interventions.
- Challenges in NTCP implementation at primary level included unstructured tobacco cessation programs at AAM facilities with limited integration, low availability of de-addiction services including counselling and nicotine replacement therapy and weak enforcement of tobacco control laws in Rajasthan, Jharkhand, and Tripura, allowing easy access of tobacco products.

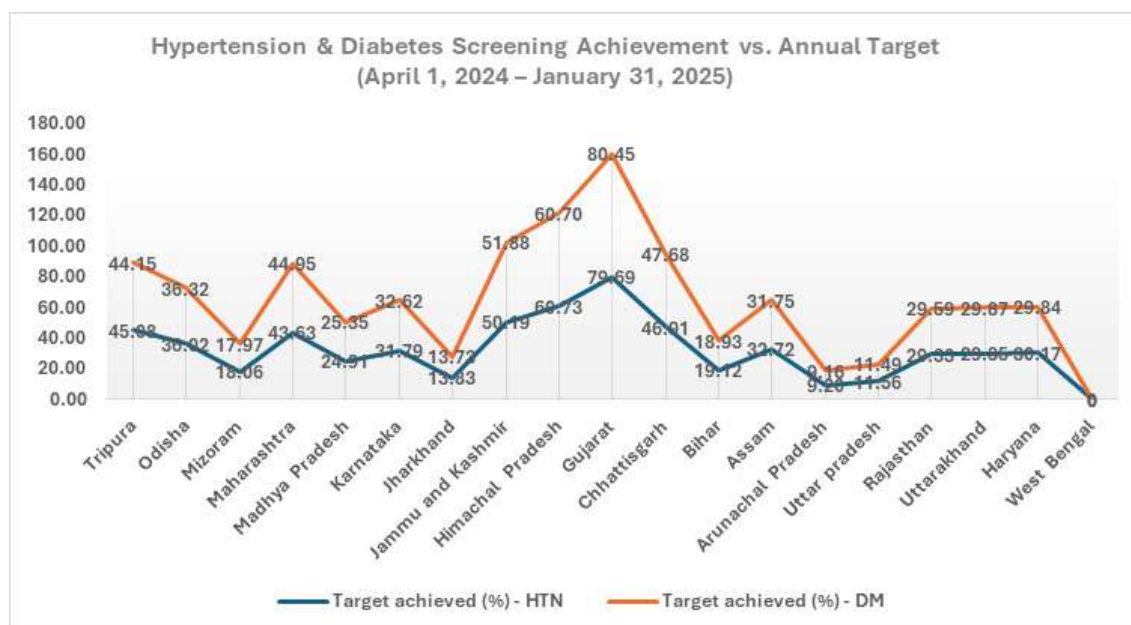
NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES (NP-NCD)

- The National Programme for Prevention and Control of Non-Communicable Diseases (NP-NCD) has been revamped in 2023 with an objective to prevent and control NCDs across all levels of care, through a range of activities spanning population enumeration, assessment of risk factors, mobilizing communities for screening at AAM, health promotion, initiation of treatment, referral to higher centres for further treatment, and follow up care— following a continuum of care approach. CPHC has an important role in the primary and secondary prevention of NCDs. The provision of NCD services at primary health care level reduces morbidity, disability and mortality at much lower costs and significantly reduces the need for secondary and tertiary care, thus highlighting the role of AAM in addressing the NCD burden. Under AAM facilities, 12 expanded packages of services are envisaged including NCD screening services as a critical component. Till date, achievement of common NCDs screening at AMM against the target is depicted in the table below:

Screening Status	In Crores	Cumulative Screening Done	Percentage of Achievement
Estimated Population	140.07	NA	NA
Estimated Population (30+)	52.54	NA	NA
	Target for screening		
Hypertension Screening	52.54	23.71	45.13
Diabetes Screening	52.54	23.53	44.78
Oral Cancer Screening	52.54	23.07	43.91
Breast cancer screening	25.75	10.86	42.17
Cervical cancer screening	25.75	5.21	20.23

Source: NP-NCD portal, Feb 2025

- Status of NCDs screening in last 09 months against the desired target in the 19 visited states are depicted below:



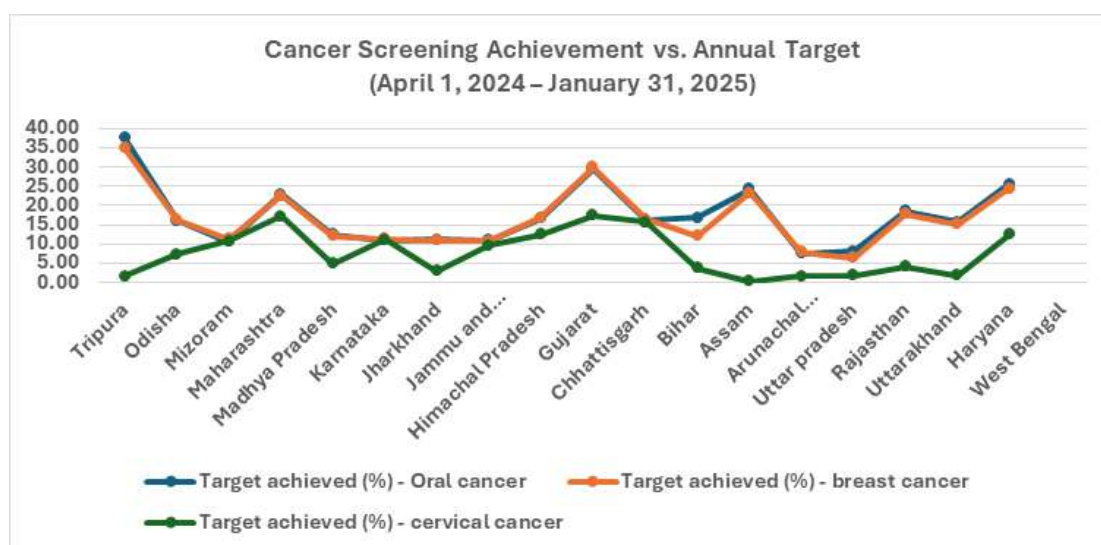
Source: NP-NCD portal, Feb 2025

- Screening for hypertension and diabetes was available at most AAM facilities, but the extent of implementation varied across states. Odisha, Gujarat, and Karnataka demonstrated strong NP-NCD service delivery, while Jharkhand, Rajasthan, and Himachal Pradesh reported gaps in screening, medicine availability, and follow-up care.
- Hypertension and diabetes screenings were routinely conducted at AAM facilities in Odisha,



Gujarat, and Karnataka, ensuring early detection. Jharkhand and Rajasthan reported inconsistent screening, with some AAM-SHCs lacking functional BP monitors and glucometers. Screening rates were observed higher in urban areas compared to rural and tribal regions, particularly in states like Tripura and Himachal Pradesh.

- It was observed that cancer screening for three common cancers (oral, breast & cervix) was available at AAM in states of Odisha and Gujarat. In states of Jharkhand, Rajasthan, and Uttarakhand, there was a low uptake of cancer screening, attributed to lack of trained health care service providers. Community reluctance and limited awareness impacted the coverage of cervical cancer screening in Arunachal Pradesh and Tripura.
- The cancer screening coverage across the 19 states is illustrated below.



Source: NP-NCD portal, Feb 2025

- Odisha and Karnataka ensured regular availability of essential NCD drugs, with state-managed procurement systems. However, frequent stockouts of antihypertensive and diabetes medications were reported in Jharkhand, Rajasthan, and Himachal Pradesh, causing high OOPe for patients. Essential NCD medicines were available in only 40-50% of AAM facilities in Uttar Pradesh and Tripura, affecting continuity of care.
- Odisha and Gujarat had structured referral pathways linking AAM facilities to higher centres for advanced NCD management. However, Jharkhand and Rajasthan lacked systematic referral tracking, resulting in loss to follow-up for



patients needing secondary or tertiary care. Follow-up mechanisms for hypertension and diabetes were weak in Uttarakhand and Tripura, leading to poor long-term disease management.

- Some key challenges in NP-NCD implementation included shortage of trained personnel to conduct cancer screening in Jharkhand, Rajasthan, and Uttarakhand, limited awareness campaigns on NCD prevention in Tripura, Himachal Pradesh, and Arunachal Pradesh, and poor medicine stock availability, forcing patients to seek treatment at private facilities, increasing OOPE.
- ASHAs in Odisha and Karnataka were actively administering CBAC surveys in respective catchment areas, ensuring early identification of at-risk populations. Though limited ASHA involvement in NCD awareness programs was reported in Jharkhand, Rajasthan, and Tripura.
- IEC campaigns promoting lifestyle modification and risk reduction were well-executed in Odisha and Gujarat but minimal in Jharkhand and Uttarakhand.

NATIONAL PROGRAMME FOR HEALTH CARE OF ELDERLY (NPHCE)



- Elderly healthcare services were observed partially integrated at AAM level, with efforts underway to expand dedicated geriatric clinics across states. Odisha, Gujarat, and Karnataka have taken significant steps in strengthening geriatric care, while other states are working towards enhancing service delivery for senior citizens.
- Odisha and Gujarat have successfully introduced dedicated geriatric clinics at select AAM-PHCs, significantly improving access to elderly care. Meanwhile, Jharkhand and Rajasthan are focusing on expanding structured geriatric services beyond basic OPD consultations to provide more comprehensive care for the elderly.
- Routine screening for elderly-related NCDs (hypertension, diabetes, arthritis) was conducted in Odisha and Karnataka but was inconsistent in Himachal Pradesh and Jharkhand.
- Odisha and Karnataka ensured the availability of essential geriatric medicines, including antihypertensives, analgesics, and calcium supplements. While frequent stockouts of elderly care medicines were reported in Jharkhand, Rajasthan, and Uttarakhand, forcing patients to buy medications from private pharmacies.
- Palliative care and pain management medicines for bedridden elderly patients were not available at most AAM facilities.

- Odisha and Gujarat had established referral pathways for elderly patients requiring specialized geriatric care at secondary and tertiary facilities. However, Jharkhand and Rajasthan lacked structured referral tracking for elderly patients, resulting in poor follow-up care.
- Routine vision, hearing, and mobility screenings were being conducted in Gujarat and Karnataka but were absent in Himachal Pradesh and Tripura.
- Some key challenges in NPHCE implementation included limited trained geriatric care personnel at AAM facilities in Jharkhand, Rajasthan, and Himachal Pradesh, absence of dedicated elderly-friendly infrastructure (e.g., ramps, seating areas, separate OPD counters) at AAM facilities in multiple states and weak home-based care support for bedridden elderly, with ASHAs in Jharkhand and Tripura lacking training in elderly care support.
- ASHAs in Odisha and Karnataka were engaged in elderly healthcare awareness, encouraging routine check-ups at AAM facilities. Limited ASHA involvement in elderly-focused home visits and care coordination was observed in Jharkhand and Rajasthan.
- IEC campaigns for elderly care, including fall prevention and nutritional awareness, were functional in Gujarat but minimal in Tripura and Uttarakhand.

NATIONAL PROGRAMME FOR PALLIATIVE CARE (NPPC)

- Palliative care services at AAM facilities are in the early stages of implementation, with ongoing efforts to expand availability across states. Odisha, Gujarat, and Karnataka have taken the lead in establishing structured palliative care programs, while other states are working towards strengthening their provisions.
- Odisha and Gujarat have successfully introduced palliative care services at select AAM-PHCs, providing crucial support for terminally ill and bedridden patients. Meanwhile, Jharkhand and Rajasthan reported focussed approach on expanding structured palliative care services at the primary level to reduce dependency on secondary and tertiary facilities.
- Home-based palliative care was reported in a few states like Karnataka and Himachal Pradesh but remained informal and largely unstructured. Karnataka implemented limited home-based palliative care services, including pain management and support for bedridden patients. While Jharkhand, Rajasthan, and Tripura had no systematic home-based palliative care programs, leaving family members solely responsible for patient care.
- Odisha and Gujarat ensured the availability of essential pain management medications, including opioids for end-of-life care, at select AAM facilities. While Jharkhand and Rajasthan faced frequent stockouts of pain management drugs, forcing patients to seek medicines from private pharmacies.
- Odisha and Karnataka had structured referral pathways for palliative care patients, linking AAM facilities with higher centres for advanced pain management. However, Jharkhand and Tripura lacked proper referral mechanisms, leading to inconsistent patient follow-ups and delayed interventions.
- Some key challenges in NPPC implementation included lack of trained personnel for palliative care at AAM facilities, limiting service availability (in states like Jharkhand and Rajasthan), weak home-based support systems, lack of training for ASHAs in palliative care and low public awareness, particularly in tribal and rural regions, leading to underutilization of available services.
- ASHAs in Odisha and Karnataka were involved in identifying palliative care patients and referring them to AAM facilities. While limited ASHA involvement in palliative care education and home visits was reported in Jharkhand and Rajasthan.
- IEC materials on palliative care were displayed in some AAM facilities in Gujarat but were absent in Jharkhand and Tripura.

NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

- Mental health services at AAM facilities are steadily expanding, with efforts focused on enhancing screening and counselling implementation across states. While variations exist, initiatives are underway to ensure a more consistent and structured approach to mental healthcare.
- Odisha, Gujarat, and Karnataka have taken important steps in integrating mental health services at AAM facilities, setting the foundation for broader implementation. Meanwhile, Jharkhand, Rajasthan, and Himachal Pradesh are working towards strengthening their mental health programs to ensure comprehensive support at the primary healthcare level.
- Odisha and Gujarat initiated basic mental health screening at select AAM facilities, primarily focusing on common disorders like anxiety and depression. While Jharkhand, Rajasthan, and Tripura lacked routine mental health screening, leaving early detection largely unaddressed. Mental health screening was limited to opportunistic cases, with no structured mental health assessment protocols at most AAM facilities.
- Odisha and Karnataka ensured the availability of basic psychotropic drugs (e.g., antidepressants and anxiolytics) at AAM-PHCs. While Jharkhand, Rajasthan, and Himachal Pradesh faced frequent stockouts of psychiatric medicines, leading to increased OOPE for patients. Many AAM facilities lacked a proper inventory of psychiatric medicines, affecting continuity of care for mental health patients.
- Odisha and Gujarat initiated counselling services at select AAM facilities, supported by trained CHOs. However, Jharkhand and Rajasthan lacked trained personnel for mental health counselling, leading to inadequate service delivery.
- Referral pathways for severe mental health cases were functional in Odisha but remained weak or absent in Tripura and Himachal Pradesh.
- Key challenges in NMHP implementation included limited awareness among frontline healthcare workers about mental health conditions in states like Jharkhand, Rajasthan, and Himachal Pradesh, low patient footfall at mental health services due to stigma and lack of awareness in multiple states and ASHAs not adequately trained to identify and refer individuals with suspected mental health disorders in most states.
- ASHAs in Odisha and Karnataka were engaged in community-based mental health awareness efforts, encouraging early help-seeking. While Jharkhand, Rajasthan, and Tripura had limited ASHA-led mental health awareness activities.
- IEC materials on mental health were displayed in some AAM facilities in Gujarat but were absent in Jharkhand and Himachal Pradesh.

NATIONAL VIRAL HEPATITIS CONTROL PROGRAMME (NVHCP)

- Screening and treatment services for Hepatitis B and C are gradually being integrated into primary healthcare, with ongoing efforts to enhance accessibility at AAM facilities. While most states currently rely on secondary and tertiary centres for management, steps are being taken to strengthen primary-level interventions.
- Odisha, Gujarat, and Karnataka have initiated screening and awareness programs, contributing to early detection and prevention efforts. Meanwhile, Jharkhand, Rajasthan, and Tripura are working towards expanding implementation to improve hepatitis management at the primary healthcare level.
- Odisha and Gujarat have successfully introduced targeted hepatitis screening as part of routine antenatal care and high-risk population screening, paving the way for broader integration of these services.
- Jharkhand, Rajasthan, and Himachal Pradesh had no structured hepatitis screening at AAM

facilities, leading to missed opportunities for early diagnosis.

- Screening efforts were largely opportunistic, with no systematic population-based approach in most states.
- States like Odisha and Karnataka linked hepatitis-positive patients to higher centres for free treatment under NVHCP. However, Jharkhand and Rajasthan lacked clear referral pathways, forcing patients to seek private healthcare for hepatitis treatment.
- Essential medicines for hepatitis management were not stocked at AAM facilities in most states, increasing the burden on patients.
- Key challenges in NVHCP implementation included limited awareness among frontline workers and community members about viral hepatitis transmission and prevention in states like Jharkhand, Rajasthan, and Tripura, weak integration of NVHCP with routine primary healthcare services, leading to poor screening coverage and no dedicated IEC campaigns on hepatitis prevention in multiple states, contributing to low testing uptake.
- Role of ASHA varied across states in hepatitis prevention and control programme. ASHAs in Odisha and Karnataka were actively engaged in awareness campaigns on hepatitis prevention, focusing on safe injection practices and vaccination. However, Jharkhand, Rajasthan, and Tripura lacked ASHA-led awareness efforts, resulting in low public engagement in hepatitis prevention.
- IEC materials on hepatitis control were displayed in Gujarat but were largely absent in Rajasthan and Himachal Pradesh.

NATIONAL ORAL HEALTH PROGRAMME (NOHP)

- Oral health services are being progressively integrated into AAM facilities, with efforts underway to ensure more consistent implementation across states. While some variations exist, initiatives are being undertaken to strengthen routine dental screenings and preventive care within primary healthcare.
- Odisha, Gujarat, and Karnataka have successfully established functional oral health services at select AAM-PHCs, enhancing accessibility to dental care. Meanwhile, Jharkhand, Rajasthan, and Tripura are focusing on expanding structured implementation to improve oral health service delivery at the primary level.
- Odisha and Gujarat had operational oral health screening programs, with routine dental check-ups being conducted at AAM-PHCs while Jharkhand, Rajasthan, and Tripura had no systematic oral health screening at AAM facilities, leading to undetected dental conditions.
- Most screenings were limited to opportunistic cases, with no population-wide oral health assessments.
- Karnataka and Gujarat had dedicated dental OPD services at select AAM-PHCs, offering basic procedures like scaling and extractions. Jharkhand and Rajasthan had no structured dental services, with most patients being referred to district hospitals.
- Availability of dental consumables (e.g., fluoride varnish, sealants) was inconsistent across AAM facilities, limiting preventive dental care.
- Key challenges in NOHP implementation included limited dental workforce at AAM facilities, with many facilities lacking trained dental surgeons or oral health practitioners, lack of awareness about oral health among community members, particularly in rural and tribal areas and weak integration of oral healthcare with routine primary healthcare services, affecting service uptake.
- ASHAs in Odisha and Karnataka were engaged in community-based oral health awareness programs, promoting dental hygiene practices. Jharkhand, Rajasthan, and Tripura had limited ASHA-led awareness efforts, reducing preventive oral healthcare uptake.
- IEC materials on oral health were displayed in Gujarat but were absent in Rajasthan and Himachal Pradesh.

NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF FLUOROSIS (NPPCF)

- Fluorosis prevention and control efforts are gradually expanding, with ongoing initiatives aimed at strengthening implementation at the primary healthcare level. Efforts are being made to enhance screening and awareness programs across states.
- Odisha and Gujarat have taken initial steps by introducing fluorosis screening and awareness programs, contributing to early identification and prevention. Meanwhile, Jharkhand, Rajasthan, and Tripura are working towards establishing dedicated NPPCF activities at AAM facilities to improve fluorosis management and outreach.
- Odisha and Gujarat initiated limited fluorosis screening in high-risk areas but lacked structured follow-up services. Jharkhand, Rajasthan, and Himachal Pradesh did not conduct routine fluorosis screening at AAM facilities, leading to undiagnosed cases.
- Screening was primarily opportunistic, with no state-wide systematic approach.
- Odisha provided basic management services, including nutritional support for affected individuals. Jharkhand and Rajasthan lacked clear treatment protocols, forcing patients to seek tertiary care for fluorosis management.
- No specific medication for fluorosis treatment was stocked at AAM facilities in most states.
- Key challenges in NPPCF implementation included limited availability of trained personnel to diagnose and manage fluorosis at AAM facilities, no structured surveillance or early detection mechanisms in most states, leading to delayed interventions and weak integration of fluorosis control activities within primary healthcare, particularly in high-burden districts.
- ASHAs in Odisha and Gujarat were involved in community sensitization programs about safe drinking water sources. Jharkhand, Rajasthan, and Himachal Pradesh lacked ASHA-led awareness activities, contributing to poor fluorosis prevention efforts.
- IEC materials on fluorosis prevention were available in Gujarat but absent in most other states.

PROVISION OF AN EXPANDED RANGE OF SERVICES (COMMON OPHTHALMIC AND ENT PROBLEMS, ORAL HEALTH, ELDERLY AND PALLIATIVE CARE, EMERGENCY MEDICAL SERVICES AND MENTAL, NEUROLOGICAL AND SUBSTANCE USE DISORDERS)

In addition to the programme specific findings, the following are the observations on the expanded package of services rolled out in AAM:

- Gujarat, Karnataka, and Odisha have made notable strides in integrating ophthalmic, ENT, oral health, and mental health services, enhancing accessibility to specialized care. Meanwhile, Jharkhand, Rajasthan, and Tripura are actively working towards strengthening implementation to ensure broader service availability at the primary healthcare level.
- Ophthalmic and ENT Services: Gujarat and Odisha initiated basic ophthalmic and ENT screening services at select AAM-PHCs. Jharkhand and Rajasthan lacked routine ophthalmic and ENT screenings, forcing referrals to district hospitals. Equipment such as Snellen charts and otoscopes were available at some AAM facilities in Karnataka but absent in Jharkhand and Tripura. IEC materials related to ophthalmic and ENT services were displayed in Gujarat but were absent in Tripura and



Himachal Pradesh.

- **Elderly and Palliative Care:** Odisha and Karnataka had structured geriatric clinics at AAM-PHCs, providing NCD management and supportive care. Jharkhand and Rajasthan lacked systematic palliative care services, with no dedicated staff trained for home-based care. Home visits for bedridden elderly patients were initiated in select AAM facilities in Gujarat but remained informal in other states.
- **Emergency Medical Services:** Basic emergency medical care (first aid, stabilization) was available at AAM-PHCs in Gujarat and Odisha. Jharkhand and Rajasthan lacked functional emergency care services, forcing patients to rely on higher facilities. Essential emergency drugs and first aid kits were inconsistently available across AAM facilities, affecting timely interventions.
- **Challenges in Service Expansion** included limited workforce availability for specialized services (ophthalmic, ENT, dental, and mental health practitioners), lack of equipment and consumables, affecting the delivery of expanded services in states like Jharkhand and Rajasthan and poor referral coordination for advanced care, leading to delays in treatment initiation.
- **ASHAs in Odisha and Karnataka** were involved in sensitization campaigns for oral health, mental health, and elderly care. Jharkhand and Rajasthan lacked ASHA-led awareness initiatives, reducing the uptake of expanded services.

GOOD PRACTICES (CPHC)

ASSAM

- **EDD Calendar:** Expected date of delivery (EDD) calendar is being maintained at AAM (Khandakhaity Char PHC) to track month-wise delivery status of all expected deliveries including High Risk Pregnancy cases.
- **Boat Clinic:** Boat clinic is operated with the support from National Health Mission to deliver essential healthcare services including ANC, PNC and vaccination in Morigaon char areas catering to 10313 population (22 villages) in the district. During the FY 2023-24, 220 camps were organised, with an average of 18 camps per month. More than 234 ANC cases were registered, out of which 28 High Risk Pregnancies were detected. A total of 210 Postnatal women were visited. In 2023-24, 90 institutional deliveries and 118 home deliveries were reported.



CHHATTISGARH

- Mukhyamantri Haat Bazar Clinic Scheme:** Launched in October 2019, the Mukhyamantri Haat- Bazar Clinic Scheme aimed to bring essential healthcare services directly to rural and underserved areas through mobile clinics at local Haat Bazaars (markets). By October 2024, the scheme had expanded to 1,720 mobile clinics operating across the state with 450 dedicated vehicles. These clinics provide a range of services, including antenatal checkups, NCD checkups, eye care, malnutrition screenings, skin disease & HIV checkups, and family planning advice. They also offer 10 types of diagnostic tests such as malaria, dengue, and blood sugar tests, and dispense 60 types of medicines. The clinics have conducted over 2,76,240 health camps, benefiting more than 19 million people. With online referrals and immediate treatment, the scheme has transformed healthcare access for millions, particularly in remote areas. Through this initiative, the government has successfully delivered essential health services where they are needed most.
- Siyan Jatan Clinic:** As National Programme for the Health Care for the Elderly (NPHCE) is dedicated to provide health care facilities to the senior citizens (>60 year of age) at various level of primary, secondary and tertiary health care; hence in line of the same, the state of Chhattisgarh organizes Siyan Jatan Clinic on first Wednesday of every month at all Ayushman Arogya Mandirs to provide essential healthcare services to people aged 60 and above. Under this, health cards are issued to all elderly citizens, ensuring they have access to personalized medical care. Those with vision and hearing impairments receive glasses and hearing aids. Wellness activities like yoga sessions promote better physical and mental health, while walking sticks are distributed to help with mobility. Dental screenings and treatments are provided, addressing oral health issues that many elderly face. Additionally, specialist medical camps are held to address specific health concerns.
- Mother's Picnic:** On the 9th day of each month, Korba, Chhattisgarh, hosts the Mother's Picnic as part of the Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA). This special event focuses on providing high-quality antenatal care to pregnant women in their 2nd and 3rd trimesters, along with counselling on health services under the SUMAN initiative, RMC (Respectful Maternity Care), and gender equality.



GUJARAT

- Gauravi/Kishori Diwas:** is celebrated every Wednesday in the second half (post Mamta Diwas). Sessions cover topics such as nutrition, age of marriage, menstrual hygiene etc. IFA supplements and sanitary napkins are also provided at the sessions.



HIMACHAL PRADESH

- **Home visits for Terminally ill Patients and Palliative care:** Special outreach camps are also being conducted. Fast tracking of TB patients. The dialysis services were provided free of cost to all beneficiaries through the CSR scheme by M/s Hans Foundation. The diagnostic testing facilities were adequate at all the levels and services were complimented by the PPP- Service provider.

JHARKHAND

- **Perpetual Calendar:** Perpetual calendar type IEC for ANC care and UIP of child (to determine the schedule and next date of immunization)

KARNATAKA

- **WhatsApp Groups on Antenatal and Neonatal Care:** Virtual referral linkages connecting PHC, CHC MOs and Specialists at higher levels had been initiated. This led to a well-functioning emergency response system utilising WhatsApp facility in referring emergency antenatal and neonatal cases, facilitating preparedness of the receiving facility as well. In Ballari, it was noted that the higher facility would even update the arrival and status of the patient, thus ensuring closure of the loop.
- **Pre-conception Folic Acid:** The State has also started the initiative to provide pre-conception folic acid to couples planning their family through ASHAs for the reduction of neural tube defects.

ODISHA

- **CHO Exposure visits:** As part of its capacity-building initiatives, Odisha has organized exposure visits for the CHOs to Chhattisgarh and Madhya Pradesh, facilitating cross-learning and knowledge sharing. During the Financial year 2023-24, a total of 60 CHOs visited these States. Furthermore, the State has also organized international exposure visits to Dubai and Singapore, providing a week-long training programme for 26 nursing officers, including CHOs, since 2023-24. These international exposure visits are part of a comprehensive capacity-building programme that caters to all levels of healthcare functionaries, from ASHAs to senior departmental officers.
- **Nirmal Scheme:** The Nirmal Scheme has been initiated to provide free ancillary services and enhanced facilities in all the State-run government hospitals, thereby ensuring accessible and affordable healthcare for all. The primary focus is on providing basic facilities like sanitation, laundry, security, lift services and to ensure quality health care services affordable for to the people. All the designed services under “Nirmal” are taken up through outsourced mode engaging competent agency decided through competitive bidding process. “Nirmal” individual agency is engaged based on the competency in the assigned area of services. Facility-wise Norms for budgeting have been laid under the Nirmal Scheme.

MAHARASHTRA

- **Night Clinic:** State has set Night Clinic under Malwan Taluka, a coastal area, where new cases of Filariasis have been detected. The night clinic is manned by HA and MPW for rigorous detection, especially night blood smear, treatment and follow up of Filariasis.

UTTAR PRADESH

- **Alternate Vaccine Delivery:** The AVD system has proven to be an effective innovation for streamlining vaccine logistics. Ensuring the timely delivery of vaccines to health facilities significantly reduces wastage and ensures consistent availability of vaccines for immunisation sessions. This system also alleviates logistical responsibilities for Auxiliary Nurse Midwives (ANMs), allowing

them to dedicate more time to community healthcare activities, such as immunisation outreach and counselling. Expanding the AVD system to cover all regions, particularly underserved areas, will improve immunisation outcomes and strengthen the vaccine delivery mechanism.

UTTARAKHAND

- **Comic Book for Awareness:** The state has introduced an innovative approach to raise awareness among children through a comic book titled “Little Chanakya-Uttarakhand Hai taiyarr, Dengue, Malaria aur Tb per hoga War” by utilizing the power of storytelling and visuals, the comic book effectively conveys important health messages, helping to instil awareness and encourage healthy behaviours from a young age.

WEST BENGAL

- **Choker Alo:** Team noted implementing Chokher Alo initiative for universal eye screening and community-based initiatives has augmented National Programme for Control of Blindness & Visual Impairment (NPCBVI) services in the community.

KEY RECOMMENDATIONS

- States to expedite the functionality of AAM in order to ensure provision of all 12 expanded range of services and wellness activities across the primary care facilities, as envisaged at national level.
- Infrastructure at AAM facilities to be standardized by ensuring consistent branding, reliable power and water supply, and the establishment of dedicated wellness spaces. Furthermore, infrastructure gaps in U-AAM facilities, particularly in West Bengal, Rajasthan, and Chhattisgarh, are to be addressed to enhance service readiness and accessibility.
- Recruitment and retention strategies for healthcare personnel are to be improved by implementing structured hiring processes and offering competitive incentives, particularly in remote areas. Additionally, training programs under SASHAKT should be expanded to comprehensively cover emergency care, NCD screening, mental health services, and teleconsultation to enhance healthcare service delivery.
- Digital tracking mechanisms for high-risk pregnancies and referral systems are to be strengthened to ensure timely interventions. In addition, the availability of essential maternal health medicines and the quality of institutional delivery facilities are to be improved to enhance maternal and newborn health outcomes.
- Routine immunization monitoring is to be strengthened to track zero-dose children and ensure the maintenance of cold chain systems. Moreover, efforts should be made to ensure an uninterrupted vaccine supply and expand community awareness campaigns to improve immunization uptake across all regions.
- Infant and Young Child Feeding (IYCF) programs are to be strengthened to ensure optimal nutrition for children. Additionally, the functionality of Nutritional Rehabilitation Centres (NRCs) is to be ensured, and referral mechanisms for sick newborns improved to enhance child health outcomes.
- Contraceptive supply chains are to be strengthened to prevent stockouts and enhance accessibility to family planning services. Furthermore, ASHA-led counselling and community awareness programs should be expanded to increase contraceptive uptake and improve male participation in family planning.
- The provision of Medical Termination of Pregnancy (MTP) services is to be strengthened by ensuring adequate provider training and service delivery. Additionally, stock availability of MTP drugs should be maintained consistently, and post-abortion counselling services expanded to

ensure comprehensive abortion care.

- Peer educator training, menstrual hygiene support, and school health programs should be expanded to improve adolescent health services. Moreover, adolescent-friendly counselling services and the regular distribution of sanitary napkins are to be strengthened to ensure better adolescent healthcare access.
- Surveillance mechanisms and community engagement for TB, leprosy, vector-borne diseases, and rabies prevention should be improved to enhance disease control efforts. Additionally, notification systems for TB and leprosy are to be strengthened, medicine availability ensured, and vector control activities improved to enhance program effectiveness.
- Hypertension, diabetes, and cancer screening services should be scaled up, particularly in rural and tribal areas. In addition, consistent medicine supply should be ensured, and referral linkages for specialized NCD care strengthened to improve primary-level management. Effective referral linkages need to be established across AAM for ensuring continuum of care.
- Mental health integration within primary healthcare should be strengthened by expanding screening and counselling services. Additionally, the availability of essential psychotropic medicines should be ensured, and ASHA-led community awareness programs expanded to improve mental health outreach.
- Routine oral health screenings should be expanded, and dedicated geriatric clinics established at select AAM facilities to improve elderly care. Furthermore, home-based palliative care services should be enhanced, and structured referral pathways for advanced care strengthened to ensure continuity of care.
- Supply chain management should be strengthened, and real-time drug tracking through DVDMS implemented to prevent stockouts. Additionally, point-of-care testing (PoCT) for NCDs and infectious diseases should be expanded to enhance diagnostic efficiency and treatment access. Penetration of DVDMS upto AAM-SHC level to be ensured.
- Compliance with biomedical waste segregation and disposal standards is to be improved by ensuring the availability of color-coded bins and training programs for AAM personnel. Furthermore, regular capacity-building initiatives should be implemented to enhance healthcare worker adherence to BMW disposal norms.
- Preventive maintenance schedules should be established, and faster repair turnaround times ensured to reduce equipment downtime. Additionally, structured repair mechanisms should be developed to ensure the continued functionality of critical diagnostic and treatment tools.

STATE SPECIFIC FINDINGS ON CPHC

ARUNACHAL PRADESH

- Out of the 12 CPHC service packages, an average of 7 packages were available in West Siang District and 9 in Longding District. Key gaps included lack of training for CHOs in eye care, ENT, palliative care, geriatrics, mental health, cervical cancer screening (VIA), and IUCD insertion.
- Community awareness of AAM services was limited, with most visits centred around routine medication refills for diabetes and hypertension. Awareness of wellness activities organized at AAM facilities was notably low.
- The state had 432 targeted AAM facilities, with 383 (89%) operational in FY 2023-24 and 390 (90%) in FY 2024-25. Longding achieved 100% operationalization in FY 2023-24, while West Siang improved from 94% in FY 2023-24 to 100% FY 2024-25.
- AAM facilities in West Siang had adequate waiting areas, dedicated spaces for labs, labour rooms, and wellness activities, and sufficient HRH as per CPHC guidelines and IPHS.

- In contrast, Longding faced infrastructural challenges, including limited space, absence of separate toilets, lack of piped water supply, staffing shortages, poor approach roads, intermittent power supply, and weak internet connectivity.
- Branding of AAM facilities was implemented in West Siang but not in Longding. The state had not uniformly rolled out AAM branding across districts.
- In Longding, the majority of PHC-AAM facilities were managed by AYUSH MOs due to the unavailability of MBBS MOs, leading to gaps in service delivery.
- Essential drugs and diagnostics were insufficient across AAM facilities. Only 6-8 diagnostic tests were available at AAM-SHCs, while ~12 tests were available at PHCs.
- The EDL included 102 drugs for AAM-SHCs and 172 for PHCs, yet only 60-80 drugs were stocked in the facilities. Frequent stockouts of essential medicines (especially for hypertension and diabetes) were observed, with 15-day lead times for replenishment.
- Family planning services were available, but no IUCD insertion training was provided to ANMs/CHOs. IEC materials on JSY, JSSK, and FP entitlements were absent at visited facilities.
- Maternal and child health services were suboptimal, with VHSND sessions regularly conducted in Longding but not in West Siang. Special health camps were organized for ANC services and immunization.
- Tracking of high-risk pregnancies was inadequate, with no separate high-risk pregnancy line lists, hindering effective monitoring and follow-up.
- IV iron therapy for anaemia was provided, but tracking of subsequent doses among pregnant and lactating women was weak.
- Home deliveries were common due to long distances and high institutional costs, despite AAM facilities functioning as birthing points.
- Training programs (SBA, NSSK, KMC, MDR, and CDR) needed expedited implementation to strengthen service delivery.
- Routine immunization and child nutrition services were satisfactory. Cold chain management, open vial policy, and vaccine stock tracking were well maintained.
- Vaccine hesitancy was high (65%), affecting routine immunization coverage. The state aimed to achieve 90% full immunization and had developed a Zero Dose Implementation Plan (ZIP) with GAVI HSS-3 Grant support.
- ORS corners were absent at AAM facilities. CHOs and ANMs required training in IMNCI, FIMNCI, and FBNC.
- Teleconsultation services were operational but affected by poor network connectivity. Specialist consultations were time-limited, and service utilization was low.
- Cancer screening services remained inconsistent, with cervical cancer screening (VIA) unavailable at the primary level due to community reluctance.
- Adolescent health services were provided through school visits, with IFA tablets available.
- Malaria screening was actively conducted, and both districts were declared Malaria-Free for the past two years.

ASSAM

- Assam has achieved 92% operationalisation of AAM facilities against the approved target of 5320 facilities, with 4901 facilities converted into AAM facilities as of November 2024. The state aimed to achieve 100% operationalisation by December 2024 during the visit.
- Rebranding of AAM facilities was completed across most of the districts. AAM-PHCs were disabled-

friendly, but AAM-SHCs lacked accessibility features.

- Inadequate waiting areas and dedicated wellness spaces were observed in many AAM-SHCs. Potable drinking water was available at all facilities, but power backup was absent at most locations.
- Challenges with internet connectivity impacted digital health services.
- Citizen charters were missing at some facilities.
- Continuous capacity building for doctors, nurses, and paramedical staff was lacking, affecting service delivery. Some ASHAs were untrained in NCDs and HBNC/HBYC modules. MOs and CHOs were not oriented to the population-based approach of service delivery.
- Availability of essential medicines was below recommended levels: AAM-SHCs stocked only 36-40 out of the 105 essential medicines, while AAM-PHCs stocked 80-100 out of the 172 required drugs.
- AAM-SHCs conducted 7-10 out of 14 recommended lab tests, while AAM-PHCs performed 37 out of 63 tests. Some diagnostic services were outsourced under PPP models, but equipment breakdowns led to service gaps.
- Expansion of the state Essential Medicines List (EML) for AAM facilities was recommended.
- The Hub and Spoke model for diagnostics was functional and effective.
- NCD screening was being conducted, but ASHAs in some facilities were unaware of how to fill CBACs.
- Teleconsultations were underutilized due to poor internet connectivity, with only 1-2 consultations per day at AAM-SHCs, mainly for acute illnesses.
- Information about referral centres was not consistently displayed, affecting patient navigation.
- Home-based follow-up care by ASHAs (e.g., HBNC services) was suboptimal.
- Annual Health Calendar days were displayed and observed at AAM-SHCs, with active community participation.
- JAS were formed in rural areas but not in urban locations; JAS members were not trained. VHSNCs were functional but lacked a focus on social determinants of health and community ownership.
- Awareness campaigns for public health service utilization were insufficient, leading to low patient footfall at AAM facilities.
- Relevant IT portals, including the state-owned “Swasthya Sewa Dapoon,” were functional, but staff lacked training in data entry and portal usage. Internet connectivity was unavailable at many facilities, affecting the efficiency of digital health records and reporting. Delayed data entry and slow IT application performance were common issues. Integration of IT systems and synchronization with the ABDM was recommended.
- E-Sanjeevani teleconsultation services were operational but faced challenges due to poor internet connectivity and lack of specialist availability. Waiting times for teleconsultations stretched to 2-3 hours, discouraging utilization.
- MOs at AAM-PHCs often handled calls meant for specialists, reducing patient confidence in teleconsultation services. A structured roster for specialist availability on teleconsultation platforms was recommended.
- Limited cervical cancer screening (VIA) at AAM-SHCs, with low community acceptance for the procedure. Family planning services were available, but IUCD insertions were limited due to a lack of trained personnel. High teenage pregnancy rates were noted, necessitating stronger adolescent health interventions.
- OOPE remained high, with patients paying for transport, diagnostics, and medications despite government provisions.

- Institutional deliveries were occurring, but many mothers left the facility within 3-6 hours post-delivery, limiting postnatal care and counselling opportunities.

BIHAR

- Bihar has 10,331 operational AAM facilities, significantly improving access to primary healthcare in both rural and urban areas. Kaimur has 151 operational AAM-SHCs and 20 AAM-PHCs, while Gaya has 447 AAM-SHCs and 30 AAM-PHCs.
- Branding and renaming of AAM facilities were completed in Gaya but not in Kaimur. Directional signage was absent, impacting visibility and ease of access. Many AAM facilities operated in government-owned buildings requiring repairs and renovations.
- Waiting areas and OPD spaces were inconsistent, with some facilities lacking seating arrangements. No ramps, wheelchairs, or disabled-friendly provisions were observed in either district.
- Separate male and female toilets were available in Gaya but missing in Kaimur.
- Electricity and water supply were available, but Kaimur lacked power backup.
- Biomedical waste management was compliant with CPCB guidelines, but IEC materials and grievance redressal mechanisms were absent. CHOs in Kaimur were posted across two AAM-SHCs, working three days at each center, which impacted continuity of care.
- ANM vacancies in Kaimur forced ASHAs to take on additional responsibilities, affecting their fieldwork. MOs were absent at APHC Karigawan (Kaimur) for two years, leaving the facility managed by a Staff Nurse and an ANM.
- CHOs had limited training, mainly in NCD management, but not in expanded service areas such as oral, eye, ENT, elderly care, palliative care, and emergency services.
- Basic health services were provided, but none of the facilities delivered all 12 CPHC packages.
- AAM-SHCs catered to 9,000 individuals across 9-10 villages, with an average daily OPD of 20-30 cases. AAM-PHCs catered to 50,000+ individuals, with an average daily OPD of 50-70 cases.
- Family planning services were available, but CHO counselling was inadequate. IUCD insertions were not performed at AAM-SHCs in Kaimur; patients were referred to CHCs instead.
- Limited immunization services at SHCs in Kaimur due to ANM shortages.
- Hypertension and diabetes screenings were routine, but oral and breast cancer screenings were unavailable. Cervical cancer screening (VIA) was not conducted due to a lack of trained personnel. No mapping of elderly or palliative care patients was performed in catchment areas.
- Rapid diagnostic tests (RDTs) for malaria and dengue were available, but preventive IEC activities were absent.
- Tuberculosis (TB) diagnostic services were unavailable at AAM-SHCs and AAM-APHCs, though TB medications were dispensed.
- AAM facilities used multiple IT systems (e.g., Nikshay, IDSP, e-Sanjeevani, NCD, AAM portal, Ashwin Portal, Bhavya Portal), but real-time data entry was inconsistent.
- No referral tracking system was in place, and follow-up of downward referrals was limited.
- Teleconsultation was underutilized due to a lack of specialist availability.
- Ambulance services were inconsistent, with delays in mobilizing patients from their residence to facilities.
- Essential drug availability was inadequate with 127 drugs were available at AAM-SHCs out of 151 notified drugs and 123 drugs were available at AAM-APHCs out of 180 notified drugs. Supply chain management was functional, with indenting performed every three months.

- Diagnostics were limited, with 10 point-of-care diagnostics available at AAM-SHCs and 5-6 diagnostics available at AAM-APHCs. Drug & diagnostic lists were not displayed at most facilities, affecting transparency.
- CHOs received Rs 40,000/month (Rs 32,000 fixed + Rs 8,000 incentives). Other staff were unaware of team-based incentives, leading to low motivation.
- Limited implementation of all 12 CPHC service packages. Infrastructure deficiencies, including lack of signage, seating, disabled-friendly facilities, and power backup.
- Critical staff shortages, particularly of MOs and ANMs. Lack of training in comprehensive service delivery.
- Limited awareness and utilization of AAM facilities among communities.

CHHATTISGARH

- 90% of AAM facilities have been operationalised, covering 5,851 out of 6,459 targeted facilities. The operationalisation rates are: AAM-SHCs: 4,472 out of 4,842 (92%), AAM-PHCs: 759 out of 792 (95%), AAM-UPHCs: 54 out of 61 (88%), AAM-USHCs: 167 out of 364 (46%) and Ayush AAM facilities: 399 out of 400 (99%).
- Rebranding and renovation completed at most facilities, except for AAM-SHC Bagdol (Jashpur), which used a temporary banner.
- Most AAM facilities had adequate waiting areas and space for Yoga and Wellness activities, except for a few non-NQAS certified centres. Separate toilets for male and female patients were available in all visited AAM facilities.
- Deep burial pits for biomedical waste disposal were present at all AAM-SHCs.
- NQAS-certified facilities had well-maintained green spaces and herbal gardens, promoting holistic healthcare.
- Uninterrupted water and electricity supply were available at AAM-SHC Bagdol and AAM-PHC Shekharpur (Jashpur).
- Gariyaband District Hospital lacked adequate infrastructure, requiring urgent upgradation.
- Permanent boundary walls were missing at most AAM facilities, increasing security risks. Facilities were not disabled-friendly, lacking ramps, wheelchairs, and accessible toilets. Lack of visual privacy in consultation areas, with no curtains or partition screens in some AAM facilities.
- Color-coded biomedical waste bins were not consistently available, requiring improved waste segregation.
- Several AAM facilities lacked dedicated laboratory/diagnostic spaces, impacting service delivery.
- Non-functional or poorly maintained water filtration systems in multiple AAM facilities raised concerns about drinking water quality. Inadequate lighting in AAM-PHCs and AAM-SHCs, affecting patient comfort and staff efficiency.
- Chhattisgarh implemented a specialist cadre with differential payments based on qualifications and difficulty of posting locations. Performance-linked payments were distributed through a dedicated software system, ensuring timely disbursement to CHOs.
- Acute shortage of MOs and specialists, with financial incentives failing to attract personnel. Recruitment decentralised at the district level, but the process needed acceleration.
- Pharmacists, ophthalmic assistants, and field officers were available in all visited primary healthcare facilities, along with ANMs, Staff Nurses, and Data Entry Operators at AAM-PHCs.
- None of the AAM facilities were delivering all 12 CPHC service packages. Essential diagnostic services were missing in some facilities, and service availability varied across districts.

- NCD screening was routine, but cancer screening (oral, breast, cervical) was rarely performed. Palliative care and geriatric health services required further integration into primary care.
- No dedicated referral pathways for complex cases, leading to overcrowding at secondary and tertiary facilities. Absence of a structured referral tracking mechanism resulted in poor patient follow-up.
- Multiple IT applications (ABDM, e-Sanjeevani, state portals) were in use, but real-time data entry was inconsistent.
- Teleconsultation services were functional but underutilized due to internet connectivity issues.
- Siyan Jatan Clinic for elderly healthcare was operational at all AAM facilities, providing geriatric care services.
- Mukhyamantri Haat Bazar Clinic Scheme facilitated mobile healthcare services in remote areas, benefiting 19 million people through 1,720 mobile clinics.
- JAS was functional but required capacity building for effective community participation.
- Limited awareness campaigns on AAM services resulted in low public utilization.

GUJARAT

- Around 97% AAM facilities were operational. The State has achieved 99-100% operationalization of AAM-SHCs and AAM-PHCs. With regard to AAM-UPHCs and AAM-USHCs, slightly lower achievement rates (92% and 77%, respectively) were observed.
- Infrastructure in U-AAM facilities was well-developed, with adequate waiting areas, laboratory spaces, and wellness activity spaces.
- AAM facilities lacked power backup mechanisms, though solar panels were installed in Kachchh using CSR funds.
- Branding and signage were completed at most facilities, but Vadodara's U-AAM facilities were still in the process of standardizing IEC materials and branding.
- Drinking water availability, sanitation, and biomedical waste disposal were well-managed. Some AAM facilities lacked disabled-friendly amenities, such as ramps and accessible toilets.
- Training on the expanded 12 CPHC service packages was completed in Vadodara but pending in Kachchh.
- Laboratory facilities were sufficient at AAM-SHCs and AAM-PHCs, but AAM-USHCs had space constraints for diagnostics.
- Wellness activities, including yoga sessions, were actively conducted under CHO supervision.
- Teleconsultation services via e-Sanjeevani were underutilized in Kachchh, mainly due to limited awareness and technical issues.
- CHOs and MOs were deployed as per norms, but training on certain service areas (e.g., geriatric care, palliative care) needed improvement.
- Staff incentives were structured, ensuring timely payments.
- Pharmacists and diagnostic staff were available in visited AAM facilities.
- Drugs were available in most AAM facilities, but state EDL needed updating to align with service expansion.
- Diagnostics were available at AAM-SHCs and AAM-PHCs, but USHC-AAM facilities had limited laboratory space.
- e-Aushadhi was used for drug stock management, but manual indenting still caused delays.

- BEMMP was functional, but equipment downtime at regional facilities needed to be addressed.
- JAS was active, but decisions taken in meetings were not well documented. VHSNCs and RKS were functional, but urban RKS funds were not optimally utilized.
- Public awareness campaigns were needed to enhance utilization of AAM services.

HARYANA

- 90% of AAM facilities have been operationalised across Haryana. AAM-SHCs, AAM-PHCs, and AAM-UPHCs were upgraded, but AAM-USHCs in Palwal were still pending completion.
- Facilities in Palwal were well-connected by roads, but there were no directional signages leading to AAM facilities.
- Most AAM-PHCs visited were NQAS-certified, with AAM-PHC Allika maintaining the Kayakalp Award since 2017.
- Branding and signage were compliant in most facilities, but some still displayed both “Health and Wellness Centre” and “Ayushman Arogya Mandir” boards.
- Disability-friendly features (ramps, wheelchairs, and stretchers) were available at AAM-PHCs, but not at visited AAM-SHCs in Palwal.
- AAM-PHCs had sufficient space for OPD, waiting areas, laboratory services, pharmacies, and wellness activities, but AAM-UPHCs lacked designated spaces for wellness activities and herbal gardens.
- Toilets for male and female patients were available in AAM-PHCs, but some AAM-SHCs in Palwal faced water supply issues, making their toilets non-functional.
- Electricity, potable water, and solar panels for power backup were available at AAM-PHCs.
- AAM-SHCs were staffed by CHOs, while AAM-PHCs had MOs managing service provision.
- AAM-SHCs handled 15-20 patients per day, while AAM-PHCs managed 40-50 OPD cases daily.
- Dental OPDs in AAM-PHCs recorded 15-20 cases per day, with services including extractions, root canal treatments, and scaling.
- Expanded service delivery remained incomplete, with limited availability of oral health, eye care, ENT, geriatric, palliative, and emergency care services.
- ANC, immunization, and family planning services were provided.
- IUCD insertions were performed regularly in AAM-PHCs, but uptake was low at the AAM-SHC level.
- Delivery points at AAM-PHCs were functional, with well-equipped labor rooms and Newborn Care Corners (NBCCs). PHC Sihol’s deliveries declined from 30 per month to just 1-3 per month due to a staff shortage. Postnatal care services were not well-utilized, as many mothers left within hours after delivery.
- Vector-borne disease surveillance (malaria, dengue) was in place, with Gambusia fish ponds maintained at AAM-PHCs.
- TB patients’ treatment records were well-maintained and mapped with the Nikshay portal.
- Routine screening for hypertension and diabetes was conducted, but cervical cancer screening (VIA) was not performed in Palwal due to inadequate training. Opportunistic oral cancer screening was performed by dental surgeons, but other cancer screenings remained unavailable.
- e-Sanjeevani teleconsultation services were available at AAM-PHCs but were not used consistently. Teleconsultation services were irregular, mainly due to staff shortages and unplanned scheduling.
- CHOs and MOs had limited awareness of IT systems and data entry for teleconsultation services.

- Home-based palliative care services were initiated at AAM-PHCs, including catheter and Ryle's tube removal for bedridden patients.
- Essential medicines were not consistently available. AAM-SHCs stocked only 20-30 of the 106 notified drugs. AAM-PHCs had 70-80 of the 173 notified drugs.
- DVDMS was not implemented; a state-specific decentralized procurement portal (DPMU) was used.
- Stock-outs were common due to delays in Non-Availability Certificates (NACs), which were issued only after three months of non-supply.
- AAM-SHCs conducted only 8 of the 14 recommended point-of-care tests. AAM-PHCs performed 16-20 of the 63 recommended tests.
- Cold chain management for vaccines was functional, but data discrepancies were noted in stock registers.
- JAS were functional but required reconstitution to include elected representatives and community members. VHSNCs were active but lacked training on their roles and responsibilities.
- Limited public awareness regarding expanded service offerings at AAM facilities affected service utilization.

HIMACHAL PRADESH

- Himachal Pradesh has 2,079 notified AAM-SHCs, with 1,221 (59%) operational. Hamirpur had an 86% operationalisation rate, while Shimla was at only 35%.
- Government-owned infrastructure housed all facilities, but branding as AAM was incomplete, with most centres still displaying the old "Health and Wellness Centre" signage.
- OPD footfall was 15-25 patients per day in AAM-PHCs, with lower footfall in AAM-SHCs.
- Power backup was unavailable in all visited AAM facilities.
- Most AAM-PHCs had functional waiting areas, designated lab spaces, and separate toilets, but AAM-SHCs lacked space for wellness activities.
- Boundary walls were missing at multiple facilities, compromising security.
- Access to facilities in hilly terrain remained a challenge, with no clear signages on approach roads.
- Disabled-friendly infrastructure, such as ramps, was absent in several facilities.
- Space constraints affected wellness activities, particularly at PHC Annadale and PHC New Shimla.
- 7-8 out of the 12 CPHC service packages were available across most AAM facilities.
- ANC services were routinely provided, with ASHAs facilitating population enumeration for NCD screening and ensuring service delivery.
- Institutional deliveries occurred at AAM-PHCs, but no AAM-SHC functioned as a birthing point.
- IUCD insertions were available at PHCs but not at AAM-SHCs.
- Hypertension and diabetes screenings were regularly conducted, with medicine dispensation.
- Cervical cancer screening (VIA) was not performed due to a lack of trained personnel.
- Oral cancer screening was conducted at AAM-PHCs by dental surgeons, but breast cancer screening remained unavailable.
- Palliative care services were initiated, including home-based physiotherapy.
- Routine immunization services were conducted, with well-maintained vaccine cold chains.
- Vector-borne disease surveillance was active, with malaria reduction targets achieved.

- CHOs were absent in several AAM-SHCs, leading to service delivery gaps.
- MOs at AAM-PHCs managed multiple centres, affecting continuity of care.
- Dental services were well-established at PHC Nalti, with a high OPD footfall.
- Lack of sanitation workers led to JAS funds being used for contractual hiring.
- AAM-SHCs stocked 36 drugs, while AAM-PHCs had up to 70 essential drugs. Stock-outs of IFA syrup and other key medicines persisted for months.
- AAM-SHCs offered only 8 of the 14 recommended point-of-care tests. AAM-PHCs performed 16-20 of the 63 recommended tests.
- Stock-outs of Antara injections and other contraceptives have been reported in some areas. IFA syrup was unavailable for six months at both SHC Neri and SHC Bhira and two months at PHC Nalti, affecting maternal and child health services.
- Sub-centers received medicines from PHCs but lack a system for indenting drugs based on consumption. The incomplete rollout of DVDMS at SHCs further hampers inventory tracking and timely supply, worsening the availability and stock-out issues.
- Laboratory services were available at AAM-PHCs through outsourced PPP models, but blood sample transportation mechanisms required improvement.
- Multiple IT platforms, including e-Sanjeevani, were in use, but internet connectivity issues hampered their effectiveness.
- Teleconsultation services were available but inconsistently utilized due to limited patient awareness.
- Referral mechanisms were weak, with direct referrals to district hospitals bypassing AAM-PHCs.
- Data entry and digital reporting systems required staff training.
- JAS was functional, but members lacked clarity on their roles and responsibilities.
- IEC materials were not prominently displayed, affecting awareness of AAM services.
- VHSNCs were active, but their focus on social determinants of health needed strengthening.

JAMMU AND KASHMIR

- 94.6% (3,092 out of 3,651) of approved AAM facilities were operational as of October 2024.
- Increased OPD footfall was observed across AAM facilities, indicating growing community acceptance.
- NCD services were widely available, leading to improved health-seeking behaviour.
- Most AAM facilities were housed in government buildings, but several AAM-SHCs continued to function from rented spaces.
- Basic infrastructure was satisfactory, with consistent water and electricity supply.
- Fixed power backups (inverters) were installed in AAM facilities in areas with scheduled power cuts.
- Internet connectivity was a major concern, with no fixed-line connections available at AAM-SHCs. CHOs and MLHPs relied on personal mobile phones for IT-based applications and teleconsultations.
- The old “Health and Wellness Centre” signage was still visible in some facilities, requiring replacement.
- AAM facilities had not yet fully implemented all 12 CPHC service packages.
- Most facilities provided services up to NCD care, but cancer screening and geriatric care services were absent.

- Commonly treated conditions included respiratory infections, ANC, and musculoskeletal pain.
- Dedicated wellness spaces were present in all visited facilities, but yoga and health promotion activities were conducted irregularly.
- Wellness calendars were displayed, but adherence to scheduled activities was inconsistent.
- CHOs were present across most facilities, but three AAM-SHCs in Uri block faced CHO shortages. In these cases, CHOs were rotated among multiple facilities, and senior pharmacists were deputed on a temporary basis.
- CHOs received a remuneration of ₹33,250 per month, with an additional ₹8,000 performance-linked incentive.
- A one-month backlog in salary payments was reported across several AAM facilities.
- Shortage of essential medicines was a major challenge. Patients frequently incurred OOPEx to purchase unavailable medicines. In some cases, alternative drug dosages were supplied, forcing patients to buy the correct dose externally.
- Diagnostic services faced supply chain disruptions, leading to irregular availability of consumables and reagents.
- DVDMS was functional only at the PHC level and partially operational, affecting medicine availability.

JHARKHAND

- The state has 3,974 notified AAM facilities, with 2,293 facilities operational as of September 2024.
- AAM facilities in East Singhbhum and Sahibganj had inconsistent service provision, with only 7 out of the 12 CPHC service packages being rolled out.
- Infrastructure branding was completed in most AAM facilities, but some centres lacked clear signages and citizen charters.
- AAM-PHCs had better infrastructure, including waiting areas, designated laboratory spaces, and examination rooms, while AAM-SHCs faced space constraints.
- Basic amenities like water and electricity were available, but some AAM-SHCs lacked boundary walls and disabled-friendly access.
- Power backup was unavailable in all AAM facilities, affecting service continuity.
- Cold chain management was functional for immunization services, but some centres lacked dedicated vaccine storage.
- Limited implementation of all 12 CPHC packages, with focus mainly on reproductive, child health, communicable diseases, and NCD screening.
- ANC, immunization, and family planning services were available, but high-risk pregnancy screening was inadequate.
- IUCD insertions were not being performed in some AAM-PHCs, despite having delivery points.
- Oral, breast, and cervical cancer screenings were not being conducted, due to lack of trained staff and awareness.
- NCD screening was limited to hypertension and diabetes, with no structured palliative care or geriatric services.
- Dental services were available at AAM-PHCs, but treatment was limited to extractions and symptomatic relief.
- CHOs were present in most AAM facilities, but some facilities had CHOs covering multiple centres, affecting continuity of care.

- Training for CHOs on all CPHC service packages was incomplete, affecting delivery of expanded care.
- Staff shortages affected service delivery, particularly in rural and tribal areas.
- AAM-SHCs stocked only 36-40 of the 106 notified essential medicines, while AAM-PHCs had 70-80 of the 173 required drugs.
- Frequent stockouts of essential medicines were reported, leading to OOPE for patients.
- Diagnostics were limited, with only 8 out of 14 point-of-care tests available at AAM-SHCs, and 16-20 out of 63 tests at AAM-PHCs.
- Drug procurement was managed through DVDMS, but supply chain delays impacted availability.
- e-Sanjeevani teleconsultation services were functional, but underutilized due to poor network connectivity.
- Multiple IT platforms, including NIKUSHAY (TB), DVDMS (drug inventory), and AB-HWC portals, were in use, but data entry was inconsistent.
- Referral pathways were weak, with patients often being sent to tertiary facilities without proper documentation.
- JAS was functional, but needed capacity building to strengthen community participation.
- VHSNCs were active, but lacked proper orientation on their responsibilities.
- Awareness about AAM services was limited, leading to low utilization of preventive health services.

KARNATAKA

- Karnataka has operationalized 7,042 (77%) AAM facilities, with a target of 9,135 functional AAM facilities by March 2025.
- The urban and rural AAM facilities were functional, with adequate infrastructure, patient waiting areas, designated laboratories, and disability-friendly features.
- Branding was standardized, with facility names displayed in local language.
- Outdoor spaces for wellness activities were well-maintained, and cleanliness and hygiene standards were followed.
- All visited facilities, including rented buildings, had appropriate AAM branding.
- AAM-PHCs had well-equipped delivery rooms with privacy measures, but institutional deliveries were limited due to community preference for higher-level facilities.
- Green initiatives, including solar power, were observed in newer PHCs designated as 'Sustainable Health Centers'.
- CSR and Smart City funds were used to enhance infrastructure, including boundary walls, electricity backup, and maintenance of buildings.
- ANC and institutional deliveries were actively promoted, but many beneficiaries still preferred private hospitals for deliveries due to privacy concerns. ANC registration was high (81% in the first trimester), and PMSMA days were organized regularly.
- Immunization coverage was nearly 100%, with strong community preference for government-sector vaccination.
- IUCD insertions were performed, and a wide basket of contraceptive choices was available.
- ASHAs maintained Eligible Couple Registers and were key contraceptive providers.
- Opportunistic screening for diabetes and hypertension was conducted, but cervical cancer screening was limited to symptomatic cases.

- A state-led initiative, 'Gruha Arogya Yojana', delivered NCD screening, drug supply, and follow-up care at home for those above 30 years.
- Palliative care and geriatric services were functional but had low uptake.
- Oral, eye, and ENT services were available at AAM-PHCs but were limited in AAM-SHCs.
- CHOs were present across all AAM facilities, with training on CPHC service delivery.
- Specialist visits to PHCs for PMSMA and referral care were organized, but not consistently available at all facilities.
- Performance-linked payments were in place for CHOs, ensuring accountability.
- Essential medicines were available in 90% of facilities, with stocks procured via Karnataka State Medical Supplies Corporation (KMSCL). Anti-Rabies Vaccine (ARV) and Anti-Rabies Serum (ARS) were available up to AAM-PHC levels. Non-Communicable Disease (NCD) medicines were available at the visited AAM-SHCs.
- Diagnostic services were mostly available in-house, but a few facilities lacked trained lab technicians.
- Cold chain management was maintained for vaccines, but power backup was a challenge in some PHCs.
- e-Sanjeevani teleconsultation was available, with 35-40 calls per day per PHC, but some centers completed consultations just to meet targets.
- Referral tracking was weak, with upward referrals occurring frequently but downward referrals not being followed up.
- Multiple IT portals were in use, including e-Aushadhi and Mera Aspataal, but connectivity issues persisted.
- JAS and VHSNCs were functional, but community awareness of AAM services was low.
- IEC materials were displayed at most facilities, and wellness activities, including yoga, were conducted in many AAM facilities.

MADHYA PRADESH

- 9,483 out of 10,189 AAM-SHCs (93%) are operational, while 1,176 out of 1,178 AAM-PHCs (99%) are functional.
- Branding and signage were in place across most AAM facilities, except in some AAM-USHCs and AAM-PHCs (Rahat, Rewa).
- IEC materials in the local language were well-displayed, covering key health services and priority areas.
- Dedicated spaces for OPD consultation, drug storage, and laboratory services were adequate, but facilities lacked designated areas for wellness activities.
- Disabled-friendly infrastructure, including ramps and wheelchair accessibility, was absent in most AAM facilities.
- Separate toilets for men and women were unavailable in most facilities, with only one common toilet in place.
- Water and electricity supply were inconsistent, with no power backup available in most AAM facilities.
- Boundary walls were missing in several AAM facilities, affecting security.
- CHOs were aware of their roles, and good teamwork was observed at the AAM-SHC level.
- MOs at AAM-PHCs were primarily engaged in OPD services, with limited involvement in CPHC

delivery.

- MOs lacked clarity on the 12 CPHC service packages and National Health Programs, resulting in insufficient supportive supervision for CHOs and other staff.
- Lab technicians were underutilized, performing only program-specific diagnostic tests.
- CHOs were trained in the expanded package of services (excluding emergency care), but other primary healthcare team members (ANMs, ASHAs, MPWs) lacked training.
- No training plan or calendar was available at the district level for primary healthcare staff.
- Service delivery was focused on RMNCHA+N services and communicable diseases such as malaria, tuberculosis, and leprosy.
- Limited implementation of the expanded package of services, largely due to a lack of training among primary healthcare workers.
- NCD screening was primarily for hypertension and diabetes, with oral, breast, and cervical cancer screenings either unavailable or conducted inconsistently.
- All AAM facilities had a designated family planning corner with a basket of contraceptive choices, ensuring easy access for clients.
- ORS corners were available in all AAM facilities, facilitating diarrhea management.
- A separate breastfeeding corner was observed in AAM-UPHC Sarekha (Balaghat).
- Drug availability at AAM-SHCs was 50-80 out of the required 126 essential medicines. AAM-PHCs stocked approximately 129 out of 300 essential drugs, while AAM-UPHCs had 130-180 of 209 required drugs.
- Diagnostics were inadequate, with AAM-SHCs offering 11-12 out of 17 recommended point-of-care tests and AAM-PHCs conducting 60-65 out of 80 recommended tests.
- Drug procurement was managed via the MP Aushadhi portal, ensuring systematic indenting.
- Some AAM facilities displayed drug stocks alphabetically, with expiration dates clearly marked for improved tracking.
- Cold chain management was functional, ensuring vaccine potency.
- Multiple IT platforms were in use, including AAM portal, ANMOL-RCH, DASTAK, MP Aarogyam, MP Aushadhi, HR-MIS, HMIS, e-Sanjeevani, and CPHC-NCD portals.
- Primary healthcare teams were not fully trained in using IT systems, leading to delays in real-time data entry.
- Teleconsultation services were conducted through e-Sanjeevani, but were often used to meet targets rather than for genuine medical needs.
- PPP-mode teleconsultation services were available at AAM-PHCs, but follow-up consultations were minimal.
- Referral mechanisms were weak, with patients often being referred directly from AAM-SHCs to district hospitals, bypassing AAM-PHCs.
- No referral tracking system was in place, and details of referral centers were not displayed at AAM facilities.
- JAS was functional, but members lacked clarity on their roles. JAS monthly meetings were not regularly conducted, and minutes of meetings were poorly maintained.
- Untied fund utilization was inconsistent, with unspent funds in Balaghat and incomplete utilization certificates in Rewa.
- ASHAs were actively engaged in community mobilization, but had limited awareness of digital tools for health record management.

- Health promotion activities were under-documented, despite wellness sessions being conducted.

MAHARASHTRA

- The state has operationalized a significant number of AAM facilities, with most facilities having appropriate branding, signage, and dedicated service spaces.
- AAM-PHCs and AAM-SHCs in Sindhudurg and Akola districts demonstrated good infrastructure, but some facilities lacked additional funding for integrating Ayush services.
- Co-location of Ayush services was observed, but no new infrastructure or financial support was provided for dedicated Ayush OPDs.
- Some AAM facilities had not undergone any major renovation since 2014, limiting service expansion.
- Adequate patient waiting areas, laboratory spaces, and separate toilets for male and female patients were available at most AAM-SHCs.
- Power backup was available through inverters, but no generator-based power supply was present.
- Drinking water availability was consistent, and boundary walls were intact at most AAM facilities.
- Some facilities lacked disability-friendly amenities, such as ramps and accessible toilets.
- No diagnostic facilities like X-ray were available at AAM-PHCs, affecting service delivery.
- Comprehensive primary healthcare services were not fully implemented, with only 7-9 out of the 12 service packages being delivered.
- OPD services were conducted from 8:30 AM onwards, followed by outreach services and home visits by ANMs and MPWs.
- Routine health screenings, including ANC, PNC, and immunization services, were consistently provided.
- NCD screening was integrated into routine services, with oral and breast cancer screening corners operational at some AAM-PHCs.
- Diabetes screening in pregnant women was performed using random blood sugar (RBS) instead of the recommended OGTT method.
- IUCD kits were available, but emergency contraceptives and Antara injections were not stocked.
- Screening and intervention for Severe Acute Malnutrition (SAM) and Moderate Acute Malnutrition (MAM) were carried out through coordination with Anganwadi workers.
- Teleconsultation services were available, with 5-6 consultations per day, but patient satisfaction remained low due to a preference for in-person consultations.
- AAM-PHCs had adequate staffing, including Medical Officers, Staff Nurses, CHOs, MPWs, and ANMs.
- Training on the expanded 12 CPHC packages was inconsistent, with many frontline workers lacking refresher training.
- Referral mechanisms for high-risk pregnancies were robust, but community confidence in deliveries at AAM-PHCs was low.
- An acute shortage of specialists (gynaecologists, radiologists, and anaesthetists) was observed at AAM-PHCs, leading to referrals to higher facilities.
- Stock availability of essential medicines was inconsistent. Emergency contraceptives and FP basket choices were incomplete. No drug kits for comprehensive abortion care were available at AAM-SHCs or with ASHAs.
- Laboratory diagnostics were available but limited. Only rapid diagnostic kits (RDks) were available

for HIV, HBsAg, VDRL, Dengue, Malaria, and UPT. Microscopy for malaria and filaria was available, but other biochemistry tests were outsourced due to a lack of centrifuge machines.

- Drug stock indenting through DVDMS was functional, but there were frequent stockouts due to delays in procurement.
- Teleconsultation services were available through e-Sanjeevani, with 5-6 consultations per day, but uptake was low due to patient preference for in-person visits.
- WIFI connectivity was strong, facilitating IT-based health services.
- HMIS data entry was performed by untrained staff, leading to incomplete and inconsistent reporting.
- JAS were active, with regular meetings and engagement of local representatives.
- RKS at AAM-PHCs were functional, but MAS had not been fully established.
- Public awareness campaigns on NCDs and MCH services were conducted through audio speakers in waiting areas.
- IEC materials on various health programs were available, but their placement was inconsistent across AAM facilities.
- Inconsistent availability of all 12 CPHC service packages across AAM facilities.
- Lack of refresher training for CHOs, ANMs, and other primary healthcare staff.
- No dedicated spaces for conducting deliveries in AAM-SHCs, leading to low utilization of institutional delivery services.
- Patient dissatisfaction with telemedicine services, with a strong preference for physical consultations.
- Shortages of drugs, especially for family planning and emergency contraceptives.

MIZORAM

- The state has 99 operational AAM facilities across Lunglei and Kolasib districts, covering SHC-AAM facilities, PHC-AAM facilities, and UPHC-AAM facilities.
- All facilities were housed in government-owned buildings, except UAAM Pukpui and Venglai East, which were in rented or community-owned buildings.
- Infrastructure was sufficient for service delivery, but dedicated spaces for wellness activities were not available in AAM-SHCs.
- Boundary walls were intact at visited facilities, ensuring security.
- Branding and signage were completed, but the state had not implemented the official rebranding of HWC to AAM as per GoI guidelines.
- Most facilities lacked ramps and disabled-friendly toilets, affecting accessibility.
- Power backup was available through inverters and solar systems, but solar power was non-functional at Hrangchawkawn UPHC.
- Water supply was consistent, supported by rainwater harvesting systems at most facilities.
- Clean and functional toilets were available in PHC/UPHCs, but separate male and female toilets were absent in some AAM-SHCs.
- AAM facilities provided OPD services, but comprehensive primary healthcare services were inconsistently available.
- On average, PHCs recorded 30-35 OPD visits per day, while AAM-SHCs recorded only 5-6, attributed to sparse population distribution.
- Family planning services were available, with trained staff performing IUCD insertions and removals.

- ANC and immunization services were well-established, but vaccine hesitancy was noted due to religious beliefs in some communities.
- High-risk pregnancy tracking was incomplete at some SHC-AAM facilities, though it was well-maintained at PHC Haulawng.
- Home deliveries persisted in some areas, especially among hard-to-reach populations, despite institutional delivery promotion efforts.
- Maternal and child health services (SUMAN program) were being implemented, but SUMAN volunteers had not been identified in some districts.
- Screening for hypertension and diabetes was being conducted, but cervical cancer screening (VIA) needed strengthening.
- Limited geriatric and palliative care services were available, with some home visits conducted by CHOs.
- Most facilities had adequate staffing, but pharmacist and lab technician vacancies were reported in Lungsen block.
- MO, Staff Nurses, and CHOs were available at AAM-PHCs and UPHCs, ensuring basic service delivery.
- Teleconsultation services were functional but underutilized, with MOs using personal mobile phones for e-Sanjeevani due to the lack of facility-based devices.
- Medicine availability was inadequate, with only 55% of the notified drugs available at AAM-SHCs.
- Near-expiry and expired medicines were found at multiple visited facilities, highlighting gaps in stock management.
- AAM-SHCs performing only 9-11 of the 14 recommended diagnostic tests. AAM-PHCs conducting 19-27 out of the recommended diagnostics.
- DVDMS had been rolled out to AAM-SHCs, but supply chain inconsistencies remained a challenge.
- Biomedical waste disposal was inconsistent, with waste segregation issues and improper disposal methods noted.
- Multiple IT platforms were in use, including NIKSHAY, DVDMS, NCD portal, AAM Portal, IHIP, and e-Sanjeevani.
- Poor internet connectivity affected real-time data entry and teleconsultation services.
- DVDMS portal was functional but not effectively used, with long gaps in medicine indenting.
- JAS were functional, with regular meetings recorded.
- IEC materials on health programs were displayed in most facilities, but placement was inconsistent.
- Community engagement was strong, with ASHAs actively involved in outreach programs.
- Advocacy efforts to address vaccine hesitancy included involvement of religious leaders.

ODISHA

- The state has received approval for 8,662 AAM facilities, including AYUSH AAM facilities. As of October 2024, 7,348 (85%) AAM facilities were operational, distributed across various levels: AAM-SHCs: 81% operational, AAM-PHCs: 97% operational, AAM-UPHCs: 100% operational, AAM-UWHCs: 91% operational and AYUSH AAM facilities: 99% operational.
- Recruitment of CHOs was ongoing to achieve full operationalisation, with a strategy to depute Nursing Officers to AAM-SHCs to address the shortfall.
- A six-month Certificate Course in Community Health (CCCH) was condensed to four months to

expedite CHO recruitment, conducted in 26 government nursing institutions.

- All visited AAM facilities had independent water sources, power supply with inverters for backup, and proper branding as per GoI norms.
- Most facilities had compound walls, with only one exception noted.
- IEC materials were consistently displayed, providing essential service information to beneficiaries.
- BMW disposal guidelines were not being followed despite the availability of color-coded bins.
- 95 out of 106 essential drugs available in most AAM facilities. Indenting for medicines was still manual, and the state planned to integrate Niramaya for timely updates and stock monitoring. 10 out of the 16 recommended diagnostic tests were available, with supply shortages affecting full implementation.
- Teleconsultations were being conducted efficiently, with specialist consultations available within five minutes via the e-Sanjeevani platform.
- Equipment kits for CPHC were provided, but their usage needed to be encouraged and monitored.
- MOs, CHOs, MPWs, and ASHAs were recruited as per sanctioned posts, with some categories exceeding required numbers.
- A significant shortage of staff nurses persisted, with only 41% of the sanctioned posts filled (535 out of 1,296 posts vacant).
- The state had made significant progress in training healthcare personnel on expanded primary healthcare services, 100% of MOs trained, 98% of MPWs trained and 69% of CHOs trained but 12% of Staff Nurses trained, with ongoing programs. Additionally, 98% of rural ASHAs and 92% of urban ASHAs were also trained
- ANC, immunization, and high-risk pregnancy tracking were well implemented.
- IUCD insertions were available, but acceptance was low.
- Injections of Antara were underutilized due to concerns about side effects.
- ORS corners were set up for diarrhea management, ensuring availability of ORS and Zinc supplementation.
- ASHAs played a key role in ensuring follow-up of pregnant women and newborns.
- SUMAN initiative was implemented, with 41 facilities certified in Sambalpur and 69 in Koraput.
- Screening for hypertension and diabetes was consistent, but cervical cancer screening (VIA) had not yet been initiated. Oral and breast cancer screenings were conducted on an ad-hoc basis, rather than being systematic.
- Palliative care services were limited, with no structured reporting system in place.
- Integrated NCD and elderly care weekly clinics were operational at AAM-PHCs and UPHCs.
- Drug stock availability was at 90% across AAM-SHCs and AAM-PHCs, with gaps noted in specific essential drugs.
- NCD medicines were available but downward referrals were not being implemented, forcing patients to visit higher facilities.
- Diagnostic test availability needed to be improved, especially in rural areas where only 10 of 16 recommended tests were available.
- e-Sanjeevani teleconsultation services were well-integrated, with specialists available within minutes.
- WIFI and IT connectivity were functional at most facilities, but data entry by untrained staff led to inconsistencies in HMIS reporting.

- Multiple IT platforms were in use, including NIKSHAY for TB, DVDMS for medicine inventory, AAM Portal for facility management and IHIP for integrated disease surveillance.
- Referral tracking was weak, with patients often bypassing AAM-PHCs in favor of district hospitals.
- JAS were functional and conducted regular meetings, but members lacked full clarity on their roles.
- IEC materials on health programs were available, though placement was inconsistent.
- ASHAs and frontline workers played a major role in community mobilization, with strong engagement in maternal and child health programs.
- BMW disposal guidelines were not being followed, despite the availability of color-coded bins.
- Downward referrals for NCD patients were not implemented, limiting medicine access at AAM-SHCs.
- Limited uptake of palliative care services, with no structured home visits conducted by CHOs or MOs.

RAJASTHAN

- Rajasthan has a target of 17,858 AAM facilities to be operationalized by 2024-25, with 9,546 (53%) currently functional.
- CHOs are essential for the operationalization of AAM-SHCs, and recruitment of 5,261 CHOs is in process through the Rajasthan Employee Selection Board.
- AAM-PHCs and UPHCs had Medical Officers (MOs), Staff Nurses, Lab Technicians, Pharmacists, ANMs, and Data Entry Operators, ensuring a functional primary healthcare team.
- PHC-AAM facilities and UPHC-AAM facilities had good infrastructure, proper branding, and designated service areas, including waiting areas, registration counters, drug dispensing counters, and laboratory areas.
- Power backup was unavailable in many PHC-AAM facilities and UPHC-AAM facilities, and water supply issues persisted.
- SC-AAM facilities had limited space, lacked proper wellness areas, laboratory infrastructure, and potable water supply.
- Most visited PHC-AAM facilities were conducting normal deliveries and operated 24×7, but the number of deliveries was low.
- OPD load at PHC/UPHC AAM facilities was 60-80 patients per day, while SC AAM facilities saw 20-30 patients per day.
- ANC were regularly conducted, with ASHAs maintaining high-risk pregnancy tracking.
- Family planning services were available, with condom boxes, oral contraceptives, and Antara injections being the preferred choices.
- IUCD insertions were not performed at SC AAM facilities, and PPIUCD uptake at PHC AAM facilities was low.
- Only one facility in Sikar was SUMAN-notified, while Bharatpur lacked awareness and implementation of SUMAN services.
- Immunization services were available, but due to power backup issues in Bharatpur, vaccine storage conditions were not optimal.
- E-VIN was functional for vaccine tracking, but the digital OTP-based system created access issues for households without phones.
- NCD screening was conducted at PHC AAM facilities, but cancer screening (cervical, breast, and

oral) was limited due to inadequate training and equipment.

- TB services were being provided, including Active Case Finding (ACF) at the community level, but there were delays in DBT payments under Nikshay Poshan Yojana.
- Mental health and elderly care services were unavailable, and no IEC materials were present for elderly care promotion.
- Palliative care services were minimal, with CHOs identifying cases but lacking palliative care kits.
- CHOs, ANMs, and ASHAs were present at most AAM facilities, but there was a shortage of lab technicians at PHC/UPHC AAM facilities, affecting diagnostic services.
- Only a few CHOs were trained in extended CPHC services (NCD, ENT, eye, palliative care), and even trained CHOs did not implement services due to lack of confidence and space.
- MOs and Staff Nurses lacked refresher training in various health programs.
- Essential drugs were available at SC AAM facilities (40-50 drugs), PHC/UPHC AAM facilities (113-120 drugs), and CHCs (165 drugs).
- Drug storage was organized at PHC/UPHC AAM facilities, but at SC AAM facilities, drugs were stored in clinical areas, violating storage protocols.
- DVDMS was operational at PHC AAM facilities but not fully implemented at SC AAM facilities, leading to delays in drug procurement.
- Diagnostic services at PHC AAM facilities were limited, with only 15-17 tests being conducted instead of the recommended 63 tests per IPHS 2022.
- X-ray services were available at CHCs but lacked compliance with IPHS infrastructure norms.
- Lab management information systems (LMIS) were not implemented, leading to manual documentation and inefficiencies in reporting.
- e-Sanjeevani teleconsultation was available but underutilized, primarily due to poor internet connectivity and lack of specialist availability.
- IHMS for OPD registration was present at a few facilities, but its adoption needed expansion.
- Sub-optimal data entry and delayed reporting were common issues across health facilities.
- JAS were not formed at all AAM facilities, and CHOs/MOs lacked clarity on their functions.
- IEC materials were displayed, but some outdated posters needed replacement.
- Wellness activities, including yoga, were not being conducted consistently at AAM facilities.
- Basic amenities, such as uninterrupted water supply, power backup, and cleanliness, were lacking at multiple AAM facilities.
- Diagnostic services were inadequate at PHC/UPHC AAM facilities, requiring expansion per IPHS 2022 norms.
- NCD clinics at PHC AAM facilities needed increased footfall through community mobilization and awareness efforts.
- Palliative care services were minimal, with no structured follow-up mechanisms.
- BMW management was inconsistent, especially at AAM-SHCs, where waste collection was delayed.

TRIPURA

- AAM facilities have been established across rural and urban regions, with a focus on accessibility and primary healthcare service expansion.

- All AAM facilities had functional branding and signage, but not all followed the official rebranding guidelines of Gol.
- Infrastructure at AAM facilities varied, with AAM-PHCs having better facilities compared to AAM-SHCs, which lacked dedicated spaces for diagnostics and wellness activities.
- Boundary walls were intact at most facilities, ensuring security and structural stability.
- Power backup was available at most facilities, with solar energy systems installed but non-functional in some locations.
- Drinking water was consistently available, supported by rainwater harvesting in some PHCs.
- Separate male and female toilets were available in PHCs, but many AAM-SHCs had common toilets, affecting patient privacy.
- Cold chain management was operational for immunization, with proper temperature monitoring and no reported vaccine stockouts.
- Ramps and disabled-friendly facilities were absent in many AAM-SHCs, limiting accessibility.
- All facilities provided basic OPD services, but delivery of the full spectrum of CPHC services was inconsistent.
- ANC and immunization services were robust, with high rates of institutional deliveries in most districts.
- High-risk pregnancy tracking was functional, but referral pathways were weak, leading to delays in emergency obstetric care.
- IUCD insertions were available, but family planning services needed further promotion, particularly in rural areas.
- Screening for hypertension and diabetes was regularly conducted, but cervical and breast cancer screening was either not done or conducted inconsistently.
- Mental health services were integrated into primary care, but uptake remained low due to social stigma.
- Oral, ENT, and eye screenings were performed, but palliative and elderly care services were limited.
- Most AAM facilities had the required workforce, but shortages were observed in lab technicians and staff nurses in certain PHCs.
- CHOs were present and engaged in community-based health promotion, but many lacked refresher training on expanded service delivery.
- Medical Officers were available at AAM-PHCs, but at AAM-SHCs, CHOs managed most services independently.
- ASHAs were actively involved in maternal and child health services, ensuring continuity of care for ANC and immunization.
- Medicine stock availability varied, with some facilities having only 60-70% of the required drugs.
- DVDMS was used for medicine procurement, but supply chain inconsistencies led to occasional stockouts of essential medicines.
- Diagnostics were available but limited, with AAM-SHCs conducting only 7-10 out of 14 required point-of-care tests.
- AAM-PHCs offering 18-22 of the recommended 63 diagnostic tests.
- Drug storage at AAM-SHCs was inadequate, with some medicines stored in consultation rooms due to lack of proper shelving.
- Biomedical waste disposal was inconsistent, with some facilities failing to segregate waste as per

guidelines.

- e-Sanjeevani teleconsultation services were available, but uptake was low due to poor internet connectivity and patient preference for in-person consultations.
- IT platforms like NIKSHAY, DVDMS, and the AAM portal were in use, but data entry was inconsistent due to inadequate training.
- Referral tracking was weak, with upward referrals being documented but downward referrals rarely followed up.
- JAS were functional, but committee members lacked clarity on their specific roles.
- IEC materials on health programs were displayed, but their placement needed improvement.
- ASHAs played a critical role in community engagement, actively mobilizing women for ANC check-ups and immunization services.
- Comprehensive service delivery was inconsistent, with many facilities offering only a subset of the 12 CPHC packages.
- Stockouts of essential medicines and diagnostic kits affected service continuity.
- Mental health services were underutilized despite being integrated into primary care.
- Referral tracking and follow-up mechanisms needed improvement to ensure continuity of care.
- Biomedical waste management was not strictly followed at many SC-AAM facilities, posing potential risks.

UTTAR PRADESH

- Uttar Pradesh has made significant progress in the establishment of AAM facilities, particularly in Agra and Kushinagar districts.
- AAM-SHCs and AAM-PHCs were operational, but gaps remained in infrastructure, service delivery, and human resources.
- Branding and signage of AAM facilities were consistent across most visited facilities, ensuring clear identification.
- Citizen Charter was absent in many AAM-SHCs and AAM-PHCs, limiting public awareness of available services and their entitlements.
- Persistent dampness, poor maintenance of staff quarters, and structural issues were observed in several AAM facilities, compromising service delivery.
- Fire safety measures were lacking in most AAM facilities, with no fire extinguishers, mock drills, or training.
- Cold chain management for vaccines was functional, but some facilities faced intermittent power supply issues affecting storage conditions.
- Toilet facilities were inconsistent across AAM-SHCs, with many lacking separate toilets for men and women.
- Most facilities lacked ramps and disabled-friendly access, limiting inclusivity.
- Basic OPD services were available across all AAM facilities, but only a subset of the 12 CPHC packages was fully implemented.
- ANC and immunization services were delivered effectively, but high-risk pregnancy tracking faced challenges due to fragmented digital platforms (e-Kawach and U-WIN).
- Maternal Death Surveillance and Response (MDSR) was operational, but reviews lacked actionable insights and often failed to address systemic issues.

- Screening for hypertension and diabetes was conducted, but cancer screening (cervical, breast, and oral) was largely absent.
- Mental health services and palliative care were minimally available, with no structured home visit programs.
- Family planning services, including IUCD insertions and Antara injections, were available, but acceptance remained low.
- SUMAN-certified facilities were limited, with only one facility in Sikar receiving certification.
- Teleconsultation services under e-Sanjeevani were available, but uptake was low due to a lack of patient awareness and weak internet connectivity.
- Severe shortage of CHOs, with over 10,000 vacancies across the state, limiting the reach of AAM-SHCs.
- ASHAs were actively engaged in outreach services, but training on expanded CPHC packages was inadequate.
- Essential drug availability varied, with frequent stockouts of psychotropic medicines and NCD drugs.
- DVDMS was operational for medicine indenting, but inefficiencies in the supply chain led to periodic shortages.
- AAM-SHCs performed only 7-10 of the recommended 14 tests. AAM-PHCs conducted 18-22 out of the 63 required tests as per IPHS 2022 norms.
- Drug storage at AAM-SHCs was inadequate, with some medicines stored in inappropriate conditions.
- BMW disposal was inconsistent, with segregation guidelines not being followed.
- e-Sanjeevani telemedicine services was used for consultations, but providers lacked confidence in using the platform.
- Referral tracking was weak, with upward referrals being recorded but downward referrals rarely followed up.
- Multiple IT platforms (e-Kawach, U-WIN, ANMOL) operated independently, creating inefficiencies in data integration and tracking.
- JAS were not fully functional, with limited community participation.
- IEC materials on health programs were available, but some outdated posters required replacement.
- ASHAs were actively involved in community mobilization, ensuring follow-up for ANC and immunization services.
- Family planning and adolescent health awareness campaigns needed expansion, particularly in rural areas.

UTTARAKHAND

- Uttarakhand has operationalised 1,916 (89%) AAM facilities against the target of 2,149 Primary Healthcare facilities for 2024-25.
- In Dehradun, a total of 191 AAM facilities (PHC: 38, SHC: 116, UPHC: 37) were functional, while in Bageshwar, 118 AAM facilities (PHC: 29, SHC: 89) were operational.
- The state has initiated recruitment of 133 CHOs/MLHPs, and construction for 35 new AAM facilities is ongoing, which was expected to be completed by December 2024.
- Many AAM-SHCs lacked proper branding in Dehradun, whereas in Bageshwar, branding was complete with all six logos displayed.

- Approach roads to AAM-SHCs were in poor condition in both districts; no ramps were available at AAM-SHCs, affecting accessibility.
- Cold chain management for immunization was functional, but intermittent power supply affected storage conditions in some facilities.
- Most facilities lacked separate male and female toilets, impacting patient privacy.
- Dedicated wellness rooms were not available in visited facilities, limiting the scope of wellness activities.
- NCD screening was being conducted at operational AAM facilities, but full coverage was not achieved.
- As per AAM portal data, a total of 81,09,055 people were enrolled, and CBAC forms were filled for 63,46,300 individuals (78%) aged 30+.
- Basic cancer screening (Oral, Breast, and Cervical) was not happening consistently in either district.
- Follow-up care for hypertension and diabetes patients was weak in Dehradun but partially functioning in Bageshwar.
- Healthcare providers lacked knowledge of all 12 CPHC service packages, indicating gaps in training.
- Teleconsultations through e-Sanjeevani were active, with 13,28,275 consultations conducted across six hubs and 820 spokes.
- Delivery points at the primary level were absent, contributing to high home deliveries in remote areas.
- CHOs were in place and aware of their responsibilities, particularly in providing promotive and preventive care and teleconsultations.
- However, there was a shortage of trained MOs and nursing staff, particularly at the AAM-SHC level in Bageshwar.
- Training gaps persisted among PHC and SHC staff, with only CHOs trained on CPHC expanded services.
- Urban ASHAs in Dehradun had received 14-day training on CPHC expanded services, but training for rural ASHAs, MOs, staff nurses, and MPWs was yet to be conducted.
- Essential Medicines and Diagnostics
- DVDMS was implemented at the AAM-PHC level but was not used in AAM-SHCs.
- Essential drug availability was poor, with only 40-50 of the 105 essential drugs available in AAM-SHCs in Dehradun.
- In Bageshwar, NCD medicines were not dispensed by MLHPs/CHOs at AAM-SHCs, forcing patients to travel to AAM-PHCs or higher facilities.
- Point-of-care diagnostic tests were minimal at AAM-SHCs, with most diagnostics being conducted via Chandan Diagnostics under a PPP model.
- Basic cancer screening (Oral, Breast, and Cervical) was lacking at AAM facilities in both districts.
- NP-NCD portal was being used at AAM-SHCs but was not fully utilized at AAM-PHCs, indicating weak digital adoption.
- Only partial data entry was completed in NP-NCD portals, largely due to poor internet connectivity in rural areas.
- DVDMS was available only at higher facilities, limiting medicine tracking and procurement efficiency at AAM-SHCs.
- Teleconsultation services under e-Sanjeevani were active, but providers lacked confidence in

utilizing the platform optimally.

- A total of 1,859 JAS were formed across the state, covering AAM-SHCs: 1,488, AAM-PHCs: 357, AAM-UPHCs: 1 and AYUSH-AAM facilities: 13.
- JAS meetings were irregular at the AAM-PHC level, affecting fund utilization and community participation.
- Untied funds were fully released for AAM-SHCs in Dehradun but only partially released in the Kapkot block of Bageshwar.

WEST BENGAL

- West Bengal has operationalized 11,051 (98.23%) AAM-SHCs, 906 (99.02%) AAM-PHCs, and 475 (95.38%) AAM-UPHCs out of the approved facilities.
- U-AAM facilities had the lowest operationalization rate (27.5%), indicating a lag in urban primary healthcare implementation.
- Infrastructure at SSK-HWCs (AAM) was well-maintained, with branding and signage following Government of India norms.
- Cold chain management for vaccines was functional, but potable water supply was absent in some facilities, particularly in Malda.
- Waiting areas were available at most facilities, but UPHCs had to increase seating capacity due to patient overcrowding.
- Separate toilets for males and females were present, but cleanliness remained a concern.
- Most facilities lacked accessibility features for persons with disabilities, including ramps and designated areas for differently abled individuals.
- Power backup systems (inverters and generators) were available at AAM facilities in Malda, while other facilities in South 24 Parganas utilized rainwater harvesting systems for sustainability.
- Some AAM-PHCs and UPHCs lacked designated space for wellness activities.
- AAM facilities were delivering core RMNCHA+N services, but uptake of extended CPHC services was inconsistent.
- ANC registration and maternal health tracking were functional, with ASHAs maintaining due lists and referral pathways for high-risk pregnancies.
- Family planning services were available, with high uptake of Antara injections but very low rates of male sterilization.
- In South 24 Parganas, doorstep ANC screening and kit-based diagnostics were provided, with high-risk pregnancies referred to PMSMA camps.
- Universal Immunization Program was well-implemented, with triple elimination of HIV, Hepatitis B, and Syphilis incorporated into routine immunization.
- NCD screening was available but focused mainly on hypertension and diabetes; oral, breast, and cervical cancer screenings were minimal.
- Yoga rooms with dedicated instructors were available at each facility visited.
- Geriatric screening was implemented at UPHCs in South 24 Parganas, ensuring priority care for the elderly.
- CHOs were present at most AAM facilities and were trained on their roles and responsibilities, but there were gaps in refresher training.
- ASHAs were actively engaged in home visits, maternal and child health tracking, and family planning counselling.

- Lab technician vacancies remained a challenge, affecting diagnostic service availability at AAM-SHCs.
- 26 diagnostic tests were available at UPHCs, but PHCs lacked laboratory services.
- AAM-SHCs performed only rapid diagnostic tests, limiting their ability to provide comprehensive care.
- DVDMS was in place for medicine indenting, but drug stockouts were reported, especially for psychotropic medicines and NCD drugs.
- BMW disposal was not consistently followed, with improper segregation and dumping observed at some AAM facilities.
- West Bengal had multiple IT applications in use, including Matrimaa, Swasthingit, ANMOL, RCH Portal, E-Raktkosh, and Nikshay Aushadhi.
- Teleconsultation services (Swasthya Ingit) were widely accepted and effectively utilized across AAM facilities.
- Unstable internet connectivity at some AAM-SHCs led to dropped calls, requiring re-entry of patient information in telemedicine services.
- VHSNCs and MAS were functional and regularly conducted meetings.
- ASHA training was well-structured, with effective HBNC equipment and medication replenishment systems in place.
- Adolescent health promotion activities included home delivery of sanitary napkins and dedicated counselling sessions.



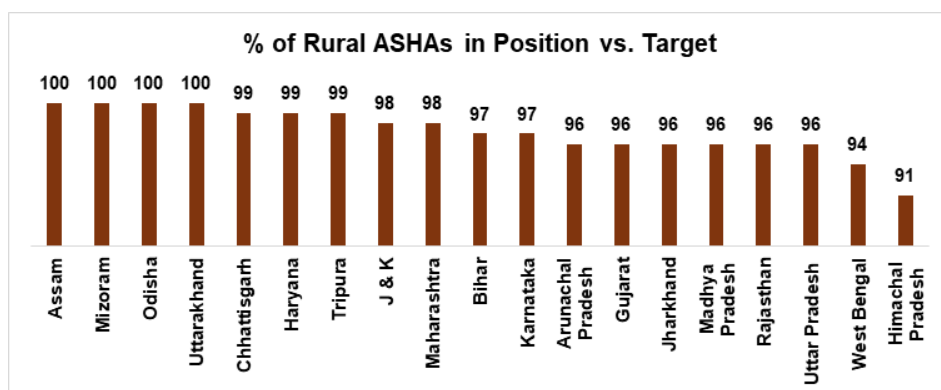
**COMMUNITY PROCESSES:
FROM THE PERSPECTIVE OF
EQUITY AND GENDER**

16th

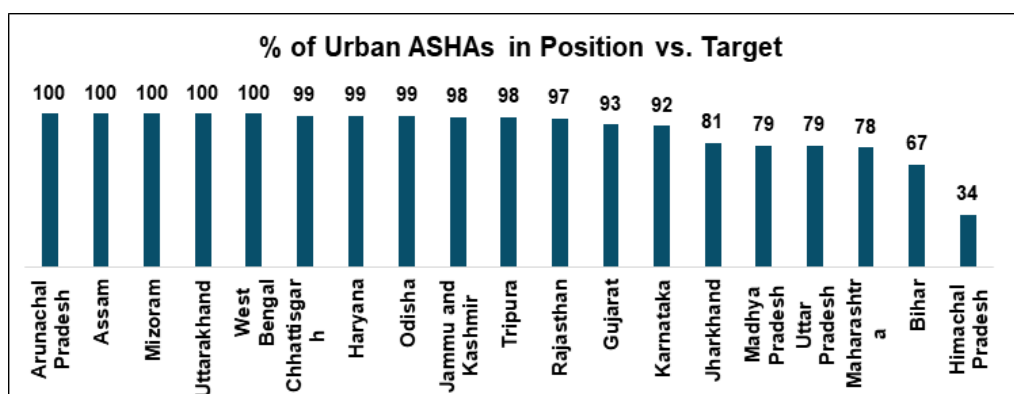
NATIONAL OVERVIEW

- The ASHA program of India is the largest community health worker initiative in the world, launched under the NHM. With 10.2 lakh ASHAs currently in position, it stands as the largest community health worker program globally.
- ASHAs serve as the first point of contact between the community and the healthcare system, playing a pivotal role in improving health outcomes through their grassroots-level engagement.
- The role of ASHA has undergone a significant evolution over the past two decades. ASHAs have been widely recognized for their crucial role in enhancing healthcare access across various domains, including RMNCAH+N, communicable diseases, NCDs and other expanded range of services at AAM such as mental health, oral, eye, ENT, elderly and palliative care.
- Community processes in healthcare extend beyond ASHAs and include various structures and mechanisms aimed at enhancing health governance and community participation. Village Health Sanitation and Nutrition Committees (VHSNCs) are led by local community representatives to ensure decentralized health planning and oversee service delivery at the village level.
- Similarly, Mahila Arogya Samitis (MAS) operate in urban areas, working to address health, nutrition and sanitation related challenges in slums and slums like settings. In the same lines, Jan Arogya Samitis (JAS) are facility-based community platforms in alignment with the government's citizen centric approach to facilitate inclusive, community-led healthcare service delivery.
- AAM facilities further strengthen primary healthcare by offering comprehensive services at the grassroots level. Additionally, community-based mentoring and monitoring groups enhance ASHA performance through skill-building and shared learning experiences. Participatory health planning ensures that communities are actively involved in identifying health needs and advocating for improved healthcare access.
- The core role of an ASHA is to mobilize the community, raise awareness, promote health, and implement home and community-based interventions to support the delivery of comprehensive primary healthcare. This is being achieved through targeted skill development, supportive supervision, and well-established monitoring mechanisms.
- Overall findings suggest that ASHAs are actively involved in their routine tasks including the newer interventions such as population enumeration, administering Community-Based Assessment Checklists (CBAC) for risk assessment, mobilizing communities for NCD screenings, and facilitating timely referrals. As active members of community-level platforms, their contribution to implementing national and state initiatives at the grassroots level is significant, supported by Male and Female Multi-Purpose Workers (MPWs) and CHOs.
- Most of the states have ASHAs in position as per the requirement. In rural areas, none of the CRM states is below national average of 91% in terms of the percentage of in-position ASHAs. While in urban areas, Bihar, Maharashtra, Madhya Pradesh, Jharkhand, Himachal Pradesh and Uttar Pradesh reported lower proportion of ASHAs in position than the national average of 86%.

The graphs below depict the % of ASHAs in-position in the 19 states.



As reported
by states, 31st
March 2024



As reported by states, 31st March 2024

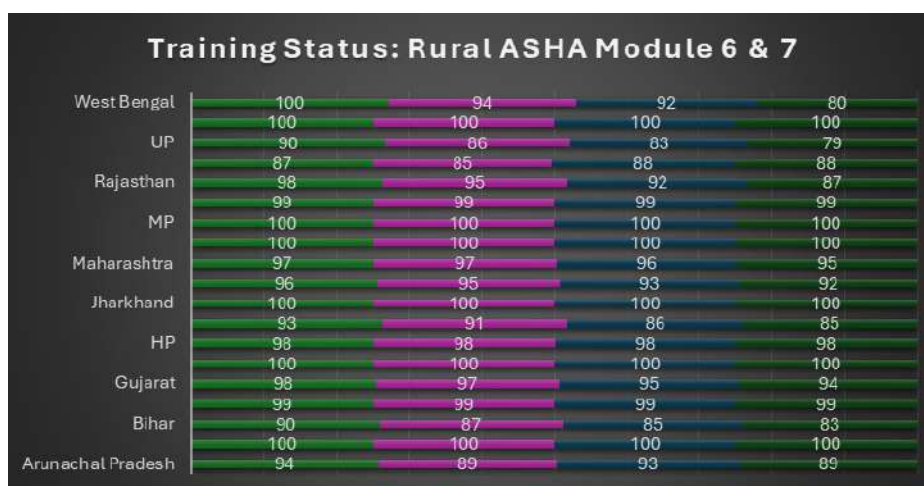
KEY OBSERVATIONS

SELECTION OF ASHA

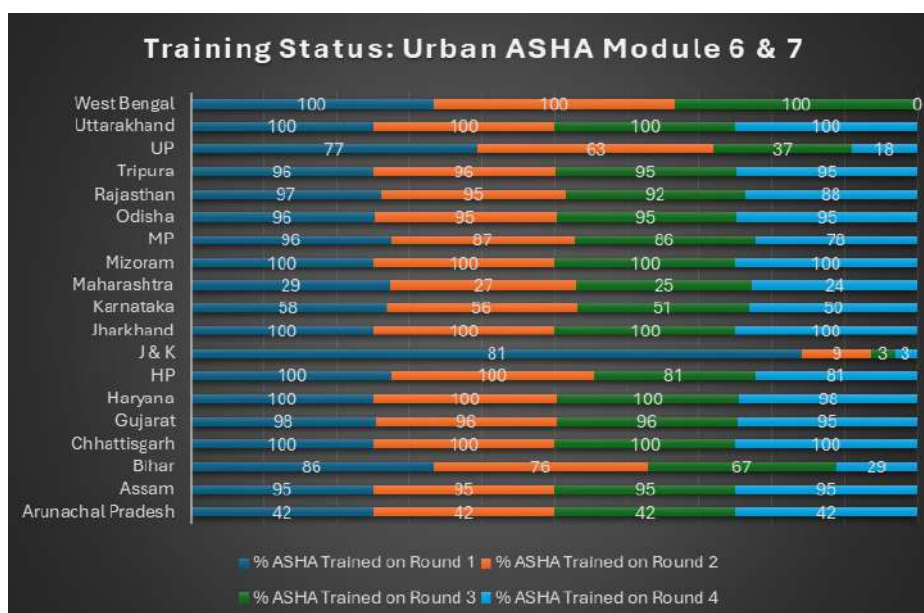
- The selection of ASHAs was largely in alignment with national guidelines across states, ensuring strong community involvement and representation. Many states effectively utilized local governance structures such as Village Councils, Gram Panchayats, and PRI members for ASHA selection, reinforcing community ownership and participation. While some states are still addressing recruitment shortfalls and adjustments in selection criteria, efforts are underway to enhance uniform coverage, particularly in urban areas.
- Community-driven selection processes have played a crucial role in fostering local participation and strengthening trust in ASHA workers. In Arunachal Pradesh, the involvement of the Village Council in ASHA selection has significantly enhanced community motivation and support. Similarly, in Bihar, the Mukhiya/Sarpanch-led selection process has ensured local leadership in ASHA recruitment, reinforcing their role as trusted community health facilitators.
- Adequate recruitment progress was observed in several states. In Assam, ASHA selection was completed as per target, with 33,656 ASHAs in position. Similarly, in Uttarakhand, 100% ASHA selection was achieved, with a fully functional ASHA Resource Centre (ARC) supporting the program.
- Special provisions for difficult areas facilitated ASHA recruitment. In Odisha, education requirements were relaxed (from 7th pass to 5th pass) in tribal/hard-to-reach areas to increase ASHA availability. In Arunachal Pradesh, additional ASHAs were deployed in villages with over 2,000 population due to long distances and dispersed settlements.
- Shortfalls in ASHA recruitment impacted outreach and service delivery in some states. In Bihar, a shortfall of 3,145 ASHAs in rural areas and 322 in urban areas affected coverage.
- Urban ASHA recruitment lagged behind rural recruitment, leading to service gaps. In Bihar, only 655 ASHAs were in position in urban areas against a target of 977.
- Overburdened ASHAs due to inadequate recruitment reduced service efficiency. In Bihar, some ASHAs were responsible for more than 1,000 people, exceeding recommended limits.
- Challenges in difficult terrain and sparsely populated areas led to ASHA shortages. In Arunachal Pradesh, long distances and sparse populations required additional ASHAs in larger villages.
- ASHAs selection and functionality was impacted in states due to governance issues. In Jammu & Kashmir, delays in PRI elections impacted ASHA selection processes.

Training and capacity building of ASHAs (Induction, Module 6 and 7, NCD, HBNC, HBYC, newer packages of oral, eye, ENT, MNS, Elderly, Palliative and Emergency Care)

- ASHAs across states have undergone structured training programs, including Induction, Module 6 and 7, HBNC, HBYC, and NCD, equipping them with essential healthcare skills. Many states have successfully implemented these trainings, ensuring ASHAs are well-prepared for their roles.
- Training on newer service packages such as oral, eye, ENT, MNS, elderly care, palliative care, and emergency response varies across states, ongoing efforts are being made to enhance coverage and consistency in these areas.



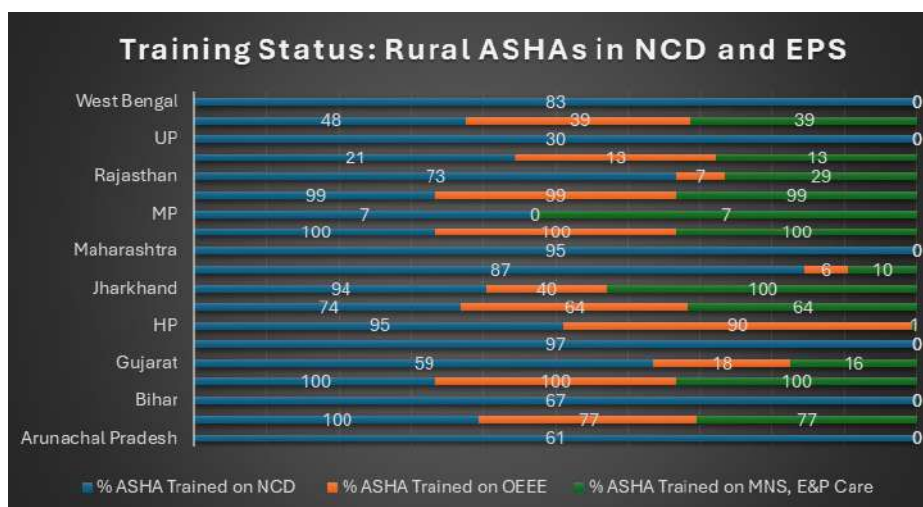
State Reported, as on 31st March 2024



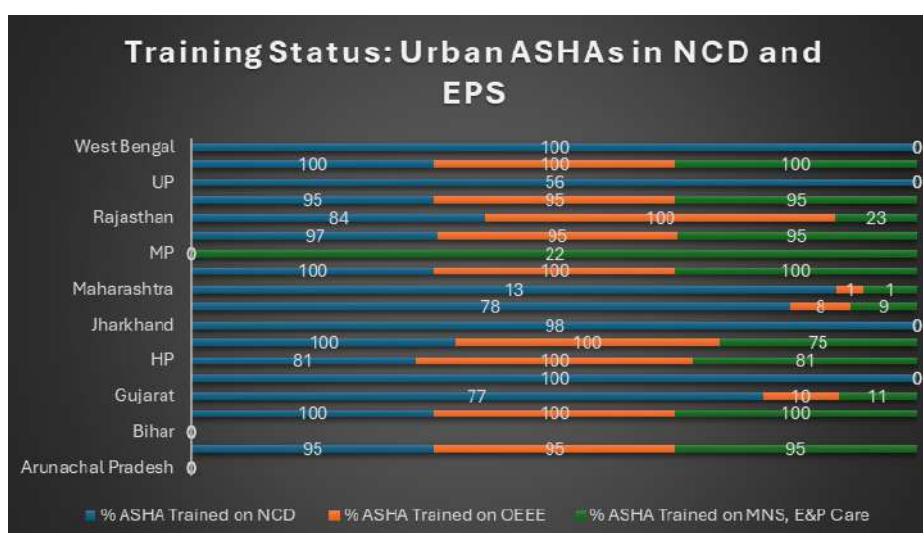
State Reported, as on 31st March 2024

- Most states had completed basic ASHA training requirements. In Himachal Pradesh, 94% of ASHAs completed Induction training, 80% underwent HBYC training, and 99% were trained in VHSNC activities. Similarly, in Rajasthan, ASHAs received training in Module 6 & 7, NCD, HBNC, and newer service packages.
- ASHA training on expanded packages was incomplete in several states. ASHA training was

completed till NCD, HBYC and Module 6 & 7, however, EPS training is yet to be done. In Madhya Pradesh, while ASHAs were trained in MNS care, no structured plan existed for training them on other expanded service packages.



State Reported, as on 31st March 2024



State Reported, as on 31st March 2024

- Gaps in refresher training affected ASHA performance. In Haryana, ASHAs and ANMs had not received any training in the last two years, which was cited as a major impediment to service delivery. In Uttarakhand, ASHAs expressed the need for refresher training in Module 6 & 7 to help them prepare for NIOS certification.
- Digital training challenges were reported across states. In Jammu & Kashmir, ASHAs shared their preference for in-person training over virtual modes due to unreliable internet connectivity. Similarly, in Mizoram, ASHAs struggled with online training due to a lack of electronic devices and poor network coverage.
- Training on HBYC remained incomplete in multiple states. In Himachal Pradesh, only 47% of ASHAs in Hamirpur completed HBYC training. In Jammu & Kashmir, HBYC training for all ASHAs was yet to be completed, despite structured ASHA training calendars in place.
- Gaps in clinical skills training were observed. In Assam, ASHAs were found lacking proper training

on blood pressure measurement, despite some ASHAs purchasing BP apparatus using VHSNC untied funds. Additionally, ASHAs in Assam were found to be carrying non-designated drugs like Rabepazole, Calcium, and Vitamin D, indicating gaps in training on drug dispensation.

- State-level innovations improved training delivery. In Odisha, a structured supportive supervision system was in place for training oversight at district and block levels. In Madhya Pradesh, digital platforms like the NP-NCD app were used for CBAC form entry, though certain sections remained incomplete in manual documentation.

SUPPORT STRUCTURE AND SUPPORT SUPERVISION

- A well-structured ASHA support system is in place across most states, comprising ASHA Facilitators, Block Community Mobilizers (BCMs), District Community Mobilizers (DCMs), and ASHA Nodal Officers. Many states have successfully implemented regular supervision, monitoring, and review meetings to strengthen ASHA performance and engagement. While some states are working to further enhance supervision quality and financial oversight, ongoing improvements aim to ensure a more comprehensive support structure.
- Dedicated ASHA support structures are actively functional in several states, reinforcing their effectiveness in community health initiatives. Assam has deployed 32 DCMs, 150 BCMs, and 2,675 ASHA Facilitators to provide structured guidance and monitoring. In Himachal Pradesh, ASHA supervision has been strengthened with one ASHA Facilitator assigned for every 20 ASHAs, with efforts underway to meet the full requirement of 437 facilitators. Similarly, in Jammu & Kashmir, ANMs have been integrated into the ASHA support system, playing an active role in facilitating and guiding ASHAs at the grassroots level.
- Regular review and supervision mechanisms were in place in some states. In Arunachal Pradesh, ASHA Facilitators were paid Rs 300 per visit, with around 15 visits per month, and attended monthly review meetings at the district headquarters. Similarly, in Bihar, regular ASHA Divas, cluster meetings, and BCM-led reviews ensured oversight.
- Weak supervision and support structures affected ASHA performance in some states. In Rajasthan, the mentoring support of CHOs to ASHAs was minimal, particularly in Bharatpur district. In Mizoram, weak integration between ASHAs and Community-Based Organizations (CBOs) like SHGs and MAS limited their support network.
- Financial constraints and delays in supervision-related expenses affected field monitoring. In Jammu & Kashmir, block and district officials often undertook field visits using personal expenses due to the lack of mobility cost reimbursement, impacting effective supervision.
- Structured digital monitoring tools being implemented in few states demonstrated improved ASHA supervision. In Karnataka, the “ASHANIDHI” software was introduced to track ASHA incentives from calculation to disbursement, ensuring transparency. In Bihar, ASHAs reported positively for the Ashwin portal, which enabled timely validation and processing of incentives.
- Regular ASHA meetings and field interactions helped maintain strong supervisory oversight in certain states. In Jammu & Kashmir, routine field visits, ASHA monthly meetings, and virtual interactions were reported as key supportive supervision activities. Similarly, in Haryana, monthly meetings helped reinforce ASHA responsibilities and program updates.

ASHA INCENTIVES

MONETARY INCENTIVES

- ASHAs across states received both fixed and performance-based incentives, ensuring financial support and motivation for their roles. Many states have implemented structured incentive models to enhance ASHA earnings, reflecting their commitment to improving financial security and retention.

- Several states have introduced additional state-level incentives to further support ASHAs. In Odisha, ASHAs received a minimum of Rs 7,000 per month, with an average monthly incentive of Rs 9,000. Madhya Pradesh provided an additional Rs 4,000 per month from the state fund, while ASHA Facilitators received Rs 6,000 per month in addition to NHM incentives. Karnataka has introduced a fixed monthly honorarium of Rs 5,000 along with performance-based incentives, further strengthening ASHA remuneration and engagement.
- Delays in payment remained a persistent issue in several states. In Arunachal Pradesh, there was a backlog of two to three months for ASHA incentive disbursement, and there was no system for incentive reconciliation. In Mizoram, HBNC and HBYC incentives were pending since 2022 and 2023, respectively and payments under JSY were either delayed or incomplete. In Jharkhand, Sahiyas in Sahibganj district only received four months' incentives in 2024, with no payments under any specific health programs.
- ASHAs faced additional expenses for documentation and service delivery. In Assam, ASHAs were spending Rs 150–300 per month on photocopies required for their incentive claims, with no reimbursement. In Mizoram, ASHAs had no transport reimbursement, often using their own money for community visits.

NON-MONETARY INCENTIVES (SOCIAL SECURITY AND MEASURES)

- ASHAs were enrolled in various social security schemes, but awareness and coverage varied. In Himachal Pradesh, eligible ASHAs were enrolled in PMJJBY and PMSBY, with additional allowances for uniforms, shoes, and bags provided through Direct Benefit Transfer (DBT). In Madhya Pradesh, ASHAs were enrolled in Pradhan Mantri Suraksha Bima Yojana (PM-SBY), Pradhan Mantri Jeevan Jyoti Bima Yojana (PM-JJB), and Pradhan Mantri Shram Yogi Maan Dhan Yojana (PM-SYM), but they lacked awareness of career progression opportunities.
- Several states lacked comprehensive social security coverage for ASHAs. In Arunachal Pradesh, many ASHAs were unaware of social security provisions, and there was no provision for death compensation. In Jammu & Kashmir, ASHAs were enrolled in PMJJBY and PMSBY, but digital literacy gaps affected their ability to manage and utilize social security benefits effectively.

IT APPLICATIONS FOR STRENGTHENING PAYMENTS

- States with digital payment systems reported smoother incentive disbursement. In Bihar, ASHAs expressed high satisfaction with the Ashwin portal, which allowed timely validation and processing of payments. In Karnataka, the ASHANIDHI software tracked ASHA incentives from calculation to disbursement, improving transparency.
- Several states still relied on manual processes, leading to inefficiencies and delays. In Arunachal Pradesh, incentive details were verified by ASHA Facilitators and forwarded through multiple levels before reaching the state, often causing significant payment delays. In Jammu & Kashmir, ASHAs used personal phones for digital data entry, but lack of reimbursement and digital training hindered efficiency.

SAFETY MEASURES AND GENDER

- Workplace safety measures for ASHAs have been implemented in several states, with ongoing efforts to enhance their effectiveness, particularly in remote areas. Ensuring access to grievance redressal mechanisms and digital safety tools remains a key focus to improve the overall security and well-being of ASHAs.
- In Jammu & Kashmir, a functional grievance redressal system is in place at the UT level, providing ASHAs with a formal channel to report concerns. Efforts are being made to increase awareness among frontline workers on utilizing this system for safety-related issues.
- In Rajasthan, improving network connectivity in certain areas will further enhance ASHAs' access

to digital safety tools and support mechanisms, ensuring a safer working environment.

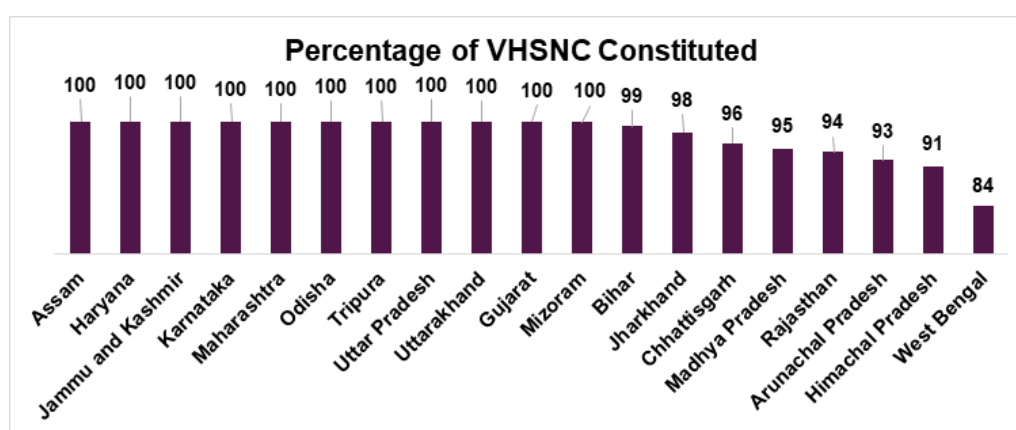
- However, ASHAs lacked gender-specific support measures in most states. In Tripura, ASHAs had minimal engagement in addressing gender-based violence, indicating a need for capacity building on gender-sensitive healthcare delivery. In West Bengal, MAS participation was male-dominated in some areas, reducing the effectiveness of women-centric health interventions.

CAREER PROGRESSION

- Career progression in ASHA programme has always been an important step towards motivating and acknowledging ASHAs for their contribution in health systems. Some states have implemented structured career pathways for ASHAs. In Chhattisgarh, Mitans (ASHAs) had the opportunity to be promoted to Master Trainers, Block Coordinators, or District Coordinators. In Rajasthan, under the ASHA Jyoti Yojana, 1,774 ASHAs completed their 10th grade, and 1,802 completed their 12th grade, enabling their career advancement. In Odisha, ASHAs were given weightage for ANM and GNM course admissions, supporting professional growth.
- In many states, ASHAs lacked clear career progression opportunities. In Bihar, ASHAs were not informed about structured career pathways, limiting their ability to transition into higher healthcare roles. In Uttarakhand, a few ASHAs were enrolled in ANM/GNM courses, but there was no formalized recruitment plan post-course completion.

VILLAGE HEALTH SANITATION AND NUTRITION COMMITTEE (VHSNC)

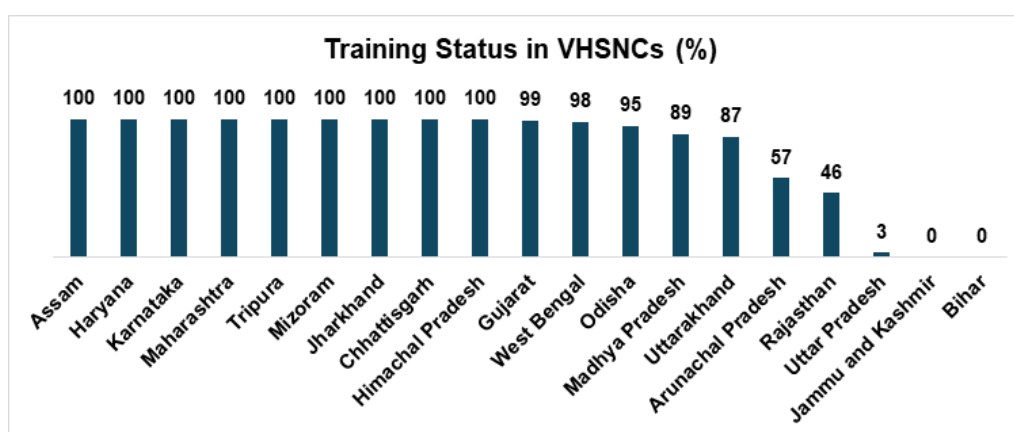
- VHSNCs have been constituted in most states, actively contributing to community health planning and sanitation initiatives. Their presence has strengthened local health governance and empowered communities to participate in decision-making for health-related activities.
- While VHSNCs are functional across states, efforts are ongoing to enhance their effectiveness by improving fund utilization, ensuring regular meetings, and increasing awareness among committee members. Strengthening these areas will further optimize their role in community health planning and service delivery.



State-reported data as of March 31, 2024

- Several states had high VHSNC formation rates, ensuring community participation. In Bihar, 99% of VHSNCs were formed, with ASHAs serving as Member Secretaries. In Assam, VHSNCs were formed as per the target, with 28,942 VHSNCs operational statewide. In Uttarakhand, 14,915 VHSNCs were functional, with 835,240 meetings held in 2024.
- Regular VHSNC meetings improved community engagement in some states. In Haryana, VHSNC meetings were held monthly, with youth groups and NGOs participating. In West Bengal, VHSNC meetings were conducted regularly in both districts visited.

- VHSNCs in some states lacked active engagement and training. In Assam, most VHSNCs were non-functional, with irregular meetings, low attendance, and poor documentation. In Bihar's Kaimur district, VHSNCs were not operational, while in Gaya, they functioned but lacked representation from key government departments like ICDS and education.
- VHSNC funds were underutilized or delayed in many states. In Arunachal Pradesh, since the implementation of the Single Nodal Agency (SNA), VHSNCs had not received untied funds, limiting their activities. In Gujarat's Kachchh district, no VHSNC funds had been used, while in Rajasthan, delayed fund release was reported.



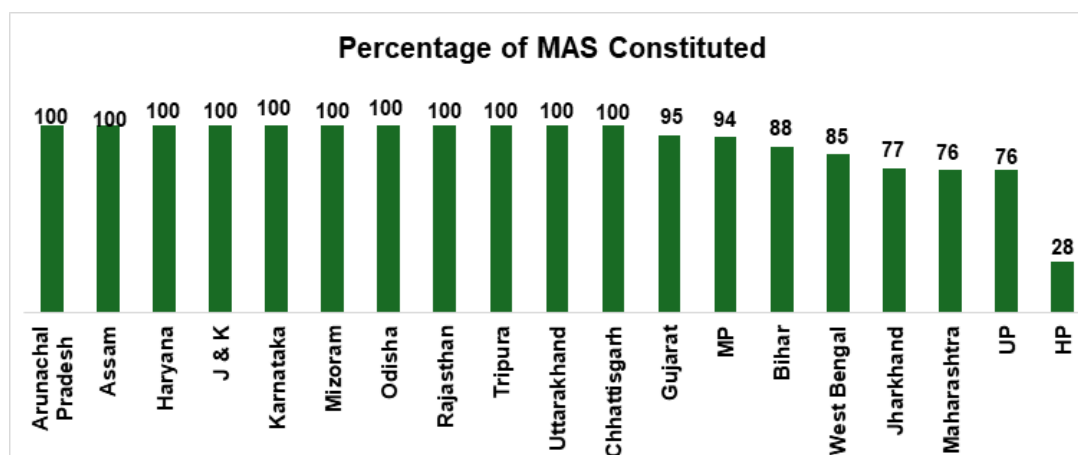
State-reported data as of March 31, 2024

- Gender representation in VHSNCs remained a challenge. In Assam, most VHSNCs were led by male PRI members, despite national guidelines recommending female leadership and 50% female membership.
- VHSNCs played a role in local health initiatives and sanitation activities. In Odisha, VHSNCs were engaged in Gaon Kalyan Samitis, which addressed health-related issues and community action. In Himachal Pradesh, VHSNCs were linked to sanitation and immunization drives, strengthening grassroots health awareness.
- Integration with PRI and local governance structures was inconsistent. In Chhattisgarh, Sarpanches were members of community platforms, but broader engagement of PRI and ULB was not as envisaged. In Jammu & Kashmir, due to delayed PRI elections, Block MOs chaired VHSNC meetings instead of elected representatives. Additionally, lack of untied funds in the J&K was a key challenge reported by the community based platforms representatives.

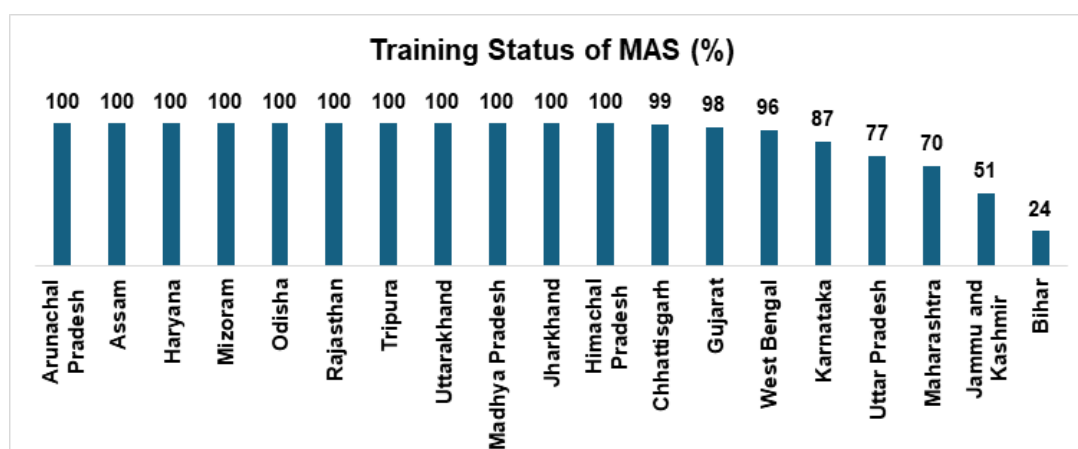
MAHILA AROGYA SAMITIS (MAS)

- MAS have been constituted in most states, serving as a vital component of urban health governance and community mobilization. Their presence has strengthened grassroots participation in health planning and service delivery. While functionality varies across states, ongoing efforts are focused on ensuring regular meetings, optimal utilization of untied funds, and improved awareness of roles and responsibilities to enhance their effectiveness.
- MAS were actively involved in urban health initiatives in some states. In Maharashtra, MAS operated as community-based peer education groups in slums, focusing on preventive and promotive healthcare, mobilization for immunization, and ANC/PNC follow-ups. In Rajasthan MAS was also reported to be actively engaged in regular monthly meetings with documented minutes.

- MAS participation in health promotion activities was observed in certain states. In Karnataka, 4,071 MAS were attached to urban facilities, actively engaging in wellness activities and participating in facility-level decision-making. In Tripura, women's participation in MAS was higher compared to other northeastern states, though decision-making remained male-dominated in some areas.
- Several states reported MAS meetings being irregular or non-functional. In Assam, MAS meetings



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were either not conducted regularly or had poor attendance, with members unaware of their roles and responsibilities. In Rajasthan, delays in the release of untied funds impacted MAS activities, and some bank accounts faced deductions due to non-maintenance of minimum balance.

- Utilization of untied funds by MAS remained a challenge in multiple states. In Mizoram, while MAS were formed and functional, untied funds were underutilized, limiting their effectiveness. In West Bengal's South 24 Parganas district, MAS accounts lacked separate bank accounts, and untied funds were not received.
- Integration of MAS with local governance and other departments was inconsistent. In West Bengal's Malda district, MAS meetings had 50% women representation and included participation from vulnerable groups and elected representatives, ensuring broader inclusivity. However, in Chhattisgarh, MAS had limited PRI/ULB participation, affecting their effectiveness.
- Training and capacity building of MAS members remained limited. In Jammu & Kashmir, MAS

members were constituted and functional, but required additional training to institutionalize their functionality. In Jharkhand, MAS members demonstrated good knowledge of reproductive and child health services, though integration with SHGs and other CBOs was weak.

VILLAGE HEALTH NUTRITION DAYS/URBAN HEALTH NUTRITION DAYS (VHND/UHND)

- VHNDs and UHNDs were conducted regularly in most states, serving as crucial platforms for delivering maternal and child health services, immunization, antenatal and postnatal care, and nutrition awareness. These initiatives have played a significant role in improving healthcare accessibility at the community level.
- While these platforms are well-established, some areas face challenges such as inconsistent service delivery, limited community participation, and a lack of integration with other departments. Efforts are being made to strengthen coordination, enhance community engagement, and ensure the seamless delivery of services to maximize their impact.
- VHND sessions were observed to be regular in certain states. In Bihar, VHNDs were conducted every Wednesday, ensuring consistent outreach. In Haryana, VHNDs were held on the 15th of every month, with ASHAs mobilizing beneficiaries for immunization and ANC check-ups. In Uttarakhand, VHNDs included health awareness sessions on hygiene, breastfeeding, and nutrition, along with NCD screenings for the 30+ population.
- VHNDs were not always fully utilized for comprehensive healthcare. In Gujarat, Mamta Diwas (VHNDs) were organized regularly, but services were mostly limited to ANC and immunization, with NCD screening and other services not covered. In Uttar Pradesh, VHNDs were inconsistently conducted, leading to missed opportunities for community engagement and service delivery.
- UHNDs were organized but faced challenges in beneficiary mobilization. In Rajasthan's Bharatpur city, 966 UHND sessions were planned, and all were conducted, but outreach to slum populations remained a challenge. In Karnataka, MAS members suggested that primary care facilities (AAM) in urban areas should operate in evening hours to cater to the working urban population, though implementation was pending.
- Community participation in VHNDs and UHNDs varied. In Jharkhand, ANC services, immunization, and nutrition interventions were provided, but logistical constraints affected testing and supplement distribution. In Assam, ASHAs, ANMs, and communities lacked awareness of PMSMA visits, leading to low participation in ANC check-ups during VHNDs.
- Gaps in documentation and integration with allied departments affected VHND effectiveness. In Madhya Pradesh, VHNDs were conducted at Anganwadi centers, but early ANC registration was inadequate, and ANC tests were incomplete due to the non-availability of urine test kits. In Himachal Pradesh, VHNDs were celebrated in Hamirpur district, but linkages with school health programs and outreach activities were weak.
- Outreach challenges affected VHND implementation in difficult terrains. In Jharkhand, one child scheduled for immunization was absent, prompting the CRM team to visit the family and ensure vaccination. In Rajasthan, marginalized communities lacked Aadhaar cards, limiting their access to free healthcare services during VHNDs.

ROGI KALYAN SAMITIS (RKS)

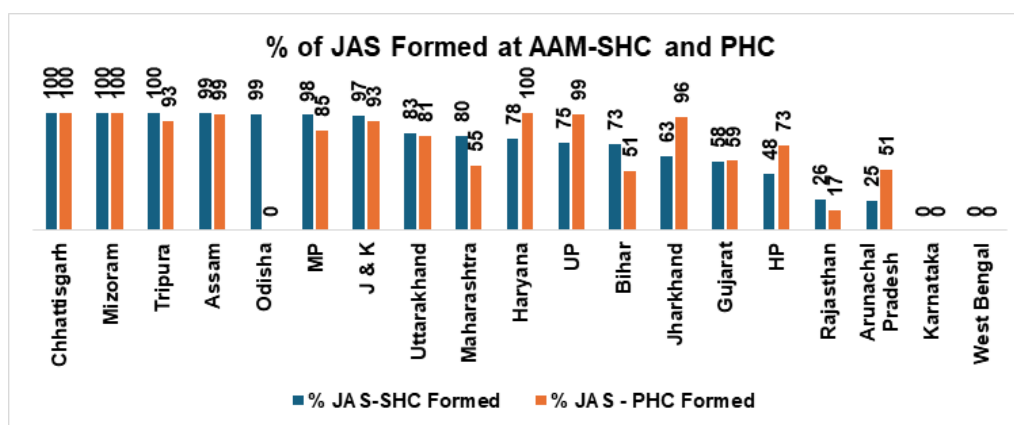
- Rogi Kalyan Samitis (RKS) were functional in most states, actively contributing to facility-level health governance, efficient fund utilization, and infrastructure improvements. Their role has been

instrumental in strengthening healthcare facilities and ensuring better service delivery.

- While RKS are well-established, some challenges remain, including irregular meetings, a lack of formal training for members, and delays in the disbursement of untied funds. Efforts are being made to enhance their functionality by improving member capacity-building, ensuring timely fund allocation, and promoting regular engagement.
- Regular RKS meetings and effective fund utilization were reported in some states. In Karnataka, RKS, known as Arogya Raksha Samiti (ArRS), conducted regular meetings, utilizing funds for infrastructure maintenance, drug procurement, and patient welfare activities. In Gujarat's Vadodara district, RKS funds were effectively used for purchasing drugs, health awareness campaigns, housekeeping, and installation of CCTV cameras.
- Irregular meetings and lack of formal training for RKS members were common challenges. In Gujarat, RKS members lacked formal training due to which there was limited awareness of fund utilization norms. Similarly, in West Bengal it was observed that despite regular meetings in absence of documentation of action points, there was no follow up and accountability of RKS. Uttarakhand also reported weak meeting and documentation practices of RKS.
- Delays in the release of RKS untied funds was also identified as a factor affecting facility-level improvements. In Rajasthan, delays in untied fund disbursement were reported, limiting the ability of RKS to address urgent facility needs.
- Utilization of RKS funds for outsourcing services and community welfare activities was observed across some states. In Gujarat, DH Vadodara used RKS funds to outsource diet, housekeeping, and HR services, ensuring better facility management. In Karnataka, RKS funds were utilized to support referral transport, disabled patient care, and community-based initiatives such as Nikshay Mitra for TB patients.
- Challenges in integrating RKS with community engagement and governance structures were observed. In Jammu & Kashmir, RKS was constituted across all visited AAM facilities, but due to non-availability of untied funds for the last two years, RKS was not fully functional. In Uttarakhand, user fees collected at PHCs and above were partially retained by the facility, but guidelines on fund utilization needed better clarity among PHC staff.

JAN AROGYA SAMITI (JAS)

- JAS were established at most AAM facilities, facilitating active community participation in health facility management and decision-making. Their presence has contributed to strengthening local health governance and improving accountability in service delivery.
- While JAS are functional across states, some challenges persist, including inconsistent meeting schedules, limited awareness among members, and difficulties in fund utilization. Ongoing efforts aim to enhance member training, ensure regular meetings, and improve fund management to maximize their impact.
- Regular JAS meetings and proper documentation were observed in some states. In Jammu & Kashmir, JAS was constituted across all visited AAM facilities, with meetings conducted and minutes documented in facility-based registers. In Karnataka, ArRS (Arogya Raksha Samiti, equivalent to JAS) members were actively involved, conducting regular meetings with AAM teams to ensure effective functioning.
- JAS funds were utilized effectively in some states, while others faced disbursement issues. In Karnataka, JAS funds were mostly used for drug procurement, cleanliness, and minor facility repairs. In Uttarakhand, PHC-AAM facilities received Rs 1,75,000 under untied funds and grants



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for patient facilities, but fund utilization norms were unclear to facility staff. In Jammu & Kashmir, due to the lack of untied funds for the last two years, JAS was not fully functional, with meetings conducted but no concrete actions taken.

- Limited awareness and training of JAS members affected functionality. In Mizoram, JAS meetings were conducted regularly, but meeting records were signed only by the chairperson and secretary, reducing accountability of other members. In West Bengal's South 24 Parganas district, JAS members lacked separate bank accounts, and untied funds were not received, affecting planned activities.
- In some states, JAS initiatives extended beyond health facility management to broader community-based support. In Karnataka, JAS committees were supporting for alternate referral transport for patients and also collaborating with local bodies to provide employment support for endosulfan poisoning victims. In Gujarat, JAS funds were being used for patient support activities such as arranging blood for critical cases and conducting patient satisfaction surveys.
- Challenges in documentation and integration with other health committees were noted. In Madhya Pradesh, JAS was functional, but minutes of meetings were not well maintained at the APHC level. In Mizoram's Kolasib district, JAS members were trained to support elderly patient groups, but disease prevention and health promotion activities were not included in JAS discussions.

LINKAGES OF VHSNC/MAS WITH PRI/ULB AND COMMUNITY ACTION FOR HEALTH (CAH)

- Linkages between VHSNCs, MAS, PRI, ULB, and CAH have been established across states, with several regions demonstrating strong integration and effective collaboration. These connections have enhanced community engagement and strengthened local health governance.
- While some states have successfully fostered coordination among these bodies, others are working towards improving participation from governance institutions and strengthening interdepartmental collaboration to ensure more cohesive and efficient health service delivery.
- Active PRI and ULB participation was observed in some states. In West Bengal, VHSNC meetings had 50% women representation and PRI involvement. In Haryana, VHSNCs engaged with ICDS, Education, and PRI for community health education.
- Limited PRI/ULB engagement weakened governance structures. In Chhattisgarh, Sarpanches were members but broader PRI involvement in CAH was low. In Jammu & Kashmir, delayed PRI elections resulted in Block MOs chairing VHSNC meetings, affecting community-led governance.
- MAS linkages with ULB were weak in some urban areas. In Gujarat, urban ASHAs were not permitted in certain residential areas, limiting outreach. In Tripura, women participated in MAS, but

decision-making remained male-dominated.

- Some states demonstrated strong intersectoral convergence. In Odisha, VHSNCs linked with Gaon Kalyan Samitis (GKS) for village health planning. In Karnataka, district health departments collaborated with Zilla Panchayats and CSR initiatives to enhance infrastructure and outreach.
- Lack of awareness and documentation hindered coordination. In Rajasthan, vacancies in community process manpower weakened VHSNC-PRI coordination. In Mizoram, inconsistent meeting documentation reduced accountability.
- In Jharkhand, MAS had good health service knowledge but weak SHG/CBO integration. In Uttar Pradesh, IEC materials for CAH activities were inadequate, limiting outreach.

KEY RECOMMENDATIONS

- States need to map the ASHA against the population in both rural and urban areas; and ensure timely recruitment of ASHAs to address existing shortfalls, particularly in urban areas. States/UT need to standardize selection processes through PRI and community participation while adopting special provisions for hard-to-reach areas.
- Enhance ASHA Training and Capacity Building: Implement structured refresher training on newer service packages (oral, eye, ENT, MNS, elderly, palliative care, emergency response) to enhance ASHA competencies. Given ASHAs' role in CPHC, her skills needs to be strengthened in alignment with requirement; and this would need timely intervention by State ASHA resource centres. State/UT also need to strengthen digital training accessibility with offline alternatives for states with poor internet connectivity.
- Strengthen ASHA Support Structures and Supervision: States to strengthen the ASHA Facilitator network to improve supervisory oversight, ensuring regular review meetings and field interactions. Provide financial support for mobility costs of ASHA supervisors to strengthen field-level monitoring.
- Ensure Timely and Transparent ASHA Incentive Payments: Implement digital payment mechanisms in all states to reduce delays. States to establish grievance redressal mechanisms for payment-related concerns and introduce reimbursement for ASHAs' out-of-pocket service delivery costs.
- Given ASHAs dependency on her supplies to undertake assigned tasks timely and efficiently, states need to ensure timely refurbishment of her kits and ensuring elimination of stockouts of equipment and supplies.
- Expand Social Security and Career Progression Opportunities: Ensure universal coverage of ASHAs under PMJJBY, PMSBY, and PMSYMY schemes, with clear communication on benefits. Develop structured career pathways, such as priority admission in ANM/GNM courses and promotions to supervisory roles.
- Revitalize VHSNCs and MAS for Greater Community Engagement: Conduct regular VHSNC and MAS meetings with better documentation and fund utilization oversight. Ensure 50% female representation in VHSNC leadership as per national guidelines. Strengthen PRI and ULB engagement to enhance accountability and functionality.
- Improve VHND/UHND Service Delivery and Community Participation: Strengthen planning and coordination of VHNDs and UHNDs to improve beneficiary outreach, service delivery, and documentation. Integrate NCD screening, adolescent health services, and health education into routine sessions.
- Ensure Functional RKS and JAS by providing formal training to RKS and JAS members on fund utilization norms and governance roles. Ensure timely disbursement of untied funds and improve documentation of meeting action points.
- Strengthen Linkages Between Community Platforms and Local Governance: Enhance collaboration between VHSNCs/MAS and PRIs/ ULBs to improve community action for health. Promote intersectoral convergence with departments like education, ICDS, and WCD for holistic health initiatives.
- Address Gender and Safety Concerns for ASHAs: Establish clear safety protocols and awareness mechanisms for ASHAs working in remote areas. Integrate gender-based violence awareness training into ASHA programs and improve grievance redressal systems at the grassroots level.

STATE SPECIFIC FINDINGS FOR COMMUNITY PROCESSES

ARUNACHAL PRADESH

- Strong bonding of the ASHA workers with the community was observed. The state has 4051 ASHAs in place including 144 in West Siang and 75 in Longding district. Long distances and sparse population are a challenge in the state. Given the scattered and dispersed population, both the districts have additional number of ASHAs in the villages having more than 2000 population.
- The ASHA selection process is conducted by the Village Council at the community level, ensuring local involvement. ASHAs were motivated, active, and well-informed about their community-level responsibilities. They were trained in HBNC, HBYC, NCD, maternal and child health, but need training on the Expanded Package of Services (EPS). Also, regular capacity building programme may be conducted for ASHAs to update them regarding new programmes and interventions. ASHA Diaries were available with the ASHAs.
- The ASHA Facilitators were paid an honorarium of Rs 300 per visit, with ~15 visits scheduled per month. Supervision and monitoring of the ASHA programme are structured through ASHA Facilitators, Block Community Mobilizers (BCM), District ASHA Nodal Officers, and District Community Mobilizers. Monthly reviews of BCMs and ASHA Facilitators are conducted at district headquarters to monitor progress and provide support, and monthly meeting was held at the block level involving ASHAs.
- ASHAs receive a fixed amount of Rs 2,000 per month from NHM for conducting eight routine activities, with an additional Rs 3,000 from state funds. They also earn incentives based on performance, with a total provision of Rs 5,890 under NHM. The Incentive details are verified by ASHA Facilitators and forwarded to the district through the Block Accounts Manager (BAM). From district, the details are shared with the state and the payments are made directly to ASHAs via bank transfer. On an average, they received Rs 5,000 per month, as the state is sparsely populated and the number of beneficiaries for each ASHA is very low. Delays in payment, often spanning two to three months was a common issue. Further, the ASHAs lack clarity on incentive provisions and amounts received as there was no system for reconciliation.
- The certification process of ASHAs through NIOS has been initiated in the state. While eligible ASHAs were enrolled under PMJJBY and PMSBY, there is no provision for death compensation. Many ASHAs were unaware of social security provisions and lacked clarity on financial incentives.
- HBYC and HBNC activities were carried out by the ASHA workers. While CBAC forms were filled, they were not uploaded to the NCD portal. There was a backlog of over three months, indicating delays in data digitization and reporting.
- The VHSNCs were constituted at the village level and headed by GP Chairpersons. Out of the total 144 sanctioned VHSNCs, 142 were operational in West Siang district, while all 63 VHSNCs were functional in Longding district. The JAS have been formed at both AAM-SHCs and AAM-PHCs. While AAM-PHC JAS registers were well-maintained and meetings were held every one to two months, AAM-SHC JAS meetings was not regular.
- The CRM team in West Siang district was informed that since Single Nodal Agency (SNA) was implemented, VHSNCs have not received their untied funds. In Longding, the untied funds for AAM-SHC JAS were handled at the block level and CHOs had limited information about fund utilization. Proper monitoring of VHSNC and JAS untied fund expenditures is required. Strengthening the functioning of VHSNC and JAS through adequate training and handholding support is essential to ensure effective community-level activities.

ASSAM

- ASHA selection has been completed as per the target. As of today, the state has 33,656 ASHAs, with 1,054 in Morigaon and 970 in Baksa. The ASHA support structure is well- established, with 32

District Community Mobilizers (DCMs), 150 Block Community Mobilizers (BCMs), and 2,675 ASHA Supervisors/Facilitators supporting the ASHAs.

- ASHAs have been trained in the 6th and 7th modules, and program-specific training is provided regularly. A structured induction training system is in place for newly selected ASHAs.
- The state has a robust ASHA incentive payment mechanism. A portal-based ASHA Payment and Performance Monitoring System (APPMS) has been developed. The state government has issued clear instructions to ensure timely payment of incentives to ASHAs.
- Most ASHAs have completed Community-Based Assessments, with forms submitted to the CHOs, who are conducting screenings.
- Pregnant women received four ante-natal check-ups, and birth companions were allowed during deliveries.
- VHSNCs have been formed as per the target. The state has 28,942 VHSNCs, including 889 in Morigaon and 935 in Baksa.
- Some ASHAs have been provided with incomplete HBNC and HBYC kits, and the items under the HBYC kit were found to be poor in quality. The state needs to ensure that complete sets of HBNC and HBYC kits with good quality are provided to all ASHAs.
- Capacity building of ASHA's on HBNC & HBYC is to be carried out.
- Some ASHAs were found with Blood Pressure apparatus but lacked proper training on blood pressure measurement. As per instructions from ANMs, some ASHAs have purchased BP apparatus from the VHSNC untied fund. The state needs to ensure that proper training is provided to ASHAs on BP measurement before giving them BP apparatus.
- Some ASHAs were found with Rabeprazole tablets, Calcium, and Vitamin D, which are not part of their drug kit. The state should ensure that ASHAs are given only the designated drugs included in their drug kit.
- Each ASHA has been provided an ASHA diary/register, but instead of using it, all ASHAs were found using around seven different types of registers. It is recommended that ASHAs be encouraged to use the ASHA diary exclusively.
- Even though VHSNCs have been constituted, most of them were found to be non-functional.
- There is no proper list of members, members are unaware of the committee's functions, meetings are irregular with low attendance, and there are no monitoring or planning registers. VHSNCs are also very poor in documentation. The state needs to revitalize these committees by (a) Re-orienting support structure staff using the VHSNC training module, (b) Conducting a community-level drive to select new active members and IEC and innovative approaches to popularize VHSNCs at the community level.
- The majority of VHSNCs are led by male PRI members, despite the National VHSNC guidelines recommending female PRI members for leadership positions and 50% female membership. It is suggested to reconstitute the committees in line with these guidelines.
- During meetings with beneficiaries and communities, it was found that there is high OOOPE among them. Beneficiaries incurred expenses on transportation, diagnostics (especially ultrasounds at private clinics), and drugs. Even though four Ante-Natal Check-ups were conducted, participation in PMSMA visits was very poor. ASHAs, ANMs, and communities need to be made aware of the importance of PMSMA and the SUMAN program.
- Even though there is a robust ASHA payment mechanism, each ASHA spends about ₹150– ₹300 per month on photocopies of supportive documents to attach with their claim forms. The state should compensate ASHAs for these costs.
- ASHAs have been enrolled under PMJJBY and PMSBY. It is suggested to enrol ASHA under Pradhan Mantri Shram Yogi Mandhan Yojna as well.

BIHAR

- In the state of Bihar in rural areas, 90,542 ASHAs are currently in position against a target of 93,687, leaving a shortfall of 3,145.
- In urban areas, however, only 655 ASHAs are in position against the target of 977, reflecting a more significant gap of 322.
- Under Module 6 & 7 training among rural ASHAs, 81,054 were trained in Round 1, 78,730 in Round 2, 76,912 in Round 3, and 75,074 in Round 4.
- In the case of urban ASHAs, 565 were trained in Round 1, 500 in Round 2, 441 in Round 3, and 187 in Round 4.
- Additionally, under the HBYC, only 25,064 rural ASHAs have been trained so far.
- Around 99% of VHSNCs have been formed, with 8,149 constituted against the target of 8,219.
- All VHSNCs have operational bank accounts, ensuring financial accountability, and ASHAs serve as the Member Secretaries of these committees.
- Furthermore, around 84% of MAS have been constituted and JAS has been constituted in 83% of health facilities, ensuring community participation in facility-level health governance.
- ASHAs were selected based on district-specific targets, with the selection process typically carried out by the Mukhiya or Sarpanch according to pre-established criteria. However, some ASHAs were found to be serving populations of over 1,000 people, which is above the recommended limit.
- During discussions with ASHAs, it was observed that while most of them were actively involved in their routine activities, their knowledge was primarily superficial. There was a clear lack of in-depth understanding of programmatic aspects, particularly in areas such as High-Risk Pregnancies, Healthy Timing and Spacing of Pregnancies, HBNC, HBYC, and family planning counselling.
- Additionally, both ASHAs and ANMs were found to lack proper orientation regarding the correct filling of MCP cards, leading to incomplete records in many cases.
- Although the ASHAs were engaged in routine activities, they were not equipped with a comprehensive understanding of various national health programmes. They had received training in Modules 6 & 7 and NCD but lacked capacity building in other expanded packages, including HBNC and HBYC.
- The average monthly monetary incentives received by ASHAs were around ₹5,000. Despite this, there were concerns about limited awareness and delayed payment of team-based incentives, which could affect motivation and performance.
- All ASHAs expressed confidence in the Ashwin portal, reporting satisfaction with the system as they receive their incentives on time. They only need to upload the form, which is verified by the ANM by the 5th of every month.
- It was noted that a strong support structure was in place and regular ASHA Divas, cluster meetings, and regular reviews by the Block Community Mobilizer (BCM) were being conducted.
- Smartphones have been provided to ASHAs by the state, and they use the mASHA app for efficient data entry and updating the community profile annually.
- Few ASHAs were enrolled in social security schemes, but there was no provision for career progression for them.
- Saas Bahu Sammelans, intended to foster better communication between mothers-in-law and daughters-in-law, were not being organized in the area. Additionally, the distribution of Nayi Pahel Kits for newlywed couples was limited, with only a few couples receiving these kits.
- ASHAs were also responsible for administering IFA syrup (both blue and red) and line-listing pregnant women and High-Risk Pregnancies. However, follow-up on these cases was poor.

- The difficult physical terrain, particularly in the Adhora block, posed significant challenges for ASHAs in effectively covering the population and delivering healthcare services.
- In Kaimur district, the VHSNC was not observed to be in place.
- In Gaya, the VHSNC was functional, and monthly meetings were organized regularly. However, representation from other government departments, such as the Anganwadi workers of ICDS, school teachers, and community members or volunteers, was missing in the meetings.
- A fund allocation of ₹6,000 per year is designated for the VHSNC. The major areas of expenditure include sanitation, maintenance, arrangements for “Piyau” (drinking water facilities), and spraying activities to maintain hygiene and prevent vector-borne diseases.
- VHNDs are conducted regularly, monthly, specifically every Wednesday.
- Several facilities did not utilise the VHSNCs fund in the Kaimur district.
- It was observed that JAS was constituted at all the visited locations. However, no training had been provided to the members of these committees. The minutes of the meetings were maintained at the SHC level. Unfortunately, similar documentation practices were not observed at the APHC level.
- Financially, an amount of ₹30,000 was allocated to the AAM SHCs to support JAS activities

CHHATTISGARH

- ASHA are called Mitadin in the state, the average population covered by a Mitadin is 350 and Urban area is 720. All the Mitadins have been trained in Module 6 and 7, NCD, HBYC. Almost all the Mitadins have been enrolled in Pradhan Mantri Suraksha Bima Yojana (PM-SBY) and Pradhan Mantri Shram Yogi Maan Dhan (PM-SYM). Mitadins are promoted to Master Trainers (ASHA Facilitators) and further to Block or District Coordinator.
- None of the Mitadin of visited facility has been trained on Expanded Package of Services.
- Enrolment of Mitadin in Pradhan Mantri Jeevan Jyoti Bima Yojana (PM-JJBY) was also found to be limited.
- Smartphones have not been provided to Mitadins, no IT platform being used by Mitadins.
- No promotion of Mitadins to Master Trainers or Block/ District Coordinator has taken place from the last 7-8 years.
- Sarpanch of the village is member of community platforms, apart from that no participation of PRI/ ULB members was noticed.
- VHNSC/ JAS has been constituted at all the facilities.
- At the level of PHC, RKS is functional in place of JAS.
- Composition of JAS/ VHSNC to be done as per guidelines, all the community platforms have female participation more than the male.
- Monthly meetings of VHSNC/JAS members found to be lacking along with untimely release of untied funds for VHSNC/ JAS.
- Untied funds are being utilised for facility upgradation

GUJARAT

- Community was observed to be more inclined to seek services from private facilities/trust hospitals. Shorter waiting time, trust in quality and convenience were cited as major factors that influenced the community's decision to go to the private facilities.
- In the urban areas, difficulties were observed in engaging non-slum populations (urban ASHAs

are not entered inside the society) and the male population (MAS are women-centric). Migrant population in the urban areas also posed concerns for delivering health services.

- The State is providing ASHAs with 50% top-up over and above their incentives accrued from the activities performed. Weekly meetings of ASHAs are conducted, which helps in monitoring their performance and also in addressing any queries they may have.
- VHSND sessions are organised regularly (Mamta Diwas), but the services are more focused on ANC and Immunisation. Other services such as NCD services are not undertaken during VHSND.
- Limited understanding of VHSNC members on roles and responsibilities was observed. The meeting minutes of VHSNC were not comprehensive, there was no documentation on the agenda of the meeting, or the decisions taken.
- JAS meetings are held regularly, and funds are utilized for various activities (e.g., purchasing drugs, IEC, housekeeping) and initiatives like arranging blood for patients, health awareness, patient satisfaction Survey conduction, installation of CCTV camera etc. were also observed in Vadodara. However, decisions that had been taken during JAS meetings are not well documented.
- RKS members lack formal trainings and meetings are not conducted regularly. Urban are not effectively utilized compared to their rural counterparts. DH Vadodara has outsourced services for diet, housekeeping, and HR (Class III and IV staff) using RKS funds.
- In Kachchh district, at both the levels of VHSNC and RKS, it was observed that the utilization of untied funds was not optimal. While no funds had been used under VHSNCs, on average only 14% of funds under RKS had been utilized at the facilities visited.

HARYANA

- Community interaction: Interactions with seven women, including two pregnant women and one recent mother from Bhanguri village, revealed that local residents regularly visited the SHC-HWCs for basic medications because the facility was easily accessible. This was further supported by a good, shared rapport between the ASHAs, ANMs as well as the CHO with the community. Pregnant women and women in post-natal period knew name of their ASHA. Pregnant women and recent mother had MCP card but was not aware of the details given on the card. They mentioned that they visit SHC for ANC check-up and blood tests. They also shared that they consumed iron and folic acid tablets regularly.
- Services such as immunization, family planning, ANC, hypertension and diabetes were being availed from SHC-HWCs while the trust and awareness regarding available services on other expanded range of services was low.
- The women were aware of and participated in meetings organized by the ASHA in the middle of each month. They also mentioned another monthly meeting where topics such as exclusive breastfeeding, the importance of green leafy vegetables for pregnant women, hand hygiene for both mothers and babies, and addressing gaps during pregnancy were discussed.
- Another interaction with eight women of reproductive age (18-49 years) from Adarsh Colony, Sallagarh, Palwal, revealed a strong preference for government facilities within the community. The majority of women frequently visited the AAM; however, there was a lack of awareness about the recent upgrades to the AAM and the range of services now available. All participants lived within a 10-minute distance from the AAM.
- Most women shared that they visit the DH Palwal for major illnesses, appreciating that everything is provided free of cost, including diagnostics and medications. The influence of the ASHA workers and the proximity to the facility were also factors influencing their choice.
- ASHA workers were generally seen as helpful and approachable. However, one participant mentioned that she had moved to Palwal six months ago after marriage, and no ASHA worker had visited her or provided any health education. The majority of participants reported attending

the meetings organized by the ASHA on the 14th or 15th of each month, where health education was provided on topics such as breastfeeding, hand hygiene, washing fruits and vegetables, the importance of green leafy vegetables and fruits in the diet, as well as IFA tablets and deworming.

- District Palwal has 287 villages, 4 blocks namely Dudhola, Hathin, Hodal and Aurangabad, 1025 ASHAs and 3 BACs. Out of 1025 ASHAs in Palwal district, 757 (81%; out of 940) were enrolled in PM-Jeevan Jyoti Bima Yojna, 833 (81%) in PM Suraksha Bima Yojna and 661 (98%; out of 676) in PM Shram Yogi Maan Dhan. The awareness of the ASHAs on their coverage under the schemes was limited.
- As per interactions and field visits with ASHAs of both the districts, the ASHAs were actively visiting the household of the villages for enumeration and provided health-related information to the villagers.
- The ASHAs had received training in module 6, 7, HBNC and HBYC training. They were aware of the activities they had to perform and the incentives for each activity. The incentives were received on time. However, awareness about the expanded package of services was lacking.
- Similarly, gaps in knowledge of community and health care workers were found around service provision under expanded package of services. Lack of training is found to be a major impediment to the delivery of services. ASHAs and ANMs have not received the training in the last 2 years.
- The ASHAs, visited across the district, block and communities, were seen to be motivated. ASHAs were conducting postnatal visits under HBNC. ASHAs were aware about incentives related to different programs. They were aware about the number and frequency of visits to be conducted.
- Entitlements under JSY were being given to eligible women via DBT mode, as per the registers kept in the facility and according to interaction with patients. ASHA satisfaction with ASHA payapp is good with timely payments compared to before and validation of payment procedures through app.
- Immunization services were being delivered effectively during Routine immunization sessions on every Wednesday and Friday and VHSND (observed on 15th of every month).
- ASHA mobilize mother & children to the session sites for vaccination as per their due list of beneficiaries. The frontline workers (ASHA/ANM/AWW) are aware about service provisions at outreach sessions and vaccination schedule of children.
- Sanitary napkins were not found to be distributed among the adolescent girls at AAM-SHC or by ASHA because of their unavailability. However, distribution of IFA tablets in the community reported to be irregular.
- Regular monthly meetings by VHSNC, and SKS were conducted. Timely disbursement of ASHA incentives, and payments of ANM, CHOs .
- PHC - AAM engagements with other allied departments were satisfactory for community level education such as with ICDS, Education, PRI was majorly for Routine immunisation, Anaemia, National deworming day.
- Across the VHSNCs visited, VHSNCs were holding meetings once a month. VHSNCs were constituted and meeting regularly, member of youth group and NGO were present. Meetings records were maintained but no training on the roles and purpose of the committee. ASHAs were not aware of the roles and responsibilities.
- AAM was facilitating the planning & implementation of health promotion and disease prevention activities through community level interventions, such as VHSNC and VHNDs. Monthly meetings of VHSNCs and VHNDs were held on the 15th of every month and records are maintained separately.
- At AAM-SHC level, Swasthya Kalyan Samitis (SKS) were in place till March 2024. No funds have been received after March 2024. At AAM-PHC level, SKS were in place, with presentations from health functionaries, community, PRI (sarpanch) only. A total Rs 1,75,000 is received by the PHC-AAM under untied funds, annual maintenance and grant for patient facilities, and was utilised in

consultation with the concerned accounts person. However, PHC staff were not aware of the fund utilisation norms. Major expenditures included, repair work, power backup, printer etc. record of fund utilisation was not maintained in the PHC.

- MOs or CHOs were not aware of the JAS or MAS.

HIMACHAL PRADESH

- The ASHA program in Himachal Pradesh has made significant progress, with 8,744 ASHAs approved and 8,377 currently in position. ASHAs receive incentives amounting to ₹5,500/- from the State Government and ₹2,000/- from the Government of India for routine and recurring activities.
- In response to feedback, the uniform colour has been changed from green to light pink, and the uniform allowance has been increased from ₹1,100/- to ₹2,100/-. Additional allowances include ₹500/- for shoes and ₹1,000/- for ASHA bags or umbrellas, both provided through Direct Benefit Transfer (DBT).
- To strengthen support, guidelines have been issued to appoint one ASHA Facilitator for every 20 ASHAs, with 131 facilitators appointed out of the required 437 so far, including 28 in Shimla and 24 in Hamirpur.
- Across the state, 94% of ASHAs have completed induction training, 80% have undergone HBYC training, and 94% have been trained in VHSNC activities. S6 and S7 module training has been completed for 99% of ASHAs.
- ASHAs were aware about their services such as RCH especially ANC related activities, anaemia, immunization, and TB services. ASHAs have a good rapport with Anganwadi worker of their area. Outreach activities in schools being done by urban PHCs but not by rural PHCs. Referral, linkages are not well established. VHSNCs has been formed.
- Hamirpur excelled in induction and VHSNC training (99%) and VHND celebrations (98%). ASHAs were aware about services such as RCH, anaemia, immunization, and TB services but had limited knowledge on mental health services and NVBDCP.
- Hamirpur showed a significant gap in HBYC training of ASHAs, achieving only 47% coverage. It was informed that ASHAs faced a huge challenge in managing the digital platforms like HIMCARE, Nikshay, and U-WIN. Utilization of PPIUCD is less in the community and the reason behind it is that the community has stigma due to misbeliefs henceforth other contraceptive methods are preferred.

JAMMU AND KASHMIR

- JAS was constituted across all visited AAM facilities, and meetings were being organized with minutes/record of discussions being documented at facility-based register. However, due to unavailability of untied funds in last two years, JAS was not functional in its full capacity and only meetings were reported with no planning and action being taken at facility/community level.
- VHSNC – since the PRI elections were delayed and due to unavailability of sarpanch across the visited villages, Block MO was reported for chairing the VHSNC meetings and also conducting the JAS meetings.
- It was observed that user fee as registration fee (of Rs 10) was being charged across all PHC-AAM facilities. Given the principle of providing free of cost care under CPHC, this was highlighted as an area of concern.
- Community perception towards AAM was found satisfactory, where screening for NCDs and increased number of medicines and diagnostic tests at AAM was quoted as main reason for increasing footfalls across the primary care centres.
- Outreach activities were reported across all visited facilities and respective catchment areas. Special outreach camps were being reported across all visited communities; however, the record

maintenance was one key focus area identified, which would need more strengthening.

- Community based platforms like VHSNC and MAS have been constituted and functional in visited districts; however, the training needs for VHSNC/MAS needs to be assessed for institutionalizing their functionality as per defined norms.
- ASHAs in the community has been mapped against the population with special focus in tribal/difficult areas for both rural and urban. ASHAs in community were found very proactive and motivated. ASHAs presence in the community was felt, and she was in sync with the health care needs of her catchment area.
- State has developed a training calendar for training of ASHAs; and districts are being followed the same for effective service delivery. ASHAs were found mostly trained, including ASHA certification training. HBYC trainings were yet to be completed for all ASHAs. During ASHA interactions, preferred mode of training for all ASHAs was in person training. Virtual training was not preferred by ASHAs due to technical issues, given the unavailability and disrupted internet facilities at district and levels below, especially in hard to reach and snow bound areas.
- In Jammu & Kashmir, ANMs have a strong role as ASHA support structure and are functioning as ASHA facilitators in field. This indicates a need for all ANMs being functional in this role to be trained on existing ASHA Facilitator module. Block level ASHAs teams and District level support structure for ASHAs was found very much aligned to their roles as ASHA support system. The ASHA support structure was found strong in terms of both supportive supervision activities as well as field presence to provide overall support to ASHA programme.
- Routine field visits and ASHA interactions were reported as the key activity being undertaken by the Block level ASHA teams. Routine reviews, ASHA monthly meeting, virtual interactions (where possible) etc. were some key activities of district and block level support structure, as reported by ASHAs. While there is no fixed number of visits being undertaken in an year by BCM, it was reported that routine interactions are planned, as and when required; which was also observed and felt during field interactions. However, availability of mobility cost aligned with the field realities was a challenge identified by block and district level officials, for ensuring effective field monitoring activities. Several time the block and district officials were undertaking field visits on personal expenses, as reported during the field visits.
- ASHAs in both the districts have been enrolled in social security schemes i.e. Pradhan Mantri Jeevan Jyoti Bima Yojana and Pradhan Mantri Surksha Bima Yojana. ASHAs were mostly found aware of the social security schemes and their benefits.
- ASHAs were using their personal mobiles for digital entries, wherever required, which was not being compensated at present. Also digital literacy across ASHAs varied, which indicates a more specific training to be planned for addressing the digital divide in ASHAs.
- Grievance redressal mechanism was reported functional at UT level; however, its translation in field was different as the understanding of its utilization in terms of safety measure and gender was not clearly known to frontline functionaries.
- During interaction with ASHAs, the key challenges reported were pertaining to timely disbursement of incentives, mapping of ASHAs tasks especially when she is engaged by other departments, and availability of smart phones for data entry.
- Intersectoral convergence was reported in the field, where several activities were reported



being undertaken in a collaborative manner with departments other than health. School health programmes including deworming and adolescent related interventions were reported at the level of community and primary care facilities. ICDS activities were being provided and convergence with Aanganwadi was observed across all visited communities.

- In addition, specific health camps with CRPF and Indian Army were being organized in a convergence mode at the level of community, which included both health and relevant non- health departments, with active engagement of local bodies. School Health and Wellness ambassadors were found actively participating community level interventions in the visited blocks.

JHARKHAND

- In East Singhbhum, most of the ASHAs/Sahiyas were actively executing their role. They were involved in antenatal care, Home Based Newborn Care, providing nutritional supplements, screening for malaria, follow up of bed ridden patients and NCD services including counselling the community for various health conditions. They were clear and knowledgeable about the services they provide. They could demonstrate their mobile application – e-ASHA. However the application was not fully updated. They reported receiving timely incentives for most of the activities.
- During interactions with Sahiyas in Sahibganj District, several challenges and gaps were identified in their functioning and support systems. It was revealed that Sahiya payments for the current financial year were processed only for four months, from April to July 2024. No incentives under any specific health programs were disbursed to them, leaving them without adequate financial motivation for their critical contributions to community health.
- Sahiyas demonstrated significant knowledge regarding essential health initiatives such as Home-Based Newborn Care (HBNC), Home-Based Young Child Care (HBYC), and the expanded package of services under these programs. This knowledge gap impedes their ability to provide comprehensive care and counselling to families in their respective areas.
- Another issue observed was the weak integration of Sahiyas with other Community-Based Organizations (CBOs) such as SHGs and MAS. This limited networking reduces the potential for collaborative efforts in addressing community health challenges. Strengthening their linkages with these groups is crucial for creating a more coordinated approach to health and welfare initiatives in the district.
- These issues highlight the urgent need for capacity-building measures, regular training, timely disbursement of incentives, and improved networking opportunities for Sahiyas in Sahibganj District to enhance their effectiveness in delivering community health services.
- In East Singhbhum, in the VHND, antenatal care including confirmation and registration of pregnancy, Immunization and nutritional services were being provided. Testing at grass root level and providing supplements was deficient – was told that logistics were not provided.
- ANM was not aware about necessity of certain ANC services and lacked knowledge about nutrition supplementation.
- On community interaction, it was found that the ASHAs visited their community and provided healthcare services and counselling regarding newborn and child care, ANC services, fever testing and management. She was aware about the services provided at Anganwadi Centre and had opted family planning service (IUCD. Common ailment in under 5 children reported by mother was diarrhea and dehydration. So management and health awareness for the same was asked about. ORS preparation technique described was incorrect and mother was not educated the importance of Oral Rehydration Therapy.
- One of the children scheduled for immunization that day had not turned up. CRM team visited the family of the child. It was found that the child was not keeping well and hence not brought. After ruling out that the cause was not a contraindication, CRM team convinced the family members that immunization was safe to be given the same day and the need for immunization and the child was

successfully immunized in same VHND session.

- Knowledge of MAS members was good. They could answer well about reproductive and child care services. MAS members are motivated and having adequate knowledge on their responsibilities

KARNATAKA

- The state has almost 40,000 ASHAs working in the rural and urban areas who were motivated and had a good rapport with the community.
- The state has recently introduced a fixed monthly honorarium for ASHAs of Rs.5000 (Rs. 6000 for ASHA facilitators) and additional incentives based on the deliverables achieved by them.
- The state has also developed “ASHANIDHI” software for the ASHAs to track their incentives from calculation to disbursement to ensure transparency in the process.
- The disbursement of the incentives is being done through DBT portal.
- At least 96% of the ASHAs are enrolled in one of the social security schemes.
- Almost 50% of the ASHAs have been certified for RMNCAH+N Component by NIOS.
- The state rewards and recognizes good performance by the ASHAs in the public forums to motivate them.
- The VHNSCs have been formed for the villages with regular meetings being conducted.
- The VHSNCs participate and encourage the AAM-SHCs to conduct wellness activities in the facility.
- Only 50% of the untied funds had been released by the state to Dakshin Kannada against the budget approved in the RoP 2024-25.
- The State had 4071 MAS that were attached to their urban facilities.
- Regular meetings of the MAS were being conducted in the facilities along with maintenance of the minutes of the meeting.
- In one of the interactions with the MAS members it was remarked that the AAM-USHCs and UPHCs should be open during the evening hours also to make the services available to the working population in the urban areas. Though the state has already issued the order for the same, it is yet to be implemented across all urban facilities.
- Active involvement of the MAS members in the wellness activities was noted.
- In Karnataka, the Jan Arogya Samiti and Rogi Kalyan Samiti are named as Arogya Raksha Samiti (ArRS).
- The ArRS members were actively involved and conducted regular meetings with the AAM teams.
- The utilization of ArRS untied funds was majorly being done to procure drugs not being supplied by Karnataka State Medical Supplies Corporation (KSMSCL) (65-70% of the untied funds).
- ArRS help ensure the maintenance of AAM including the cleanliness, availability of drinking water, clean toilets, BMW disposal and clear signage were observed at the all the facilities.
- The ArRS in one of the centres has also been instrumental in arranging alternate modes of referral transport for the community and has been volunteering as Nikshay Mitras.
- ArRS committees in collaboration with the BPMU ensure care of disabled patients, patients with vision or hearing loss, etc.
- The District Health and Family Welfare Department along with the District Administration and Zilla Panchayat regularly approach private companies for CSR, NGOs and private medical colleges for monetary and other support. Facilities at their level also were procuring support from CSRs to provide extra services in the facility.

- The state has also utilized District mineral funds to procure NAAT machines.
- Intersectoral convergence with the education and WCD department was observed at the AAM-SHC/ AAM-PHC level. Growth monitoring is regularly done by AWCs and the ASHAs and AWWs both coordinate on following up with malnourished children. Regular health education sessions and anemia surveys were conducted in the schools.
- The health department in Dakshin Kannada coordinates with Skill Development and Employment department to ensure Endosulfan poisoning victims get gainful employment. They have also collaborated with the transportation department to ensure they can travel on state transport free of cost along with one caregiver.
- The ArRS Committees had tried to conduct minor repairs by engaging labour through MG-NREGA, however, the inherent lacunae in MGNREGA like delayed payments and absenteeism of labour caused impediments.
- The community was satisfied with the primary healthcare services provided through the AAM, especially the availability of CHO or PHCO in the quarters at night in cases of emergencies. Interaction with beneficiaries, especially, elderly patients confirmed this finding.
- The community was also appreciative of the CHO and the availability of medicines at the AAM-SHCs.
- In areas where the MO post was vacant in the facility, few community members mentioned that the availability of doctor and delivery of services round-the-clock at the AAM-PHCs, UCHCs, etc. would further improve service utilization.
- The pregnant women visited were also aware of their Hb, weight and Expected Date of Delivery and had been counselled on birth preparedness and care during pregnancy.
- Many patients from Kerala came to access services at all levels of public health facilities in Dakshin Kannada district.

MADHYA PRADESH

- Madhya Pradesh has engaged about 68,574 ASHAs cumulatively, for rural and Urban areas. ASHAs are trained and supported to function in their own villages/ slums with the goal to facilitate provision of primary health care, advice on sanitation, hygiene, ante-natal and post-natal care, and escorting expectant mothers to hospital for safe delivery. The status of in position ASHA against the target is shown in table below:
- Overall, the ASHAs were well motivated and clear about their role and responsibilities. The majority expressed a strong determination to improve the health status of their community, stating that their primary reason for becoming an ASHA was to serve the community and raise awareness about the available health services. ASHAs and the ASHA Supervisors were seen to share a good rapport with the community and were well aware of the major health issues of the community. This was common to ASHAs working in rural as well as urban areas.
- In Balaghat district, an Urban ASHA shared an inspiring story of her dedication during a diarrhoea outbreak in a neighbouring ward. Despite it not being her assigned area, she felt compelled to support the affected community. Each day, she would start by assisting families in the endemic ward, ensuring they received the care and guidance they needed, before returning to her own ward to continue her regular duties. Her commitment to serving the community went above and beyond her formal responsibilities.
- The ASHAs were actively visiting the household of the villages for enumeration and provided health-related information to the villagers. The ASHAs also accompanied pregnant women to the hospital for delivery. ASHAs were also seen to be involved in Saas Bahu Sammelan and conducting monthly Gram Sabha Swasathya Tadarth Samiti Meetings, which is the state equivalent of VHSNC. They served as the member secretary of these committees. Regarding NCD services, a gap was

observed in the completion of CBAC forms. While ASHAs were manually filling out the revised CBAC forms, Section D (PHQ-2) was left incomplete in most of the forms reviewed in Balaghat district. In Rewa district, ASHAs were filling the CBAC form digitally using the NP NCD app.

- The 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 for expanded packages for the delivery of Comprehensive Primary Health Care is pending. As reported by ASHAs, they had only been trained in MNS care from the newer packages. There is no plan at the district level for upcoming training of ASHAs either for expanded package of services.
- Awareness related to social security schemes among the ASHAs was satisfactory. Some of the eligible ASHAs had been enrolled in the social security measures launched by the Govt of India: Pradhan Mantri Suraksha Bima Yojana, Pradhan Mantri Jeevan Jyoti Bima Yojana and Pradhan Mantri Shram Yogi Maan Dhan yojana.
- On an average ASHAs received Rs 10-12 thousand per month. State of MP is providing additional Rs 4000 per month routine incentive to ASHA and Rs 6000 per month as additional incentive to ASHA Facilitator. In context to assessment, the 10-indicator grading system for assessing the performance of the ASHAs was found to be non-functional.
- State has initiated enrolment of ASHAs in ANM/ GNM course. However, on consultation with ASHAs in Balaghat district, they were unaware about any career progression process.
- In the state of Madhya Pradesh, the VHSNCs were known as 'Gram Sabha Swasathya Tadarth Samiti'.
- ASHAs are working as member secretary of these committees and are conducting the meetings in the AWC regularly.
- MAS have been constituted and functional as per the guidelines. The MAS members were extremely motivated to improve the health outcomes of the community. They have been working as MAS members since last 8 years. Each committee had 10-12 members on an average wherein Urban ASHA was the member secretary and convener to conduct the monthly meeting.
- The monthly MAS meetings were being held regularly in the AWC. The details of monthly meeting minutes were not available with MAS members at the time of visit.
- MAS had received the untied fund of Rs 5000 annually. The chairperson was confident and told the key areas where the expenditure of this untied fund was done in past few months. However, the documented details of expenditure were not available with the members at the time of visit.
- The MAS meetings were largely serving to discuss health and social challenges in the community, prevention strategies for spreading communicable diseases like malaria, first aid in emergency, etc.
- The AWC had displayed the details of the ward of the MAS, health facility nearest to the ward, etc.
- Discussions with community members revealed that they were well aware of the AAM facility in their area and frequently utilized its services. The CHO had established a strong rapport with the community, fostering trust and encouraging people to visit AAM for a range of health concerns, including common colds, fevers, diarrhoea, hypertension, and diabetes.
- Most community members reported obtaining medications regularly for hypertension and diabetes from the AAM, with no complaints of delays or shortages. They mentioned that medicines were consistently available, and they typically received a one-month supply for chronic conditions like diabetes and hypertension. They mentioned that their OOPE had significantly reduced after increased availability of medicines at AAM as previously they had to go to the private facility for accessing health services and availing required drugs and diagnostics.
- Additionally, the community appreciated the active involvement of ASHAs in their area. ASHAs were noted for their frequent household visits, which served various purposes, such as conducting HBNC visits, providing hygiene counselling, educating adolescent girls on menstrual hygiene

management, offering family planning advice, and motivating families to participate in VHND sessions. These efforts were seen as instrumental in improving health awareness and practices within the community.

- Members of the CRM team attended the VHND session at Anganwadi Centre Mahajan Tola No. 5 in Rewa district. An outreach session was conducted at the Anganwadi Centre with two ANMs and one ASHA present. Due to the non-functioning u-WIN app, a manual due list was prepared, while the ANMOL app was actively used. Need for improvement in injection technique was observed during the session. ANC tests were conducted except for Urine Albumin and Sugar due to the non-availability of Urostix for over a year. Early registration efforts were inadequate; the ANC registered in 4th month despite residing in the catchment area of ASHA and ANM. Issues were identified with the digital Hb meter, showing inconsistent readings (2 gm and 4 gm) for an ANC who did not appear anaemic. Beneficiaries like adolescents, eligible couples, and PNC mothers were not invited to the session.
- Members of CRM team visited the RBSK team in Rewa district. The team included two AYUSH Medical Officers, other positions remaining vacant. The doctors had undergone training and were equipped with the necessary kit and vehicle. Branding was done on the vehicle. The team had access to ATP, which was effectively utilized to notify the Anganwadi worker a day in advance, ensuring the participation of beneficiaries, particularly out-of-school adolescents. Both doctors demonstrated a thorough understanding of program guidelines. Their interactions with children and the techniques used during examinations were notably commendable.

MAHARASHTRA

- ASHAs are active and motivated and had a good rapport with the community. Some observations included career progression for ASHAs, assured amount from state, timely disbursement of incentives and active involvement of in JAS Committee.
- MAS acts a community-based peer education group in slums, involved in community mobilization, monitoring and referral with focus on preventive & promotive health care. Each MAS consists of 10-12 women from about 50-100 households with an elected chairperson. Member secretary is ASHA.
- In the Patient Welfare Societies (PWS)/ Rogi Kalyan Samiti (RKS) Committee, a group of trustees for the UPHCs is appointed to manage the affairs of the facilities. Untied Grant for UPHCs where RKS is registered Rs 1.75 Lakhs/UPHCs. Untied grants are given for purchase of medicine, equipment etc., referral services, lab services, minor repairs, contingency etc.

MIZORAM

- VHSNC meetings were being held monthly to discuss community health, nutrition, cleanliness, mother & child care interventions.
- Community intervention through UAAM-Tumpui was observed in the process where one topic is chosen and information regarding the same topic is delivered through WhatsApp and local Newspaper.
- Interdepartmental convergence was observed in Lunglei district where at SHC Water and sanitation department has constructed separate male and female toilets.
- MAS were constituted and functional in the Urban areas, however utilization of untied fund for MAS was low.
- JAS constituted and functional in all visited facilities. JAS meetings conducted regularly and meeting records were maintained, however MOM were signed only by JAS chairperson and secretary in Lunglei district.
- In the Kolasib district JAS members were also trained for the elderly patient group.

- The disease prevention and health promotion activities were not being discussed in the JAS meetings
- There was no provision of support payments of ASHA due to which many times ASHA pay from their own pocket for transportation etc.
- There was backlog in incentive payments of ASHA for HBNC, HBYC incentives pending from 2022 and 2023 respectively.
- ASHAs were available and well versed with their work, however facing challenges in the online trainings and data entry due to the unavailability of electronic devices and poor internet connectivity.
- ASHA training and payments need to be addressed at many places as payment of JSY incentives to ASHAs was pending. Even if the payment was done, it was reported to be incomplete against the due amount.

ODISHA

- Odisha has made significant strides in community health initiatives, with 49,990 ASHAs, each serving a population of 852 individuals on an average. The selection criteria for ASHAs have been relaxed to accommodate areas with hard-to-reach populations, and education requirements have been adjusted to class 5 pass in areas where 7th pass ASHAs are scarce. All ASHAs have received training in various modules, including induction, HBNC, HBYC, NCD, and EPS, with supportive supervision from district and block-level officials. ASHAs receive a minimum incentive of Rs. 7,000 per month, with an average monthly incentive of Rs. 9,000, and one-time assistance of Rs. 10,000 for community-level activities.
- Additionally, ASHA Gruhas have been established in 143 health institutions, and measures for career progression, such as weightage for admission into ANM and GNM courses, have been implemented. Furthermore, Odisha has established Gaon Kalyan Samitis, with 46,162 committees functioning at the village level, addressing health-related issues and promoting community action. Most AAM facilities have constituted JAS, with members oriented about their roles, and annual untied funds have been allocated for health service delivery, promotion, and social accountability.

RAJASTHAN

- Both Bharatpur and Sikar towns are covered under NUHM. Total population of Bharatpur Municipal corporation is 350149 and there are 135 nos of urban ASHA's are in-positioned out of 138. There are 55816 no of ASHA sanctioned and 53902 no of ASHAs are positioned. There is a provision for the retirement of ASHAs at the age of 60, resulting in 2 to 3% vacancies throughout the year. In Bharatpur ASHAs are 1144 in posited out of 1153 approval and similarly in Sikar 1539 ASHAs are in-positioned out of 1600 approval. Average incentive of ASHA per month in 2019-20 was Rs. 3582 and the same has been increased to Rs. 4498 per month in 2023-24. The average ASHA incentives in 2023-24 in Bharatpur is Rs. 4354/- per month and in Sikar is 4205/- per month.
- The patients are using the 108 ambulance and Janani express services as referral transport. Bharatpur city has five UPHC to cater the healthcare needs of the urban population. Total 35 outreach sessions were planned in a month and 30 sessions were conducted during October 24. Total 966 UHND sessions planned and 100% sessions held. 63 MAS sanctioned and 62 MAS formed to look at community level services in Bharatpur city. MAS are formed to create awareness among the slum community on various programs and schemes. They were involved in mobilisation of beneficiaries for immunization sessions, institutional delivery , motivation for ANC/PNC and participation in the slum cleanliness. Monthly meetings have been organized and minutes prepared by the MAS members.
- ASHA in both urban and rural areas received module 6 & 7 training, NCD, HBNC, new year service packages of oral, eye, ENT, MNS, Elderly. ASHA's are getting their incentives from the State level through ASHA software.

- ASHA's are covered under the social security schemes(PM-JJBY, PM-SBY, PM-SYMY).
- There is a provision of career progression for ASHA under ASHA Jyoti Yojana to enhance their educational qualifications by completing the 10th and 12th grades. So far, approximately 1,774 ASHA workers have passed the 10th grade and around 1,802 ASHA workers have completed the 12th grade.
- ASHAs are given a 10% reservation for admission to ANM course. 97% ASHAs are using SMART phones and Rs. 600/- per Month paid to ASHA for PCTS application entry. The ASHAs are using PCTS applications. Review of ASHA program conducted at State and district level in virtual mode.
- ASHA incentives are not paid regularly and ASHA sector meetings are also not conducted as per the norms.
- The mentoring support of CHO to ASHA is minimal(Bharatpur district).
- Bank deducted some amount from the MAS untied fund due to the non-availability of minimum balance (Bharatpur urban).
- Delay in releasing of annual untied funds to MAS was reported. Vacancy of district and block level manpower to community process intervention was also observed.
- Due to the low level of education of ASHAs, they are facing difficulty in using smartphones and also found telephone network problems in some areas. State has not been initiated the process for gradation of ASHA to A, B, C and D grade.
- A Focus Group Discussion (FGD) was conducted with antenatal mothers, postnatal mothers, Children (1–6 years), elderly women and TB patients. The FGD covered a diverse range of healthcare services, including preventive, promotive, and curative aspects. Key topics included immunization services, access and utilization of antenatal and postnatal care (ANC/PNC), delivery services, and government-provided entitlements/benefits such as Janani Suraksha Yojana (JSY), Janani Shishu Suraksha Karyakram (JSSK), and free transport services. The importance of breastfeeding was also emphasized. Beneficiaries displayed awareness of the nearest public health facility and its available services. The community predominantly preferred utilizing public health facilities, except for ultrasound services (USG), for which they relied on nearby private healthcare facilities equipped with sonography services. A marginalized segment of the community in one area reported not having Aadhaar cards, despite multiple attempts to obtain them. This limitation prevented them from accessing free healthcare services at public facilities. Beneficiaries expressed overall satisfaction with healthcare services, particularly maternal and child health (MCH) and family planning services provided by ASHAs and ANMs. ASHAs and ANMs were reported to conduct regular visits, provide services, and organize awareness sessions with active community participation. Record-keeping practices were also appropriately maintained. The use of IEC/BCC materials for awareness activities was positively received. Topics addressed included prevention of vector-borne diseases, IFA supplementation, deworming, prevention of air pollution, and utilization of nutritional services at Anganwadis. The community demonstrated awareness and utilization of terminal sterilization and interval contraception methods. Awareness about and utilization of free sanitary napkin distribution through schools and Anganwadis were noted. Home-based elderly care services were unavailable, and diagnostic services were limited across healthcare facilities. Dissatisfaction was expressed regarding the availability of doctors and healthcare staff. One woman reported undergoing a hysterectomy at a private healthcare facility, incurring a significant out-of-pocket expenditure (approximately ₹40,000). A marginalized pocket of the community lacked access to clean drinking water, requiring residents to travel 2 kilometres daily. Additionally, electricity supply was inconsistent, and open defecation was prevalent due to the absence of sanitation facilities. The community was unaware of the conversion of primary health facilities into Ayushman Arogya Mandirs. They reported no noticeable changes in the services provided at these facilities. The community was aware of the 104 and 108 ambulance services. Beneficiaries reported satisfaction with these services and confirmed having availed their benefits when needed. There were no reported cases of maternal, infant, or child deaths or deaths of individuals in their productive years. During the interaction with a tuberculosis (TB) patient in the community, it was observed

that the patient was initially screened and diagnosed at the nearby Primary Health Centre (PHC) AAM and subsequently referred to the Community Health Centre (CHC) for a TrueNAAT test. The patient received a one-month supply of medication from PHC AAM and chose the Auxiliary Nurse Midwife (ANM) for treatment support throughout the course. Additionally, a Direct Benefit Transfer (DBT) of ₹500 was provided to the patient. However, the most recent prescription indicated that the patient had discontinued treatment at PHC AAM and had opted to continue treatment at a private hospital. Family members of the patient were also screened as part of contact tracing and preventive measures.

- Another FGD was conducted with ASHAs and Anganwadi Workers. All the ASHAs who participated in the discussion had undergone training in Modules 6 and 7. All ASHAs had functional HBNC and HBYC kits. They demonstrated awareness regarding the appropriate usage of these kits. ASHAs actively used IEC materials on anaemia to counsel beneficiaries. Counselling included information on dietary diversity and the promotion of locally available iron-rich foods. ANMs were well-versed in protocols for the treatment of severe anaemia. Two women in the community with anaemia were identified and were receiving proper treatment. Shakti Divas was being conducted regularly at Anganwadis, and the community was both aware of and benefitting from the program. Saas Bahu Samelan were organized every Tuesday to facilitate intergenerational communication and awareness on maternal and child health. All ASHAs interacted with had received training related to cancer awareness and early detection. None of the ASHAs had received training on the NIKUSHT portal, and there was a lack of awareness regarding its use and purpose. There was no awareness among the ASHAs regarding elderly care protocols. Additionally, no Information, IEC materials were available for elderly care promotion

TRIPURA

- ASHAs were actively engaged in maternal and child health awareness but had minimal engagement in addressing gender-based violence.
- Women's participation in VHSNCs was relatively higher compared to other northeastern states, but decision-making was still dominated by men.
- Low awareness of reproductive rights and services among adolescent girls and women.

UTTAR PRADESH

- Village Health, Sanitation, and Nutrition Days (VHSNDs), designed to provide essential health services and foster community engagement, are inconsistently conducted at Anganwadi Centres. These sessions often lack adequate planning, resulting in reduced participation from beneficiaries and missed opportunities to deliver critical healthcare services such as immunizations, antenatal checkups, and nutrition counselling. However, by strengthening the regularity and quality of VHSND sessions, we can significantly improve their impact on community health, fostering a sense of hope and optimism for the future.
- Family planning and anaemia prevention awareness are not adequately emphasized during community events. This gap limits the reach and impact of these critical health programs, particularly in rural and underserved areas. Additionally, the absence of high-quality Information, IEC materials further hampers efforts to educate and empower communities. Providing accessible and well-designed IEC materials on family planning, anaemia prevention, and maternal-child health can enhance awareness and encourage behaviour change.

UTTARAKHAND

- Regarding selection of ASHAs, it was found that 100% selection was done for ASHAs at the state as well as district level. State has a total of 12018 ASHAs against the population of 11795000 (2024 Projected population)- average 1000 population covered by one rural ASHAs and 1500 population by Urban ASHAs. State has a full-fledged ASHA Resource Centre (ARC) to support the ASHA

program.

- State has formed VHSNCs in 2015 as per state notifications. The total number of functional VHSNCs in the state is 14915. The total number of meetings in a year until October 2024 is 835240.
- ASHAs were interacted in each of the facilities visited. All ASHAs mentioned that they received Induction and Module 6 & 7 training. NCD training was the last training they received. Many ASHAs were of the opinion that they receive refresher training on Module 6 & 7 for appearing for NIOS certification examination. More than 2800+ ASHAs already passed NIOS examination for ASHA Certification. Most of the ASHAs are aware about CBAC form fill up but not aware about follow up action for DM and HTN patients.
- On HBYC, ASHAs were trained and conducting HBYC visits using the kits provided to them.
- The ASHAs and ASHA Facilitators of Dehradun district were trained on Participatory Learning and Action (PLA) on pilot basis.
- ASHAs in Dehradun districts were aware on CPHC expanded packages and know about Rs. 1000/ month additional incentives for various activities under CPHC expanded packages. State has already defined the breakup of Rs. 1000/ month for various CPHC expanded packages activities for ASHAs.
- All ASHAs were well supported by ASHA Facilitators (AFs) and Block Community Mobilisers.
- Awareness status and enrolment of ASHAs on Social Security Schemes (SSS) found to be very encouraging in the state. The Rural ASHAs were aware of the schemes like Pradhan Mantri Jeeva Jyoti Bima Yojana (PMJJBY), Pradhan Mantri Suraksha Bima Yojana (PMSBY) and Pradhan Mantri Shram Yogi Maan Dhan (PMSYMY).
- Regarding career progression of ASHAs, state reserved few seats for ASHAs & AFs for ANM/GNM courses. Three (03) ASHAs from Dehradun district were enrolled for ANM/GNM courses in the last three years. However, state may define a clear-cut plan for career progression of ASHAs for reservation of seats for ANM/GNM course and recruitment after completion of courses.
- ASHAs were aware of a District Grievance Redressal mechanism for ASHAs for registration and resolution of complaints. Five (05) complaints were received in FY 2023-24 in Dehradun district, and all were addressed by the district committee. No complaints received in Bageshwar district.
- Holding regular VHSNC meetings was a cause of concern but few ASHAs have been conducting regular meetings which was evident from the VHSNC meeting minutes. Regular MAS meetings are also a cause of concern but few Urban ASHAs have been maintaining meeting minutes on monthly basis. In the meetings, topics related to sanitation & hygiene, programs to be conducted in the next month etc. issues related the area/village were being discussed.
- In Dehradun, ASHAs were provided with a smart phone, 02 years back as mentioned by ASHAs. The android phone is being utilized for daily communication only, no specific mobile app has been used by ASHAs as of now. ASHAs in Bageshwar mentioned that they received mobile phones many years ago and were nonfunctional now.
- VHSND is being conducted by ASHAs on regular basis which is accompanied by ANM and local AWW. During VHSND, awareness sessions are being conducted on health and nutrition, hygiene, breastfeeding, Antenatal checkup, Postnatal checkups. Also, during VHND outreach sessions NCD screening is also being conducted for 30+ population of the area.
- Few ASHAs were raising the issues of retirement for ASHAs as many ASHAs have been working since 2006-07. As on date, there is no retirement policy for ASHAs. State should plan for a retirement policy for ASHAs as per GOI norms.
- ASHAs were of the opinion that they have been receiving the incentives on time but are not sure for which are the activities they have been incentivized for. Few ASHAs were of the opinion that ASHA Sangini app may be revived again with new additional features which will not only track the ASHA activities but also will track ASHA incentives every month.

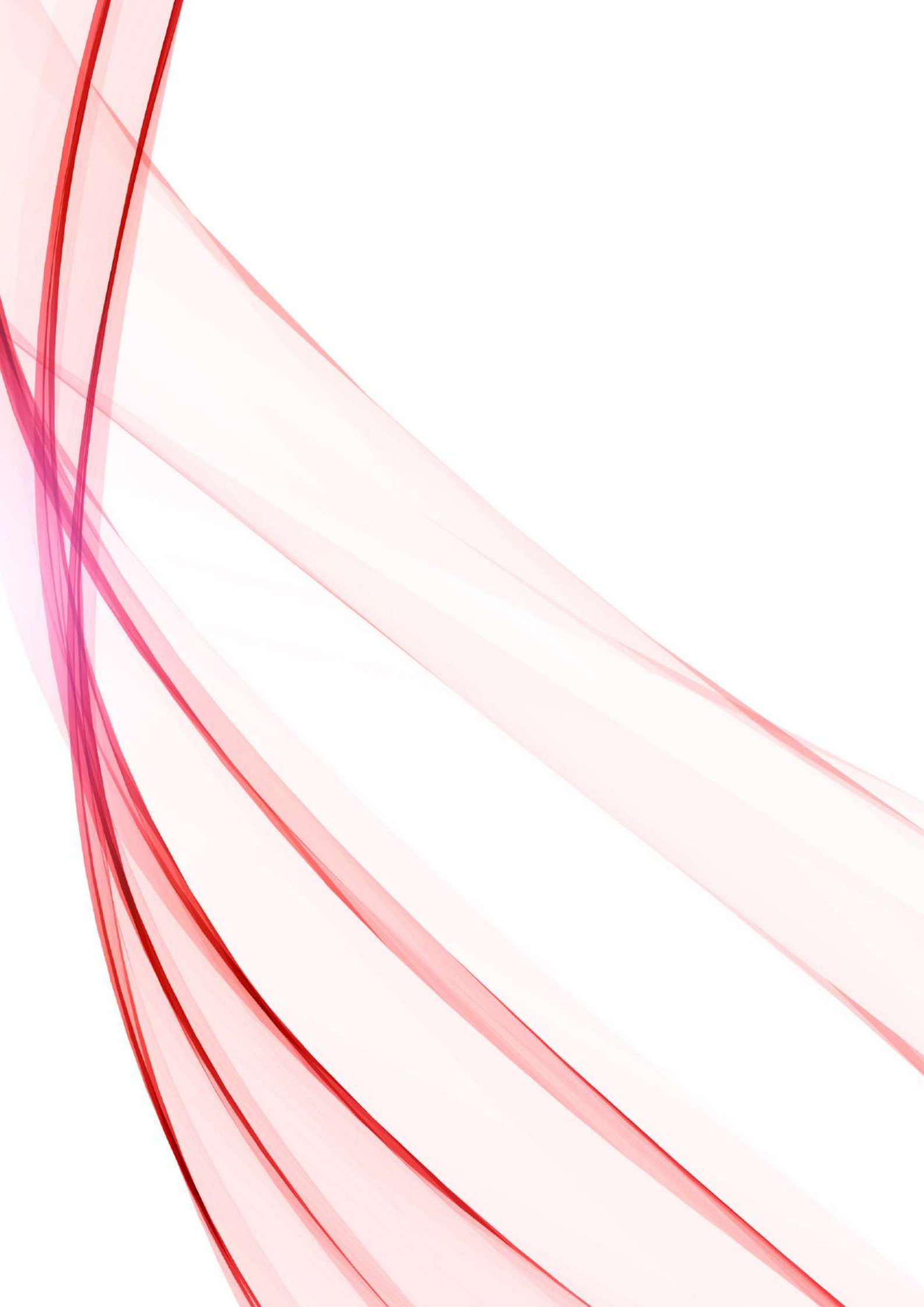
- With regard to the training of ASHAs, ASHAs mentioned that offline mode of training is the most suitable one. Online training is not beneficial for them as most of the content they cannot understand.
- ASHAs were dynamic and active in providing services for immunization, institutional delivery, counselling services, screening, referral, and follow-up of beneficiaries. ASHA has been receiving a monthly honorarium of Rs. 1000/- per month from the State Fund and Rs. 2000/ month from NHM fund, above all other incentives on various activities performed by ASHAs.
- State has also initiated team-based incentives for ASHAs under AAM facilities.
- The community awareness about many national programs like Anemia-Mukt Bharat, National Tuberculosis Program, Viral hepatitis, Tobacco control program, Free Drug Initiatives, National Rabies Control Program, and National leprosy control program was inadequate. Districts and the facilities may plan to conduct awareness campaign on the various programs as initiated by State Government.
- Rogi Kalyan Samiti (RKS) or Hospital Management Committees are available at District Hospital and at Community Health Centre (CHC) level. Regular untied fund has been received by DH, SDH and CHCs. However regular RKS meetings are a cause of concern along with the maintenance of RKS meeting minutes.
- All facilities from PHC-AAM level and above have been charging users fees for registration, lab fees etc from all except for Pregnant Women, newborn and lactating mothers. All users' fees are being deposited at the respective facility bank account, 50% of which goes to treasury every month.
- During the focus group discussions with villagers/ communities it was found that the community seeks healthcare from the nearest AAM, but AAM facilities are not providing all the facilities, especially facility of safe delivery and medicines near the villages. Thus, foreseeing out-of-pocket expenditure for medicine is to be expected to be available in the health system. This is also one of the reasons for inadequate community participation in health care system. But community opined that the available public health services are of good quality, although not everybody utilizes it, and the behaviour of the grassroots-level health workers was good.
- In Bageshwar, the community interaction highlighted that they were satisfied with the health care staff and services, however there are gaps like non availability of basic medicines including for DM and HTN at AAM-SHC for which they have to visit higher facilities, and this sometimes causes delays in taking medicines. The community also felt the need for more gynaecologists in the district for maternal health care and pediatric care services for critical cases to be made available within the district as currently they have to travel to Almora/ Haldwani for services.

WEST BENGAL

- Team observed that diagnostic facilities were functional and community participation was there. VHSNCs, JAS, MAS, Panchayat meetings were conducted regularly in both the districts.
- ASHAs were provided HBNC equipment, training materials, and medications and supported by effective replenishment system in both the districts.
- In South 24 Parganas, while PRI support was effective, there was lack of convergence with the education, forestry, veterinary sectors & disaster department.
- In South 24 Parganas, attendance at the MAS level was primarily by males.
- In South 24 Parganas, the Team observed that the JSY payment system was operating smoothly, with documents collected in the ward upon discharge, and payments made via computer-based system. Also, separate bank accounts were not available, untied funds of JAS were not received.
- Team observed that the staff members were well motivated, receiving trainings and well-informed about the schemes, however trainings of HR was not updated at SASHAKT portal. Team observed

that convergence meetings were conducted regularly in Malda district and also 50% women representation and vulnerable groups representation was there along with elected representative as Chairs.

- It was observed that actions taken to the discussion in last meeting were not documented. Although, ASHAs and young nursing cadre were well motivated and confident.
- In Malda district, JAS bank accounts were functional with joint signatories and hassle free JSY payment system was there-all documents submitted in the ward at the time of discharge. Payment sent through RTGS.
- In Malda district, Terms of References for training were not defined and yearly calendar for training of the staff was not found. Team observed that the HR at HWC-PHC was very limited and needs to be trained on extended packages of services.
- It was found that ASHA were well respected in society for their healthcare support and high intake of public health services.





HEALTH PROMOTION AND WELLNESS INITIATIVES

16th

Health promotion is a key public health strategy aimed at improving overall well-being by addressing social, environmental, and behavioural factors influencing health. It focuses on empowering individuals and communities to take control of their health through awareness, education, and policy interventions. It is a crucial component of achieving Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs). The National Health Policy (2017) emphasizes preventive and promotive healthcare through lifestyle changes, nutrition, sanitation, and education. Ayushman Arogya Mandir focuses on health promotion through behaviour change communication, community engagement, and screening for risk factors of diseases. With time, wellness activities have been recognized as an integral part of AAM functionality.

KEY OBSERVATIONS

WELLNESS ACTIVITIES

- Wellness activities were regularly conducted in all the visited states except Jharkhand, Uttar Pradesh, and Uttarakhand. The frequency of the monthly wellness sessions varied across the states. Documentation of these activities needed attention in most of the visited states.
- Most of the AAM facilities in Assam, Bihar, Gujarat, Rajasthan, Uttar Pradesh, Haryana, Arunachal Pradesh, West Bengal, and Maharashtra had adequate space for wellness activities. Karnataka had specifically demarcated outdoor spaces for yoga and wellness activities.
- In Arunachal Pradesh, Gujarat, Jharkhand, Bihar, and Karnataka, yoga sessions were conducted by the staff of Sub-Health Centres (SHCs) and Primary Health Centres (PHCs). These sessions were held by a designated yoga instructor in Madhya Pradesh, Haryana, Rajasthan, and Malda district of West Bengal.

IEC AND AWARENESS GENERATION

- Information, Education, and Communication (IEC) materials were prominently displayed in all the visited facilities to foster community awareness. However, most of the materials primarily focused on Reproductive and Child Health (RCH), with limited IEC content on wellness.
- Notably, Madhya Pradesh, Haryana, Rajasthan, and the Malda district of West Bengal effectively highlighted wellness-related IEC, demonstrating good health communication practices. The IEC materials displayed in most states were in their regional languages except in few states/UT like Jammu & Kashmir. Additionally, a 42-day annual health calendar was displayed in majority of the visited facilities.

AYUSHMAN AROGYA SHIVIR

- The regular organization of Ayushman Arogya Shivirs was observed in Madhya Pradesh, Jammu & Kashmir, Haryana, Bihar, and Himachal Pradesh, while states like Tripura and Karnataka exhibited inconsistencies in implementation. On the other hand, West Bengal and Rajasthan did not implement this activity.
- All visited states followed a fixed-day approach, conducting Shivirs once a month, except for Haryana and Madhya Pradesh, where they were held twice monthly. Chhattisgarh adopted a distinct approach with the AAM team organizing weekly sessions. The primary activities in these Shivirs included community-level screening and updating data on the portal. No significant innovations were noted.

EAT RIGHT CAMPAIGN

The 'Eat Right' toolkit was available in most of the visited AAMs, except in Chhattisgarh, Rajasthan, and Uttarakhand. However, the implementation of activities related to the toolkit was unsatisfactory, with no structured awareness or counselling sessions conducted. While a few PHCs in Haryana observed 'Eat Right' Day monthly at the PHC level, no documentation was maintained regarding these activities.

KEY RECOMMENDATIONS

- The States may conduct targeted IEC campaigns to disseminate information on various schemes and improving service uptake among the eligible population in the public health institutions.
- States need to strengthen and improve participation in wellness activities through targeted campaigns and community outreach programs, emphasizing their role in preventing diseases and promoting overall health. Engaging local leaders, healthcare workers, and educational institutions can further amplify the message and encourage widespread participation in these activities.
- To enhance awareness, wellness-related IEC should include information on planned wellness activities, designated wellness days, healthy lifestyle promotion (nutrition, physical activity, stress management), and yoga and AYUSH interventions.
- States need to ensure that the Eat Right toolkit is available across all AAM facilities. Related activities should be increased at all levels. AYUSH doctors may be involved to achieve better results with the program.
- Patient support groups for NCD and TB patients should be established and strengthened throughout India to improve patient support and care.
- Community platforms, such as VHSNC, MAS and JAS may be leveraged to create awareness for activities conducted by AAM facilities to support health promotion activities as per the health calendar days.
- Documentation of wellness activities needs to be strengthened.

STATE-SPECIFIC FINDINGS

ARUNACHAL PRADESH

- PRI members in the state demonstrated a strong commitment to strengthening wellness activities, actively supporting the construction of a wellness room and the fencing of the facility at SHC AAM Darka. ASHAs and CHOs further engaged the community in wellness activities such as yoga, along with other health promotion initiatives.
- The West Siang district of Arunachal Pradesh received the first prize in the state's IEC Creative Competition for its video. Additionally, the District Tobacco Control Cell (DTCC) of West Siang was recognized for its outstanding performance in IEC monitoring during the 60-day Tobacco-Free Youth Campaign in 2023.

ASSAM

- Periodic yoga and wellness activities were conducted to promote overall well-being. The Eat Right initiative was integrated into VHSND sessions to encourage nutritious dietary practices during pregnancy. School health programs required further strengthening to enhance their impact and reach.

- Annual Health Calendar days were displayed at the SHC-AAMs. The facilities celebrated these health days with the community. However, the State's school health programs needed further strengthening.

BIHAR

- Wellness sessions were conducted by the Community Health Officers (CHOs) at the AAM-SHCs and by the Staff Nurses at the APHC. However, documentation of wellness activities was not adequately maintained.
- Monthly health melas were conducted and reported on the portal at the SHC level. Outreach activities varied across the state.
- Under the Adolescent Friendly Health Clinic, a few facilities developed interactive activities and games with the support of Population Services International (PSI) India to increase awareness among the participants.

CHHATTISGARH

- The facilities were observed to celebrate health days as per the Annual Health Calendar. The AAM team even conducted weekly health Shivirs. Most of the facilities displayed adequate Information, Education, and Communication (IEC) materials, but the content was repetitive.
- Most of the schools had Health and Wellness Ambassadors. The Community Health Officers (CHOs) delivered yoga sessions at their facilities; however, the frequency of the sessions was less than recommended. In general, the focus on wellness activities and health education could be improved. The Eat Right Toolkit was not available in any of the visited facilities.

GUJARAT

- The staff of AAM-SHC and AAM-PHC were trained in yoga and meditation, and wellness sessions were organized as recommended. Patient support groups for NCD and TB patients were formed in Vadodara, which could be replicated in other districts.

HARYANA

- The State has initiated wellness activities and has appointed Yog Sahayaks. However, the facilities did not maintain adequate records for the same. The school health program was in its early implementation phase, with health and wellness ambassadors identified in schools. A training schedule has been prepared to equip them on designated themes.

HIMACHAL PRADESH

- Annual health calendars were available and consistently followed across all facilities.
- Yoga sessions were conducted in various camps and schools, with activity registers maintained at each facility and IEC materials prominently displayed in PHCs.
- Medical Officers conducted health education sessions in PHCs, and yoga sessions were organized either in nearby schools or within the AAM premises.

- Regular initiatives, such as the 'Eat Right' campaign and monthly Arogya Shivirs, were organized across all facilities.

JAMMU AND KASHMIR

- Health promotion activities required significant improvement. Monthly Arogya Shivirs were conducted across the visited areas, following a fixed-day approach.
- At one of the visited SHCs, NCD-related videos were played in Gujarati, limiting their effectiveness in addressing local needs.
- While the Tele MANAS QR code was displayed in one facility, overall awareness of Tele MANAS was lacking across all health facilities.



JHARKHAND

- The state had been conducting wellness activities for the primary healthcare team to promote holistic well-being among healthcare providers. However, community-level wellness activities remained sporadic and required better planning for consistent and effective implementation.

KARNATAKA

- The state planned and observed wellness activities as per the annual health calendar by notifying the community in advance. ASHAs conducted awareness activities at regular intervals, enhancing community engagement. Weekly yoga sessions were conducted consistently by both rural and urban AAM teams, with VHSNCs and MAS actively supporting and encouraging their organization.
- However, the School Health and Wellness Programme needed attention—health and wellness ambassadors were yet to be appointed. Additionally, the activities under the 'Eat Right' toolkit were found to be unsatisfactory, with no awareness or counseling sessions planned to promote healthy dietary practices.

MADHYA PRADESH

- The state uniquely designed an immunization wheel, which was effective in raising awareness and helping parents remember their baby's immunization schedule.
- The Mannhit app was used for self-assessment and provided information on the AAM and staff availability. It included IEC videos and fact-checking tools and offered a user-friendly experience for the community.



MAHARASHTRA

- Pamphlets and booklets on government schemes and non-communicable diseases (NCDs) were available for the patients. Health education was reinforced through audio announcements in the local language, played in the waiting area during OPD hours.
- A 3D working model demonstrated essential foods and their nutritional values, supported by a dedicated centre for nutrition-related IEC.
- The facility also had a breastfeeding corner, children's play area, library, and informative resources for parents.

MIZORAM

- Wellness activities were not conducted in AAM. IEC for health promotion and prevention was placed in all the facilities visited. Posters for hand washing were also placed above the wash basin, except in a few places.

ODISHA

- Health promotional activities such as yoga sessions were provided. School Health and Wellness Ambassadors were selected and trained under the School Health and Wellness Programme of Ayushman Bharat, conducting weekly sessions on select themes including wellness, health, and hygiene.

RAJASTHAN

- Wellness activities were conducted by a certified yoga master as per norms, though there was a lack of proper documentation and adherence to the wellness calendar at some facilities.
- The AAM-SHCs were limited by space constraints, hindering their ability to conduct wellness sessions.
- The state was yet to implement the School Health & Wellness Programme.

TRIPURA

- Ten health promotion activities were conducted monthly, including yoga sessions. Considering the existing infrastructure, it reflected a strong intent of health workers to promote well-being.

UTTAR PRADESH

- While the facilities had adequate space for yoga and wellness activities, supporting the vision of holistic health promotion, wellness activities and preventive care services were not regularly implemented.
- The Ayushman Bharat School Health and Wellness Program (AB-SHWP) showed a slow rollout and limited reach, requiring focused attention.

UTTARAKHAND

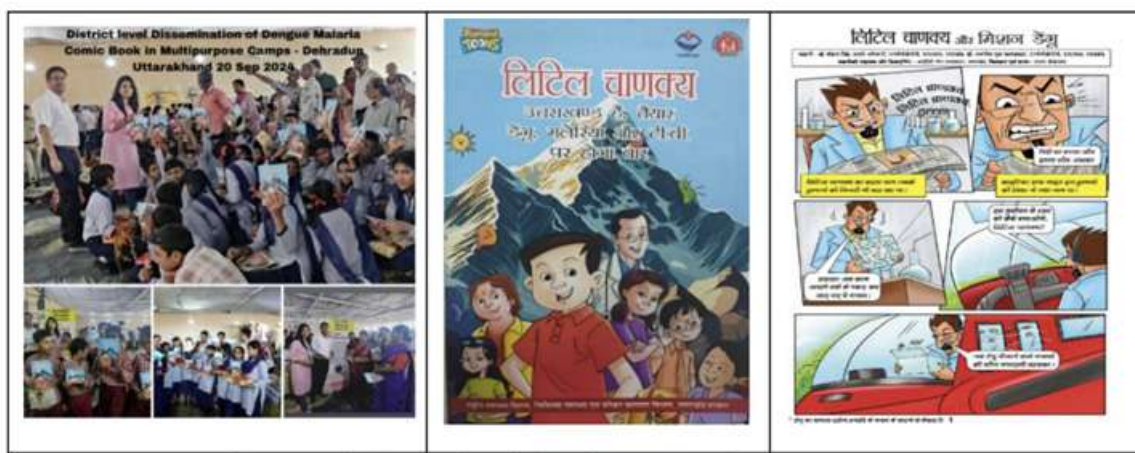
- The 'Eat Right' toolkit was unavailable at any of the visited AAM-SHCs, and the staff lacked awareness about it. Additionally, no training sessions were conducted for the Primary Healthcare team on the 'Eat Right' toolkit or the 'Eat Right Magic Box'.

WEST BENGAL

- The AAM visited in the state did not follow the health calendar, resulting in inconsistent wellness activities.
- Malda district was observed to have wellness-specific IEC, a dedicated yoga room with an instructor, and documentary evidence in place at visited AAMs. However, wellness services needed to be strengthened in South 24 Parganas

BEST PRACTICES

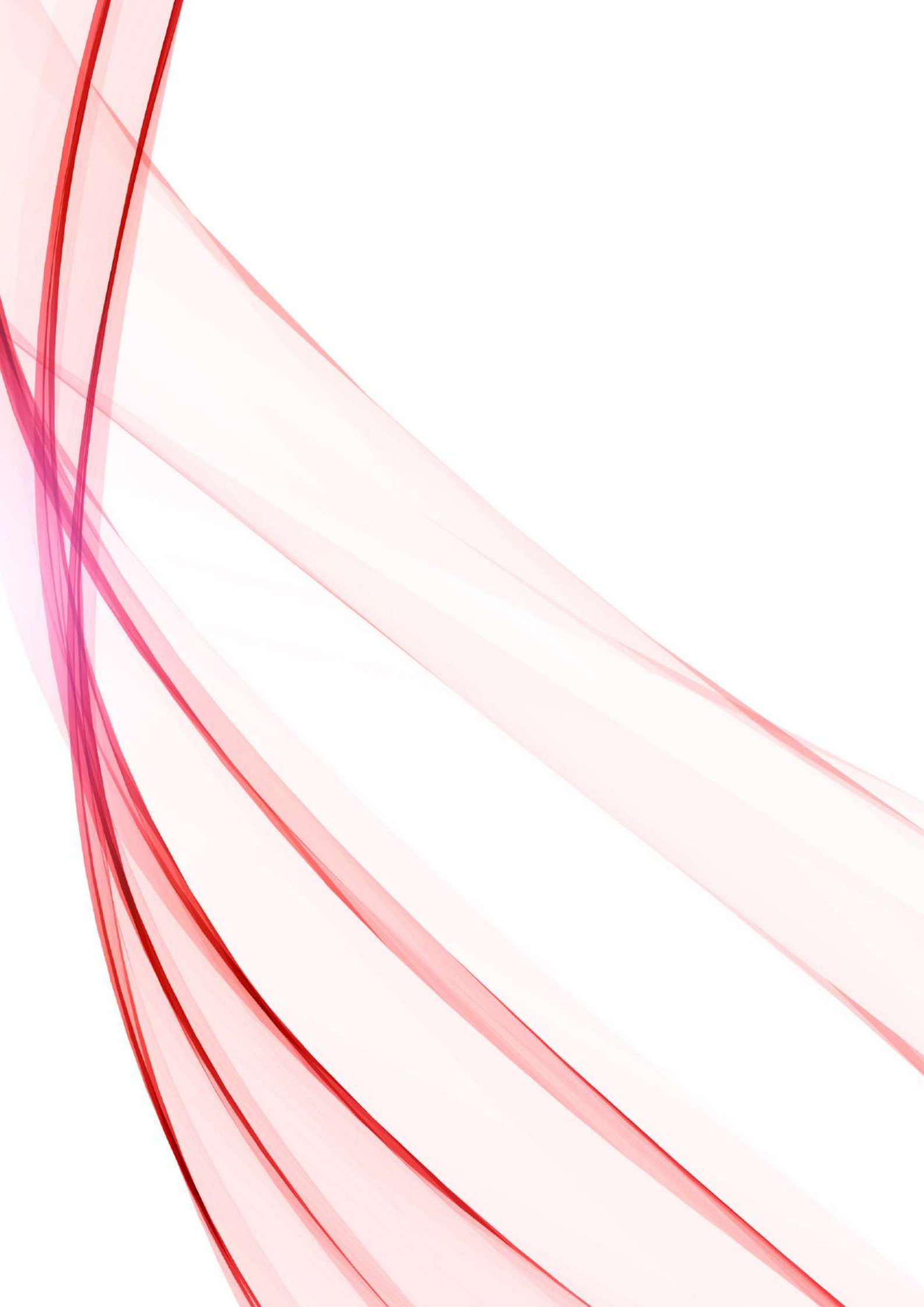
- Tobacco-free zone at Darak Circle in Arunachal Pradesh:** An initiative by the Women's Social Body from Darka village in West Siang successfully transformed their village into a tobacco-free zone. The sale of tobacco products, gutka, pan masala, and similar items was banned throughout the entire Darak circle. Meetings were held with local organizations, the Darak Market Committee, PHC, and other stakeholders. Secret selling was curbed through the imposition of fines and counseling of defaulters. This led to reduced consumption, improved cleanliness, better health, and economic benefits for families.
- Comic Book for Awareness in Uttarakhand:** The state introduced an innovative approach to raise awareness among children through a comic book titled "Little Chanakya – Uttarakhand." The tagline is "Hai Taiyaar, Dengue, Malaria aur TB per Hoga War." By utilizing the power of storytelling and visuals, the comic book effectively conveyed important health messages, helping to instill awareness and encourage healthy behaviors from a young age.



- The Nirmal Scheme of Odisha** is an initiative aimed at improving sanitation and cleanliness in all the state-run government hospitals. The primary focus is on providing basic facilities like sanitation, laundry, security, and lift services, ensuring quality healthcare services affordable for the people. All the defined services under "Nirmal" are taken up through outsourced modes by engaging competent agencies decided through a competitive bidding process.



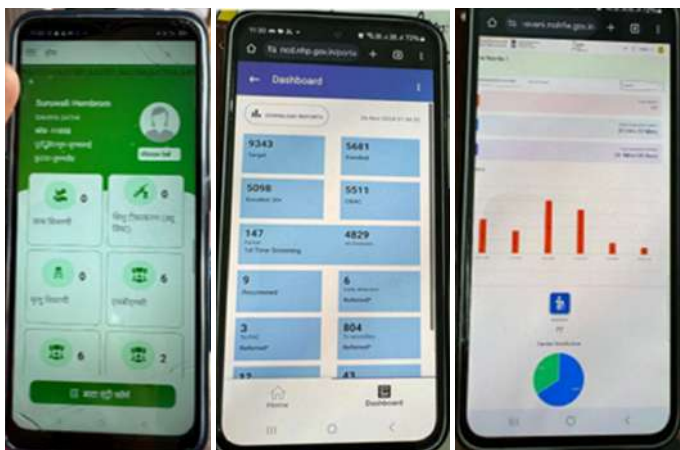
- The Mannhit app in Madhya Pradesh** is used for self-assessment and provides information on center and staff availability. It includes IEC videos and fact-checking tools, offering a user-friendly experience for the community. The Immunization Wheel in Madhya Pradesh is effective in raising awareness and helps parents remember their baby's immunization schedule.





**REVIEW OF IT APPLICATIONS
CP-CPHC – STATUS, UTILIZATION
AND CHALLENGES**

- At the primary health care level, IT-based solutions are prioritized, and NHM places a strong emphasis on using standardized digital solutions to facilitate deployment by creating a smooth information flow between care levels. In addition to supporting data management, the IT-based solutions at the Ayushman Arogya Mandir (AAM) level are intended to guarantee an integrated approach through an interoperable structure of current applications/software, allowing programme officers to better understand and analyze their population. Effective service delivery at the AAM in both rural and urban locations would require the use of information technology.
- Several programme specific and process driven IT based portals or software are operational at the primary level across all states/UT. In addition to nationally designed IT based solutions, some states have also developed specific IT based platforms to support NHM related activities and processes. These platforms capture the information at the facility level and community level as per their design, and are being used to provide an overall status at state level dashboards, thus ensuring availability of information as per the need of the programmes.
- While the IT based solutions are a step towards ensuring expanded service delivery, in alignment with nation's path towards attainment of Universal Health Coverage, several factors like sufficient availability of IT support in terms of equipment and network are crucial for ensuring smooth functioning of these platforms.
- The CRM teams visited the states to understand the availability as well as functioning of the IT based solutions in similar contexts, across the primary health care level.



KEY OBSERVATIONS

- Most of the states visited were using a diverse range of portals for entering programme specific data, including portals such as RCH, ANMOL, AAM portal, Ni-kshay, HMIS and others. UP and Chhattisgarh reported not using ANMOL.
- Internet connectivity and limited server space was observed to be a consistent issue across most states except Himachal Pradesh and Rajasthan, where most of the visited facilities had good internet connectivity. Fixed line connections were not available in most of the visited facilities in states.
- Infrastructure for IT usage such as desktops/laptops were available at some facilities. Karnataka reported that the desktops at AAM-PHCs were outdated and not in the proper condition to work efficiently.
- The loss of data while syncing NCD portal entry of CBAC forms was a concern highlighted by the teams.
- DVDMS was rolled out and functional in some states, however, the functionality was only up to the AAM-PHC level in most states. Chhattisgarh was using its own developed **Drug Distribution and Management Information System** in place of DVDMS for indenting and procurement of medicines.
- Nikushth portal for leprosy case reporting was observed to be functional only in a few states like Gujarat, Karnataka and Tripura
- Training gaps in using IT portals were identified in most of the States, except in Himachal Pradesh, J&K and Mizoram. In Madhya Pradesh, the ASHAs were not using the NP-NCD applications and

were manually filling the CBAC forms.

- Gujarat and Bihar have integrated multiple portals for creating unified digital frameworks to increase efficiency and streamline data, namely TeCHO+ and BHAVYA portal respectively. However, Uttar Pradesh has not integrated the portals including the state specific E-Kawach and Mantra, which contributed to increased workload due to duplication of data entry.
- The ASHWIN and mASHA portals in Bihar, and MP Arogyam Portal in Madhya Pradesh have been designed to streamline ASHA incentive disbursement process to reduce delays in payment and to increase efficiency of data entry by ASHAs
- In Himachal Pradesh, the access to the RCH portal is only with the block level, thus the ASHA needed the OTP from the block every time to access the portal, which reduced efficiency.
- Gujarat and Tripura reported increased burden on the health staff due to duplication of data entry on multiple portals as a challenge.
- The Vadodara Municipal Corporation in Gujarat has developed a mechanism to enable paperless patient registration and other healthcare services through the HMIS.

KEY RECOMMENDATIONS

- Adequate IT infrastructure including smartphones/tablets/laptops/desktops may be provided to all facilities to ensure timely uploading of data in portals.
- Continuous and uninterrupted internet connectivity across all facilities needs to be ensured, and fixed line connections may be provided.
- Training and orientation should be facilitated at all facilities for human resources to ensure awareness and accuracy in uploading the service delivery data.
- Workshops may be organized, and support sessions may be provided to improve the ASHAs' ability to use digital platforms like NP-NCD, Nikshay, and U-WIN etc.
- Mobile modules and interactive content for continuous, role-specific training on data handling and guidelines may be developed for healthcare staff.
- Quarterly audit of data entered in portals should be done to verify its timeliness and authenticity by the facility in-charge and district/state level officials.
- Synchronization of the IT platforms for ABDM compliance should be expedited to reduce workload on the healthcare workers and to ensure accuracy.
- States may explore mechanisms to link the data entered in the portals with the users' ABHA IDs.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- CHOs in the visited facilities were using several systems like NCD, e-Sanjeevani, SASHAKT, AAM, FPLMIS, but their functionality couldn't be verified due to poor internet.\
- Internet connectivity was a major issue in both the visited districts. Dedicated broadband lines may help tackling connectivity issues.
- RCH Portal and ANMOL were not working in the districts.

ASSAM

- All relevant IT portals along with state owned portal (Swasthya Sewa Dapoon) with name based tracking feature & payment of wage compensation & incentive were in place at the visited facilities.

- Internet connectivity was a pertinent issue across all visited facilities. Due to this, IT applications were reported to be slow, which delayed data entry in RCH portal and HMIS.
- Primary healthcare teams were found to lack training in using the IT portals/ or in data entry, which may hinder accurate and timely data entry.

BIHAR

- The state utilizes Nikshay, IDSP, e-Sanjeevani, NCD, Ayushman Arogya Mandir portal, Ashwin Portal, Bhavya Portal. RCH data entry is mostly done through ANMOL. The NIKUSTH Portal had not been used for updating leprosy data for over a year. The usage of digital tools was low in primary care facilities.
- IT infrastructure like desktop/laptop/tablet was not adequately available at the visited AAM, however, ASHAs were given smartphones.
- On the NP-NCD portal, real-time data was not being uploaded by the CHOs of the visited facilities. Follow-up data entry in the NCD portal by the MOs was not observed due to non-availability of MOs at some APHCs.
- The percentage of diagnoses reported on the NCD Portal was relatively lower than expected. Individual-level reports of registered beneficiaries were not available on the app at the hub facility user level.
- The e-Aushadhi app was fully functional in some facilities visited. Pharmacists at a few centers were well-versed in using the e-Aushadhi app for routine tasks such as indenting, acknowledging stock receipt, and updating consumption status.
- Govt. of Bihar has rolled out the Mukhyamantri Digital Health Yojana (BHAVYA). This initiative aims to unify existing web portals such as the RCH Portal, AAM Portal, NCD Portal, HMIS, PMSMA Portal, and e-Sanjeevani Portal to improve efficiency and accessibility.
- The ASHWIN portal is designed to help ASHAs in readily entering all service-specific data delivered in the community and at the facility, for receiving the incentives timely. ASHAs also utilized the m-ASHA app for entering beneficiary registration for women and children.
- ICICI proprietary software was being used to make DBT payments to beneficiaries.

CHHATTISGARH

- The utilization of ANMOL, e-Sanjeevani, and NIKUSTH was limited due to technical concerns.
- Internet connectivity was a major issue, especially at the AAM-SHCs. This affected timely entry of updated information in the portal needed for delivering quality healthcare.
- The Chhattisgarh Medical Service Corporation utilized its own Drug Distribution and Management Information System. The Healthcare Facilities (HCFs) indented using this portal. Manual indenting of drugs being done from AAM-SHC on need basis, mostly monthly.
- NIKSHAY portal entry was done at the block level.
- RCH, PMSMA and HMIS portals are being used, however, discrepancies in data entry were observed.
- The districts reportedly organized monthly training sessions for the staff to build their capacity for data entry and portal usage. However, a lack of adequate understanding of data entry into the respective portals was observed during the visits.

GUJARAT

- The state uses TeCHO+ as a unified digital framework. All the facilities submit RCH data, fill and

update CBAC forms, and generate ABHA IDs through the TeCHO+ portal.

- Limited server space and network issues were also reported to cause delays in data submissions and make data entry time consuming.
- Additionally, duplication of data entry across 58 different portals in the state was as a major concern, as it significantly increased the workload for staff.
- U-WIN was not in use in the state at the time of the visit. Vaccination status is updated in TeCHO+ after each session, which is then integrated with eVIN. The state has requested the U-WIN API from the central government to streamline this process.
- A significant challenge with the NCD portal was the loss of data when syncing CBAC forms that were filled offline once they connect online.
- Entries were not being made for dengue and malaria on the IHIP portal. NVHCP portal was not functional at the AAM-SHC level, but the state has adopted the NIKUSTH portal.
- The Vadodara Municipal Corporation has developed a mechanism to enable paperless patient registration and other healthcare services through the HMIS.

HARYANA

- Applications that are being used at the PHC - AAM level for reporting included HMIS, Birth/Death registration portal, IDSP - IHIP, e-Saral, IDR - MDR, AAM portal, NHM- Progress Monitoring System, RCH, UWIN, FPLMIS, Nikshay, NP-NCD, e-Upchaar and e-Sanjeevani.
- Training on IHIP portal, AAM portal, HMIS, U-WIN, NCDs, Pneumonia and Anaemia has been provided to the staff beside induction training. ANM & ASHAs were well oriented with the services and portals such as Anmol, NCD portal.
- Data discrepancies between the several portals and their manual registers were observed at PHC-AAM and AAM-SHC.
- Separate protocols for data reporting to follow the programme guidelines are not developed at the facility level.
- Data entry mechanism, for almost all the national programme manual registers are maintained separately along with the portal entries leading to duplication of work.

HIMACHAL PRADESH

- Multiple portals were being used at the health facilities, such as RCH, AAM portal, PMSMA, NCD, Nikshay, DVDMS, IHIP, HMIS in both the visited districts. Data reporting was conducted daily.
- Internet connectivity was good across most of the visited facilities, with occasional network issues. Availability of IT infrastructure such as laptop/desktop was observed at most facilities.
- The access to the RCH portal was only available at the block level. Hence, every time the ASHA needed OTP from the block to access the portal, which reduced efficiency.
- Duplication of work on RCH and Anmol app was observed. Some erroneous entries were also observed on HMIS.
- NCD portal had certain issues like the inability for the MO to add new patient unless ASHA adds them. The MO also can't mention customized drug regimen and has to use drop down menu only.
- The staff was familiar with most of the IT portals, however, some portals such as FPLMIS were not being used at some facilities. Overall, the health staff were proficient with Android devices for data entry and demonstrated effective use of the applications.

JAMMU & KASHMIR

- The state utilizes multiple IT platforms such as JK eSAHAJ, JK eSEHAT, Mera Aspataal, PMNDP portal, ANMOL, U-WIN, RCH, HMIS, PFMS-EPFO, IHIP, DVDMS, 104-Grievance Redressal and e-Samadhan, Saksham Portal, ABHA portal, PCPNDT portal, AAM portal, Nikshay, e-VIN among others.
- Availability of internet was highlighted as an area of concern, with none of the AAM-SHC reporting the availability of a fixed line connection.
- DVDMS was observed to be functional only till the AAM-PHC level, and at AAM-PHCs also it was partially functional, thus making availability of medicine a challenge.
- The MLHP/CHOs and other AAM team were using their personal mobile phones for using IT based applications, including portals and tele-consultation.
- In the use of e-VIN/U-WIN app use, OTP issue was found in relation to the vaccine beneficiary
- The staff had good knowledge and were hands on in using the portals.

JHARKHAND

- While portals were in use, several portals were not fully functional or utilised in both the visited districts, such as Nikusth, DVDMS and SaQushal. NIKUSTH portal was not being utilized effectively for leprosy case tracking.
- Internet connectivity was an issue across most facilities visited.
- e-Hospital platform, which facilitates registration, consultations, lab tests, and medicine indenting from IPD wards, has yet to achieve full operationalization.
- A significant gap was observed in staff awareness and orientation regarding these portals.

KARNATAKA

- Data was being uploaded on various State and National portals like HMIS, RCH, NIKUSHTH, NIKSHAY, UDAD etc. regularly.
- The computers at the AAM-PHC were outdated and lacked functionality. Internet connectivity was also a major issue at the AAM-PHCs, which forced the staff use their personal data cards for data entry and reporting.
- Healthcare facilities were integrated with portals such as e-Aushadhi and Mera Aspataal.
- Data quality was found to be compromised due to lack of training/orientation of DEOs/staff entering the data.

MADHYA PRADESH

- Most of the relevant IT portals for the primary level facilities such as AAM portal, ANMOL-RCH portal, DASTAK portal, MP Aushadhi, HR-MIS in addition to HMIS, e-Sanjeevani, CPHC NCD etc. were in use.
- Primary healthcare team was not trained in using the IT portals or in data entry.
- ASHAs were not using the NP NCD applications and were filling the CBAC form manually.
- The records and registers maintained by the CHOs were not updated as per the latest data.

- The state has developed an MP Arogyam portal for issuing Performance Based Incentive through online mode.
- State has their own ASHA web-based application for managing ASHA database, training planner, work performance monitoring, incentive payment and reports.

MAHARASHTRA

- Wi-fi connectivity was good in the visited primary facilities.
- NCD portal was being used in real time, and a desktop was available for data entry into NCD portal.
- NIKSHAY portal is updated and well utilized.
- Under IDSP, quality of data entered in IHIP portal should be monitored at the district level.
- ASHA and CHO face double burden of online data entry and maintenance of offline registers. Lack of registration of Thalassemia and Hemophilia cases on national portal was observed.

MIZORAM

- Various IT platforms like Nikshay, DVDMS, NCD portal, AAM Portal, IHIP, RCH portal, FPLMIS, U-WIN etc., were being used in the visited facilities
- There was no fix line connection in the visited facilities. Wi-fi was available in AAM-PHCs, however poor internet connectivity was observed as one of the major challenges in effective utilization of IT applications.
- Desktops were available at the AAM-PHCs/UAAM. Tablets were available with ANMs.
- DVDMS portal was being used for indent and inventory management till the AAM-SHC level. However, sometimes the purchase of medicines is done locally and entered in DVDMS.
- The staff was observed to be well versed with various IT platforms.

ODISHA

- Network issues due to remote locations hindered healthcare delivery at the healthcare facilities.
- The NCD portal data was identified as a valuable tool for periodic review of NCD care, encompassing health promotion, screening, early diagnosis, treatment initiation, and follow-up, including control levels.

RAJASTHAN

- The State has been implementing digital software and 35 portals like IHMS, PCTS, OJAS, AAM Portal, IHIP Portal, E-Raktkosh, E-Aushadhi, eVIN, Nikshay Aushadhi, HMIS, PMSMA, e-Upakaran, ASHA software, FPLMIS, Marudhar & Rajhealth.
- Computer & internet facilities were available at most of the facilities, however Sub-optimal internet connectivity for data entry at AAM-PHC Randheergarh and AAM-AAM-SHC Chakdharsoni was observed.
- Compliance of State specific portals with ABDM framework for enhancing digital adoption and ease of integration was limited.
- IHMS platform has been used for OPD registration and PCTS is being used for tracking Pregnant women and Child for the MCH Services.

- Data entry was being done in NCD/AAM/other portal at AAM-PHCs, however monitoring and timely reporting was sub-optimal.
- E-Raktkosh Portal was functional in Sikar and online records were available.
- State has engaged one DEO for each AAM-PHC/AAM-UPHC and three DEOs in each CHC for reporting purposes.

TRIPURA

- The state utilized a diverse range of health portals, including HMIS, RCH, AB-HWC, NCD, PMSMA, e-Sanjeevani, e-hospital, e-HRMIS, NHP, Nikshay, Nikushth, SCMS, PFMS and e-Office.
- Several mobile applications have also been deployed, such as ANMOL, AAM app, CPHC ASHA app, e Sanjeevani app, FPLMIS, UWIN, IDSP, and Nikshay
- **Amar Sarkar Web Portal** is an innovative portal launched by the State government in the month of November 2022 to serve the rural common people of the state. Through this, the online platform is playing a significant role in informing the public about various problems and solving them quickly. It has the facility of filing complaints online as well as through mobile applications.
- There were pertinent network issues especially in the far-off districts, therefore, the staff were not able to upload the data on time.
- The state reported that due to multiple portals and apps in place, the efficiency of data entry has reduced and workload on the staff has increased.
- Data entry in the NVHCP portal revealed discrepancies.
- The state HMIS team conducts regular monthly training and monitoring sessions at healthcare facilities to ensure accurate data entry and reporting across all relevant portals.

UTTARAKHAND

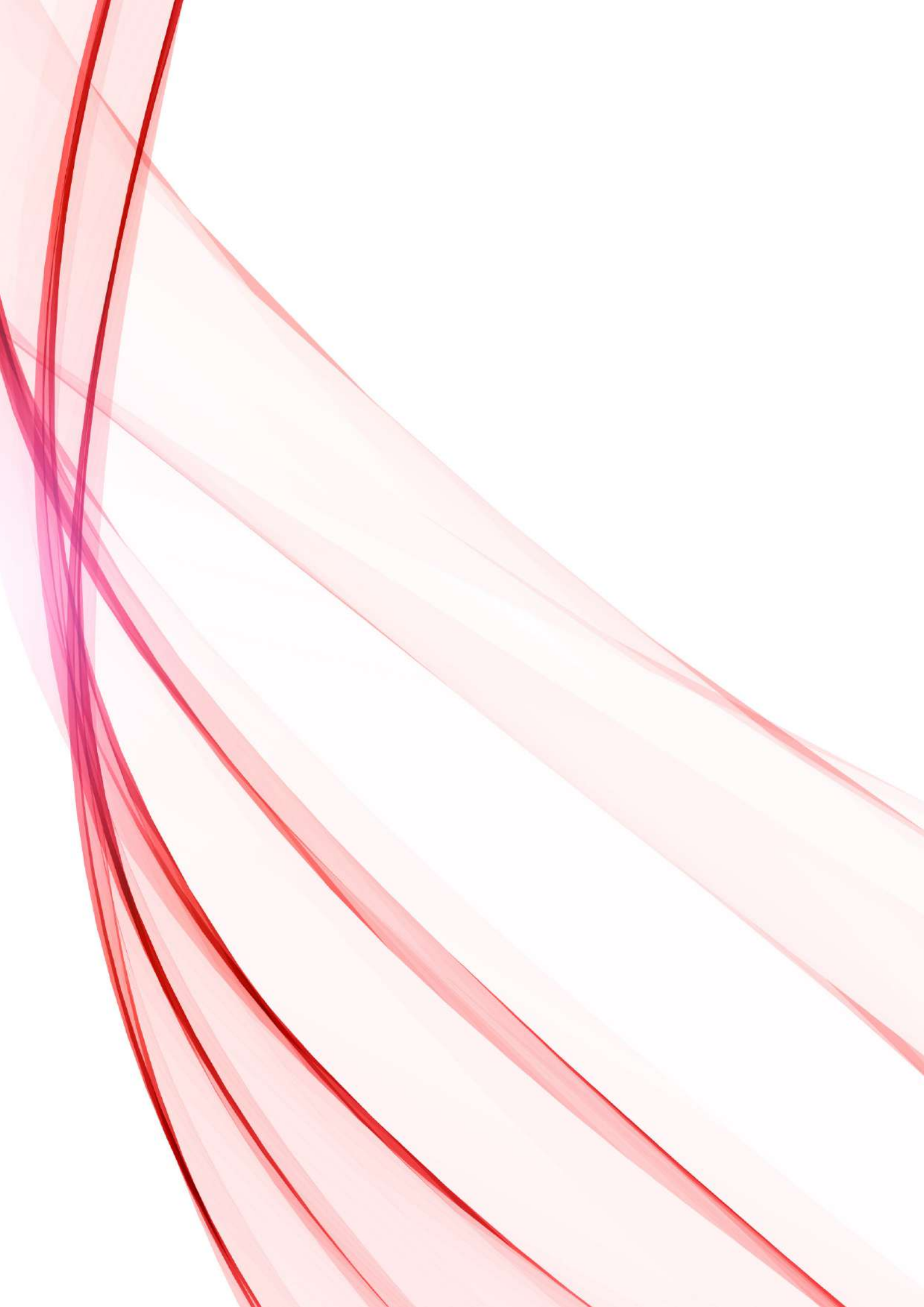
- FPLMIS was not being used at any level. There was no orientation/training done of staff on FPLMIS.
- In all AAM-SHC-AAM, NP-NCD portals were being used, however, at PHC-AAM level, the use of NP-NCD portal was very limited.
- DVDMS was implemented till AAM-SHC-AAMs level, but DVDMS was not being used at AAM-SHC-AAM level in the districts visited.
- The UWIN portal was being used and updated regularly, however, ANMs report delays in OTP generation, affecting the timely update of immunization data.

UTTAR PRADESH

- The state has not integrated the portals, not even the state-specific ones, such as E-Kawach and Mantra.
- E-Kawach does not allow users to backtrack data to check the quality and compliance of the entered data.
- Network issues across facilities was a barrier to the operability of IT portals.
- Data validation processes lacked standardized templates, leading to inconsistencies.
- Staff reported not using ANMOL and NP-NCD.
- Awareness about discrepancies between source registers and the HMIS portal was low, resulting in unverified and potentially inaccurate reporting.
- Comprehensive training for HMIS data handlers was not provided.

WEST BENGAL

- In South 24 Parganas, dedicated desktops with Wi-Fi network were available at all facility. But it was found that multiple Unique ID were created during registration.
- In Malda district, the reporting of the data across the applications/portals including HMIS was efficient and timely.
- While the data is regularly updated in the MatriMaa portal, there appears to be a backend error affecting the data storage within the portal and the data displayed at the user end.





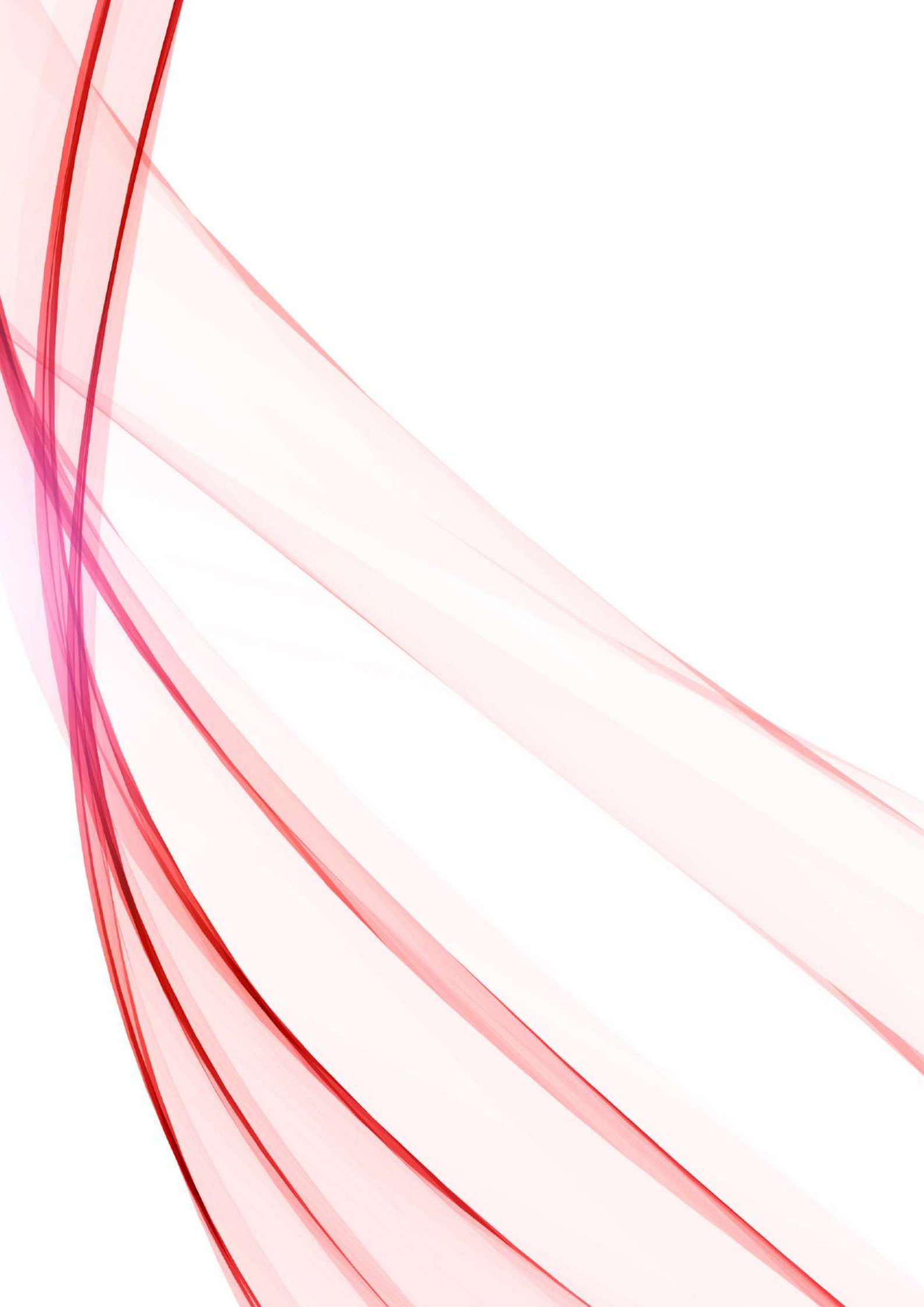
**CONTINUUM OF CARE:
TELECONSULTATION SERVICES
AND UPWARD AND DOWNWARD
REFERRAL MECHANISM**

KEY OBSERVATIONS

- The referral mechanism was found to be differentially established across the States. Gujarat demonstrated a well-implemented referral system for severe anemia and malnutrition cases. In contrast, Chhattisgarh has yet to establish a referral system for non-communicable diseases (NCDs). In Jammu and Kashmir (J&K), the referral mechanisms are defined according to protocols, but referrals are made based on proximity rather than to the designated higher centers. In Madhya Pradesh and Himachal Pradesh, due to the absence of predefined upward and downward referral pathways, patients from AAM-SHC levels are being directly referred to district hospitals.
- An absolute lack of institutional mechanism for downward referrals was observed in Jammu & Kashmir, Chhattisgarh (NCD Services), Arunachal Pradesh, Bihar and Karnataka due to which patients who were referred to higher facilities were not followed routinely thereby seriously hampering Continuum of Care. In Karnataka, the patients who were discharged from the hospitals were not linked to any home-based care or follow up mechanism through primary health providers.
- Information about referral centres were not displayed in Assam and Madhya Pradesh.
- For NCDs, the mechanism for downward referral and systematic follow-up of patients post treatment was found to be inadequate. In Haryana, there was no defined referral mechanism between the PHCs and the DH for NCD services resulting in poor service delivery and a lack of downstream follow up. Similarly in Odisha, AAM – PHCs continued to manage all NCD patients without initiating downward referrals, which could have facilitated easier access to medication at AAM-SHCs.
- Tele-consultation services were operational in almost all the states for upward referral. These services were mostly utilised for fever, skin diseases, NCD prescriptions. In Bihar, the most common conditions attended through e-Sanjeevani was high-risk pregnancy (HRP) cases, diabetes mellitus, hypertension and complicated cases of diarrhoea.
- Tele-consultation services were, however, affected due to poor internet connectivity issues, especially in rural & tribal areas, and non-availability of specialists at Hub-sites. In some states like Assam, the beneficiaries were hesitant to avail teleconsultation services as they expected to be treated by specialists beyond the primary level of care. This reluctance was further compounded by the fact that most Medical Officers deployed at the Hubs are General Duty Medical Officers (GDMOs) with only an MBBS qualification, which made beneficiaries feel less confident in the service. Additionally, calls from SHC-AAM were sometimes routed to PHC-AAM due to limited supply of specialists at the Secondary level of health facilities (Hubs) who are primarily occupied in providing services physically at the Hub facilities. This further eroded the community's trust in the service. In West Bengal, unstable internet connectivity at the Spokes affected the quality of consultations. If a call dropped during a telemedicine session, the patient's information would need to be re-entered, further hindering the effectiveness of the service and impacting user trust.
- Other factors affecting the service was long queuing time due to OPD timings and busy schedule of MOs/Specialists at the higher centres leading to significant delay in service delivery and unavailability of the prescribed medicines at the spokes. In Jammu & Kashmir, oftentimes the drug prescribed after teleconsultation was unavailable at the AAM level leading to patients having to buy medicines out of their own pockets. In Uttar Pradesh, video consultations are underutilized due to technical challenges and limited training of the providers. Additionally, post consultation follow-up was found to be inconsistent across States.
- The targets-based system for teleconsultations has led to the provision of redundant services. In Jammu & Kashmir, routine checkups and ANC visits were also being routed through teleconsultation to achieve the target of specified number of consultations. Similarly, in Karnataka, the same patient's name, ID and complaints were used to make multiple calls from the CHOs app. In Maharashtra and Madhya Pradesh teleconsultation services was being provided in PPP mode.

KEY RECOMMENDATIONS

- The State health teams need to define a well-established referral pathway connecting primary level health facilities to Secondary (DH) and tertiary level (MC) facilities. This will ensure proper gatekeeping and address patients' needs which can be addressed at the level of PHC / CHC / SDH level and ease the burden on district hospitals / Medical college.
- The downward referral mechanism needs to be strengthened as patients who are discharged from the hospitals are not linked for further home-based care or follow-up via primary healthcare providers by the higher facilities.
- It is essential to strengthen bidirectional referral of stable NCD cases and ensure the availability of common NCD drugs at the primary care level.
- There is a need to ensure optimal mapping of specialists at hubs, such that hubs can cater to the requirements of the Spokes. Moreover, there is a need to ensure that patients requiring specialist consultations only are advised telemedicine at PHC.
- A dedicated roster system should be introduced which ensures that Specialists are available for teleconsultation services for the primary level healthcare facilities at regular OPD hours. These rosters should be made accessible at spoke sites to schedule calls at appropriate times.
- Provision of dedicated equipment (laptop / desktop and provision for internet connectivity) to CHOs/MOs at the primary level healthcare facilities with adequate training on their usage to facilitate seamless teleconsultation services at the periphery level.
- Teleconsultation services should be provided based on patient's needs rather than adhering to a 'daily target', which can compromise service quality.





TOR 2 SECONDARY CARE

CATEGORY 1: AVAILABILITY OF CRITICAL CARE SERVICES AND OPERATIONAL STATUS OF CRITICAL CARE AREAS: EMERGENCY, SNCU, ICU, OT, MOT, LDR, OBSTETRIC HDU & ICU ETC. AT FRUS-CHC/SDH/DH, NMTI/SMTI

SUBCATEGORY 1: ASSESSMENT OF ADEQUACY AND ACCESSIBILITY TO CRITICAL CARE SERVICES WITH REFERENCE TO POPULATION AND TIME TO CARE APPROACH

INTRODUCTION

Critical care services are a vital component of secondary healthcare, ensuring timely intervention for life-threatening conditions through structured emergency management and intensive care. Well-equipped emergency units, Intensive Care Units (ICUs), High Dependency Units (HDUs), Labour Delivery Recovery (LDR) rooms, and neonatal care units play a crucial role in reducing preventable mortality and improving patient outcomes. The demand for critical care is driven by the burden of maternal and neonatal complications, trauma, non-communicable diseases, and infectious conditions, making accessible and well-functioning secondary care facilities essential for addressing emergency medical needs.

At the Community Health Centre (CHC) level, basic emergency and surgical services are available, while Sub-District Hospitals (SDHs) and District Hospitals (DHs) serve as key referral centres for comprehensive critical care. The availability of specialists, ventilator-supported beds, emergency obstetric and neonatal care, and essential life-saving equipment is essential for effective service delivery. However, challenges such as shortages of trained personnel, inconsistent oxygen supply, and delays in referrals continue to impact the quality of care in many regions.

Effective critical care services require continuous oxygen supply, medical gas pipeline systems, robust infection control measures, and a well-coordinated referral network to ensure seamless patient management. Strengthening infrastructure, human resources, and facility preparedness at the secondary level is necessary to bridge existing gaps in emergency and intensive care services.

This section examines the availability, accessibility, and operational status of critical care services across states visited during 16th CRM, identifying key strengths and challenges in the provision of emergency and intensive care at secondary healthcare facilities.

KEY OBSERVATIONS

EMERGENCY SERVICES

Well-functioning emergency services were observed at DH in West Bengal, Gujarat, and Maharashtra, where triaging systems were in place, essential equipment was available, and emergency staff demonstrated good preparedness. Facilities had continuous oxygen supply and multipara monitors, and infection control protocols were followed.

Gaps in emergency services were noted in CHCs and SDHs in Jharkhand, Haryana, Tripura, and Uttarakhand, where structured triaging systems were absent. DH in Uttarakhand and CHCs in Jharkhand faced challenges such as space constraints, delayed referrals, and poor patient segregation. Biomedical waste segregation and infection control practices were weak in Rajasthan (Bharatpur) and in West Bengal. Delays in the repair of critical equipment were also commonly reported.

CRITICAL CARE SERVICES (ICU, HDU, CCU)

Dedicated and well-managed ICU, HDU, and CCU services were found at district hospitals in West Bengal, Maharashtra, and Karnataka, where essential equipment, trained staff, and proper critical care management protocols were in place. Some facilities had ICU beds supported by centralized oxygen supply and ventilators. West Bengal had structured critical care monitoring with well-trained teams.

Many DHs in Uttarakhand, Jharkhand, Gujarat, Haryana, and Mizoram lacked fully functional ICU services due to HR shortages and lack of trained intensivists. DH in Madhya Pradesh (Rewa) had ventilators provided under the PM CARES fund that remained non-functional due to missing connectors. Obstetric ICUs were not available in DHs in multiple states, limiting access to emergency maternal critical care.

OPERATION THEATRE (OT)

Well-equipped and fully functional OTs were observed at DHs in Karnataka, Gujarat, Rajasthan, Mizoram, and Maharashtra, where proper zoning, infection control standards, and active surgical procedures were maintained.

Non-functional OTs were observed in CHCs and SDHs in Jharkhand, Haryana, and Uttarakhand, primarily due to specialist shortages and inadequate equipment. Lack of proper zoning and infection control measures was observed in Gynecology OT at SDH in West Bengal and CHCs in Rajasthan and Tripura. Fungal growth on OT walls was noted in SDH Vikasnagar (Uttarakhand), and sterilization protocols were compromised. Delays in equipment repair affected surgical services in multiple locations.

LABOUR DELIVERY RECOVERY (LDR) COMPLEX

LaQshya-certified labour rooms were observed in Mizoram, Maharashtra, and Karnataka, where infrastructure, staffing, and infection control protocols met national standards. Birth companions were allowed in some facilities, and Point-of-Care (PoC) tests were readily available.

LDR services were underdeveloped or non-functional in CHCs and SDHs in Jharkhand, Uttarakhand, and Tripura, where dedicated LDR beds and trained staff were lacking. CHC Bharatpur (Rajasthan) had rusted delivery tables and unhygienic conditions. Caesarean section rates were high at DHs in South 24 Parganas (West Bengal) (44.5%), indicating a potential need for improved case management. Home deliveries were still prevalent in Mizoram, largely due to transportation challenges in difficult terrain.

PEDIATRIC INTENSIVE CARE UNIT/NEONATAL INTENSIVE CARE UNIT (PICU/NICU)

Dedicated PICU/NICU facilities were functional in a few states, with well-equipped units available at district hospitals in Karnataka and Madhya Pradesh. These units had ventilator-supported beds, centralized oxygen supply, and round-the-clock pediatricians, though shortages of trained staff nurses remain a challenge.

In Tripura, a functional PICU at the state hospital was equipped with ventilators, oxygen-supported beds, and essential critical care equipment. In Jammu & Kashmir, NICU services were available, but staff nurses were not yet fully trained to handle NICU cases in the absence of a pediatrician. District Hospital Vadodara, Gujarat reported functional PICU/NICU services, but lacked adequate access to critical equipment, and fire safety measures needed improvement. Uttar Pradesh (DH Kushinagar) has a well-equipped 25-bedded Mini PICU, but rotational staff lacked training to operate medical equipment. Maharashtra has reported no PICU/NICU services in the facilities.

NEWBORN CARE SERVICES (SNCU, NBSU, NBCC)

Well-functioning SNCUs were observed in district hospital Karnataka (MusQan-certified), Maharashtra, and West Bengal, where standard treatment protocols, and infection control measures were maintained. Newborn services were provided free of cost under JSSK in some facilities. Functional NBSUs and NBCCs were also observed in several states, providing immediate neonatal stabilization.

Severe overcrowding in SNCUs was noted in DHs in Uttar Pradesh (179% occupancy rate) and West Bengal (Malda), leading to compromised neonatal care. Many SNCUs in Jharkhand, Rajasthan, and Uttarakhand lacked dedicated pediatricians, with facilities being managed primarily by nursing staff. Infection control measures were inadequate in Bharatpur (Rajasthan), where swab cultures were not regularly conducted. High LAMA rates and poor referral tracking were reported in multiple facilities, affecting follow-up care for sick newborns.

MIDWIFERY INITIATIVE

The Midwifery Initiative has been operationalized in Karnataka and Maharashtra, with dedicated training institutes established. Karnataka has a National Midwifery Training Institute (NMTI) at Vanivilas Hospital, Bengaluru, along with three State Midwifery Training Institutes (SMTIs) in Mysuru and Belagavi. In Maharashtra, DWH Akola has been identified as a midwifery training institute, where five midwifery educators were currently under training, and the first batch of students is expected to begin next year. Uttarakhand is planning to start a Midwifery-Led Care Unit at DH Dehradun.

In Tripura, the state has not yet identified a State Midwifery Promotion Initiative (SMPI), nor have dedicated training programs been conducted. No specific findings on midwifery training or services were reported in Bihar, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Jammu & Kashmir, Madhya Pradesh, Mizoram, Odisha, Rajasthan, Uttar Pradesh, and West Bengal.

BLOOD BANK

Functional blood banks were available in most of the states- Bihar, Chhattisgarh, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Mizoram, Rajasthan, and Uttarakhand, with some acting as mother blood banks supporting smaller facilities.

Rajasthan (DH Sikar) has the only government Blood Component Separation Unit (BCSU) in the district. Jammu & Kashmir provides blood transfusion services at CHC FRU and DH levels, and Chhattisgarh (Jashpur District Hospital) reported providing free-of-cost blood to patients. DH Bageshwar, Uttarakhand has a functional blood bank, whereas DH Dehradun only has a Blood Storage Unit (BSU).

In Haryana (DH Palwal), the component separator was non-functional due to space constraints, and storage refrigerators were not working. West Bengal (Malda Medical College and SDH Chanchal) reported expired blood bank licenses (2020, 2022), requiring urgent renewal. Arunachal Pradesh has procured a Blood Component Separation Unit, which was to be inaugurated soon.



MECHANISED LAUNDRY/CENTRAL STERILE SUPPLY DEPARTMENT (CSSD)

Mechanized laundry services were available in some states, while others rely on outsourced services. Odisha was providing laundry services through an outsourced model under the “Nirmal Scheme”. In Haryana, Himachal Pradesh, Bihar, and Jammu & Kashmir, laundry services were outsourced to private agencies. Jammu & Kashmir has formulated SOPs for laundry services, though most facilities lack

mechanized laundry and rely on small capacity washing machines. Uttarakhand (DH Bageshwar) has a mechanized laundry facility but faces space constraints, and protocol compliance was compromised.

Functional CSSD units were reported in Maharashtra (DWH Akola), Karnataka (Ballari District Hospital), Bihar (District Hospitals), and Uttar Pradesh (DH Agra). However, in Uttar Pradesh, the CSSD was not used for dental procedures, and a rusted autoclave machine was found to be in use. In Rajasthan, sterilization turnaround times of up to four days were observed, affecting availability of sterile instruments.

DIETARY AND KITCHEN SERVICES

Dietary services were functional in most district hospitals, but management models and quality assurance mechanisms vary. In Bihar, Karnataka, and Maharashtra, dietary services were outsourced, with kitchens located in separate buildings. Jeevika provides dietary services in Bihar, ensuring timely and appropriate meals for patients. In Tripura, in-house dietary services cater to 285 beds at the state hospital and 20 beds at CHCs while in Chhattisgarh self-help groups (SHGs) were managing dietary services in district hospitals, though storage, ventilation, and infrastructure gaps were reported.

In Rajasthan, the Red Cross Society was operating kitchen services, with subsidized meals under the Annapurna Rasoi Scheme. Himachal Pradesh and Uttarakhand (DH Bageshwar) have outsourced diet services, while Uttarakhand's facilities kitchen conditions were poor, and no diet chart was displayed. Haryana (DH Palwal) was providing only one meal per day, which could impact inpatient nutrition. West Bengal reported functional dietary services, but infrastructure did not meet GoI norms, despite had FSSAI certification.

KEY RECOMMENDATIONS

- States/UT need to strengthen emergency services by implementing structured triaging systems in CHCs and SDHs, ensuring timely referral and reducing burden on higher facilities.
- Expansion and strengthening of HDU, ICU and ventilator-supported beds in DHs to be ensured by recruiting trained intensivists, ensure functional Medical Gas Pipeline Systems (MGPS) and uninterrupted oxygen supply.
- Appropriate protocols in the OT regarding zoning, unidirectional flow of services, infection control protocol, air exchange, etc., need to be ensured.
- States/UT need to ensure dedicated human resources in each critical care unit and effective utilisation of the staff needs to be guaranteed for round the clock services. There is need to recruit key specialists including a paediatrician, obstetrician, and anaesthetists at secondary level facilities to meet IPHS norms and enhance service delivery.
- States/UT need to improve referral pathways by establishing structured digital tracking systems to monitor patient movement and prevent unnecessary referrals to tertiary care facilities.
- Continuous training programs including refreshers to be implemented to keep the medical and nursing staff updated on new technologies, advanced surgical techniques and emergency procedures.
- SNCU bed capacity in high-burden districts to be upgraded and expanded to address challenges pertaining to overcrowding. This needs to be complemented with assured availability of dedicated paediatricians, and strengthened referral tracking to reduce high LAMA rates.
- LDR services to be strengthened by ensuring adequate infrastructure and trained staff, while addressing high C-section rates through better case management. LaQshya-certification of Labour rooms may be expedited to ensure quality of services delivered.
- Infection control practices to be established by operationalizing non-functional CSSD units and

establish mechanized laundry services in DHs and SDHs.

- Enhance in-house dietary services with FSSAI-certified kitchens to be ensured in secondary care facilities with nutritional support interventions in place for long-stay inpatients.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

Critical Care Services

DH Aalo in West Siang district provides critical care services through a well-maintained setup that includes 5 ICU beds, and 4 HDU beds. However, the facility lacks a dedicated Cardiac Care Unit, which limits specialized cardiac interventions. While the ICU, and HDU were functional, infection prevention and control (IPC) protocols and hand hygiene practices require significant strengthening. There is an urgent need for staff training on IPC measures to ensure patient safety.

The hospital was recognized as a Nodal Emergency Service Centre, reinforcing its role in providing critical emergency care. In addition, the absence of essential drugs such as Anti-Snake Venom (ASV) and medicines for poisoning cases posed a serious gap in emergency care preparedness.

The hospital had one orthopaedic surgeon and one general surgeon, but it lacked essential surgical and orthopaedic equipment, including a C-ARM, orthopaedic table, and laparoscope. The absence of these critical tools limited the scope of surgical interventions available to patients. Furthermore, the OT in Longding DH remained non-operational, further constraining surgical care accessibility in the region. Addressing these infrastructure and equipment gaps is necessary to enhance the quality and range of secondary care services available in the state.



Labour Room

The labour room at DH-Morigaon was well-maintained, featuring a functional newborn care corner, all necessary equipment and instruments, and appropriately equipped biomedical waste management colour coded bins with clear signage. On average, the hospital was conducting 300 normal deliveries and 150 caesarean sections per month.

The staff was reported to be adequately trained. The labor room had recently received State LaQshya Certification and had applied for National LaQshya certification. However, the facility lacked initiatives for birth companions and proper documentation practices. The Labour Room of DH Aalo (West Siang) was LaQshya certified, facilitates an average of 3 deliveries per day, amounting to approximately 80-

90 deliveries per month.

The Labour Room followed a zoning system, but beds designated for red and yellow zones were not available, impacting emergency triaging. Despite the availability of critical equipment and drugs, the Labour-Delivery-Recovery (LDR) concept was not implemented. Nonetheless, birth companions were allowed, and respectful maternity care was practiced. Point-of-care (PoC) test kits for Hb, HIV, Syphilis, blood glucose, urine sugar, and protein were readily available.

Audio-visual (AV) aids were displayed within the Labour Room to aid patient education, and centralized oxygen beds have been recently introduced in the ICU to support maternal and neonatal care.



Special Newborn Care Unit (SNCU)

A Special Newborn Care Unit (SNCU) is available in Longding, while the SNCU in West Siang was under construction. However, concerns regarding compliance with standard guidelines were noted, including improper wall and floor tiling and the lack of frosted glass windows. While newborn death audits were reportedly conducted, there was no documentation of records or meeting minutes; limiting accountability and quality improvement efforts. Additionally, data on perinatal and neonatal deaths was not being uploaded to the Maternal and Perinatal Child Death Surveillance and Response (MPCDSR) portal, highlighting a need for improved data management.

Midwifery Initiative- No midwifery-led care unit was present.

Blood Bank- The blood bank at the DH was functional. DH Allo in West Sinag district had procured a Blood Separation Component Unit, which was to be inaugurated soon

BIHAR

Emergency Services

Emergency services were available 24/7 at the district hospital in Gaya. However, at lower healthcare facilities like Community Health Centres (CHCs), emergency services were primarily managed by AYUSH doctors. These facilities face significant resource constraints, including a lack of reliable oxygen supply and multi-parameter monitors, limiting their ability to effectively manage critical medical emergencies.

The triaging was being followed at the District Hospital Kaimur, with the emergency department

effectively managed and equipped with essential medications and equipment. The emergency tray was well-stocked, ensuring readiness for urgent situations. Additionally, doctor and staff rosters were followed diligently, maintaining adequate staffing at all times.

The key challenges included a non-functional central oxygen supply and suction compressor. Staff were not trained on Basic Life Support (BLS) and Advanced Life Support (ALS) modules. Regular checks of the emergency tray were lacking, and laryngoscope blades were missing. Some emergency drugs were nearing expiration and require urgent replacement.

The Sub-Divisional Hospital had only a yellow zone in the emergency area, with beds available but no monitoring equipment.

At CHC Dhobi in Gaya district, an emergency room/ward was available, but there was no oxygen supply and no multi-parameter monitor. An oxygen cylinder was present at the facility, but resource constraints, especially during nighttime emergency duties, remained a concern. A well-equipped ICU was available, but currently non-functional, limiting critical care services.

Special Newborn Care Unit (SNCU)

The District Hospital Gaya lacks SNCU, which was instead available at other district hospitals like Janana Hospital and Prabhawati Hospital. The SNCU at Prabhawati Hospital in Gaya operates with two paediatricians. To optimize human resources, the Medical Superintendent (MS) has reassigned an additional paediatrician from the maternity ward to the SNCU, ensuring comprehensive newborn and maternal care.

The SNCU reported the mortality rate of 2%, a referral rate of 10%, and antibiotic usage at 51%. However, the electrical unit was currently installed at the entrance of the SNCU, and there was no dedicated emergency exit apart from the main entry point, posing a potential risk.



The current bed capacity appears insufficient, as the SNCU caters to both inborn and out born neonates, with approximately 80% being out born cases. Nearly 50% of admitted patients were cases of perinatal asphyxia, highlighting delayed identification and management of high-risk pregnancies (HRPs) at the community level, leading to late referrals to the SNCU.

A well-functional SNCU was observed at District Hospital Kaimur, where the paediatric wards were well-managed and patients expressed satisfaction with services.

Labour Room

The Labour Room at the District Hospital in both districts was well-managed and equipped with all necessary instruments and equipment. Birth companions were allowed to stay with delivering women, offering emotional support during labour. The triage area ensures effective segregation of pregnant women upon arrival, allowing better prioritization of care. However, hygiene concerns were observed, including rodent presence in the labour ward and triage area of District Hospital Gaya, compromising safety and cleanliness. Additionally, infrastructural challenges pertaining to cracks and untidy waiting area were observed in the facility, which would need immediate attention.

Number of labour tables at District Hospital Kaimur was insufficient for the monthly delivery load of approximately 500 deliveries, including 150 caesareans. Both districts were equipped with functional radiant warmers and phototherapy machines, ensuring proper newborn care.

At District Hospital Gaya, the labour ward was operating with only two nurses per shift, posing a challenge during peak hours and emergencies. In District Hospital Kaimur, only two OBGY doctors managed both OPDs and deliveries, which strained the system. At Prabhawati Hospital, the team consisted of five doctors supported by two deputed post-PG bond doctors. However, the anaesthetist position at District Hospital Gaya was reported vacant, with a retired anaesthetist engaged on a call basis until 5 PM, limiting the hospital's capacity to conduct C-sections at night.

At CHC Chainpur in Kaimur, hygiene and infrastructure issues persist. Another challenge identified was poor condition of labour table and new born weighing machine which were found rusted during visits, posing potential health risks. Also insufficient labour tables and unavailability of gynaecologist or MOs trained in Basic Emergency Obstetric Care (BEmOC), was impacting emergency maternal care.

Blood Bank

At District Hospital Kaimur, the blood bank was well managed with a counsellor and three trained staff members. Procurement of platelet bags (PRBC) and other blood products was required for managing dengue cases and other conditions. There was a felt need to initiate the blood component separation in order to improve specialized care.

Mechanised laundry/Central sterile Supply Department (CSSD)

The District Hospital had a functional CSSD and mechanized laundry facility that met the required standards for sterilization and cleanliness. However, CSSD services at SDH and CHCs need further strengthening in terms of infrastructure and resources.

Dietary and Kitchen Services

Jeevika was providing dietary services in the District Hospital. The facility was well managed and ensured timely and appropriate meals for patients.



CHHATTISGARH

Emergency Services

The triage facility at DH Gariyaband was not available, lacking staff and proper connectivity, impacting patient transfer. Two Liquid Oxygen Plants (LOPs), including one supported by PM CARES, were non-functional. CHCs did not comply with IPHS norms, leading to overcrowding and service inefficiencies. OT zoning was absent, with some OTs opening into open corridors, compromising infection control.

HDU & ICU and NICU/PICU

A Critical Care Unit (CCU), HDU, NICU, and PICU were under construction in the new district hospital. Temporary accommodation for patient relatives and food services were lacking, violating IPHS 2022 guidelines. The absence of designated sterile storage areas affected hygiene and operational efficiency.

Labour Room

Labour rooms were clean with infection control measures, but staff lacked training in sterilization and radiant warmer use. Standardized case sheets were not used, and documentation like Partographs and Safe Birth Checklists was incomplete. Due to shortages of gynaecologists and anaesthetists, C-sections were performed only at DH Jashpur.

Blood Bank

Only District Hospital Jashpur has blood bank facilities and providing free of cost blood to the patients.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

CDSS was not present in any visited facility in Jashpur.

Dietary and Kitchen Services

Dietary services were mostly in-house. At the District Hospital (DH), dietary services were run by an SHG group, which was a good initiative. However, there were no separate rooms for storage, receiving, and pre-preparation, and there was a lack of exhaust systems. There was also no separate provision for dry, sun-dry, and wet storage. Food at DH was served using trolleys. Some facilities had a feedback mechanism for patient satisfaction regarding the quality of food.

GUJARAT

Emergency Services

A high number of trauma cases were observed at CHC Jarod due to its proximity to the highway. However, the facility has not yet been upgraded to a trauma centre, limiting its ability to handle critical trauma cases effectively. Additionally, a lack of a formal triaging system was noted in both Vadodara and Kachchh districts, with no red or yellow zones mapped in Vadodara. The emergency departments in both districts also lacked sufficient multipara monitors, with only one available in Kachchh SDH.

Labour Room

In DH Vadodara, a Maternity OT was attached to the labour room, facilitating quick access to surgical intervention when needed. However, the labour room did not have toilets, impacting patient comfort and hygiene. The Obs-Gyn OT in Kachchh lacked a dedicated changing room for staff, which could affect operational efficiency and hygiene standards.

HDU/ICU

HDU/ICU and obstetric ICU facilities were unavailable at DH Vadodara, which limits advanced critical care for high-risk patients. Non-functional ventilators were also reported in CHC Jarod, Vadodara, further restricting emergency response capabilities. Oxygen availability through pipelines was well-maintained in Vadodara but was lacking in Kachchh, despite the presence of a PSA plant.

Operation Theatre

In DH Vadodara, modular OT was unavailable, which poses a challenge for surgical and transfusion services. Additionally, the OT areas were not properly zoned, lacking clear distinctions between clean and sterile areas. The old building and space constraints were cited as challenges for OT upgrades, though approvals for renovation have been received, and planned improvements were ongoing. In Kachchh, the ophthalmology OT was non-functional due to the absence of an ophthalmologist.

SNCU

SNCU was well functioning in the state. At SSG Medical College, Vadodara, SNCU staff have developed a structured criterion for segregating newborns based on high-risk factors, ensuring better neonatal management. Kangaroo Mother Care (KMC) chairs were available in SNCU, and family members actively participated in KMC for 8-10 hours a day, promoting better newborn health outcomes. The SNCU inborn discharge success rate was above 90% and out born success rate was less than 70%, attributed to the referral of severe cases, indicating a need for strengthened referral mechanisms and early intervention strategies for neonatal care.

PICU/NICU- The PICU and NICU in DH Vadodara lacked sufficient access to critical equipment. Fire safety measures at SNCUs need to be improved to ensure patient safety.



HARYANA

Emergency Services

Emergency services were available at DH Palwal, but the absence of a fully functional critical care block and a physician was compromising the hospital's ability to manage critical cases. SDH Hodal has triaging, beds, and multipara monitors; however, it lacks key specialists such as a physician, surgeon, paediatrician, and orthopaedician. CHC Sondh does not provide emergency services, citing its proximity to SDH Hodal (within 5 km), though it has dedicated staff and point-of-care test kits.

While DH Palwal had provision of fully functional emergency obstetric care, it reported unavailability of a Paediatric Intensive Care Unit (PICU) and a full-time physician. The overall patient load remains on the lower side, but the absence of a PICU affects the hospital's ability to manage critically ill newborns and paediatric patients effectively. At SDH Hodal, ICU and HDU facilities were not available, and the hospital lacks critical care services for severe cases.

Operation Theatre

DH Palwal was equipped with three operation theatres, supporting a range of surgical procedures. At SDH Hodal, the OT was functional but limited to Lower Segment Caesarean Sections (LSCS) and Postpartum Sterilization (PPS) procedures, restricting comprehensive surgical care. CHC Sondh lacks an operation theatre, limiting its ability to conduct even minor surgeries.

Labour Room/ NBSU/SNCU

The labour room was well-equipped with a separate Maternal and Child Health (MCH) area, trained staff, and essential drugs. A Newborn Stabilization Unit (NBSU) was available. However, critical services such as Obstetric and Paediatric HDU, SNCU/NICU were missing. Additionally, staffing at SDH Hodal was below IPHS norms, with an urgent need for paediatricians, obstetricians, and anaesthetists. At CHC Sondh, while the labour room was functional, the facility lacks HDU, ICU, and PICU services.

PICU/NICU

Emergency facilities in the obstetric domain were fully functional. However, the facility lacks a PICU and a physician. At SDH Hodal, the ICU/HDU facility was not available. At CHC Sondh, HDU/ICU/PICU are yet to be established.

Blood Bank

At DH Palwal, staff includes five lab technicians, two nursing officers, and one microbiologist. Training

was conducted once a year. There was an equipment gap as the component separator was not functional due to space constraints, and the storage refrigerator was broken down. Records of adverse events following transfusion and transfusion reactions were not maintained properly. A total of 430 units were received from in-house blood donation, 413 units were issued, and 45 units were discarded.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

Laundry and sterilization services were outsourced through Bharat Vikas Parishad and ISKCON, specifically for postnatal mothers.

Dietary and Kitchen Services

Dietary and kitchen services were outsourced. However, only one meal was provided for patients at DH Palwal. The hygiene at the site of food preparation was adequately maintained. Food services were specifically outsourced through Bharat Vikas Parishad and ISKCON for postnatal mothers.

HIMACHAL PRADESH

Emergency Services

Emergency services were operational at Civil Hospital and Community Health Centre, Galore block. The emergency ward at these facilities was equipped with essential equipment such as ECG machines, multipara monitors, crash carts, and oxygen concentrators. The Civil Hospital at Tauni Devi, functioning as a CHC, provides emergency medical services, including thrombolysis for acute MI patients.

The availability of emergency medicines was ensured, with an adequately stocked emergency tray. Referral linkages were observed, with cases being transferred to higher-level centers such as Dr. R.P. Tanda hospital, Kangra and PGIMER Chandigarh as needed.

HDU/ICU

SNCU and PICU services were available at District Hospital (DH)/Medical College Hamirpur and DH Shimla, with separate provisions for inborn and out born admissions. The facilities experienced high bed utilization, often exceeding their capacity, necessitating referrals to tertiary centres.

There was an absence of dedicated paediatric and neonatal ICUs at DHs, requiring critically ill neonates to be referred to institutions like IGMCH or Kamla Nehru Hospital in Shimla. Limited staffing and equipment shortages, such as the need for additional paediatricians and newborn ventilators, were reported.

Operation Theatre (OT)

DH Hamirpur, functioning as a Medical College, had four operational OTs, including surgical, ophthalmic, and orthopaedic units. The Civil Hospital at Tauni Devi did not have surgical services, conducting only normal deliveries. Despite infrastructure availability, CHCs and PHCs were not equipped to handle major surgical procedures, leading to patient referrals to higher centres. The OT at DH Hamirpur faced spatial constraints, compromising unidirectional flow and zoning of sterile and non-sterile areas.

Labour Delivery Recovery (LDR) Complex

LDR services were functional at DH/Medical College Hamirpur with a high caseload. The Civil Hospital at Tauni Devi had a functional LDR unit but reported a very low delivery load of four to five cases per month, with most deliveries occurring at higher referral centres. The maternity section at DH Hamirpur faced operational challenges due to ongoing renovation work, leading to partial closure of facilities such as Labour Ward II and the breastfeeding corner.

Special Newborn Care Unit (SNCU) Services and PICU/NICU

SNCU and PICU services were functional at both the district hospitals, with separate provisions for inborn and out born cases. The facilities reported high bed utilization, often exceeding available capacity. NICU was available in DH Hamirpur. A 12-bedded SNCU was under construction at DH Shimla, currently functioning as an NBSU with only two paediatricians and limited neonatal care equipment. Challenges in managing high-risk neonates, including the need for additional staff and critical care equipment like CPAP and newborn ventilators, were identified. None of the facilities have New Born Care Corner (NBCC) only the warmer was kept in OT except for Medical College/District Hospital Hamirpur.

Blood Bank

The district hospital was equipped with a blood bank and has blood transfusion facilities.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

The state has outsourced laundry services to a third party through a tender process.

Dietary and Kitchen Services

Dietary and Kitchen Services were available through outsourced mode.

JAMMU AND KASHMIR

Emergency Services

Triage facilities were available at DHs and CHCs in Jammu & Kashmir, but proper color zoning of beds as per triaging was lacking. Also the District Hospital upgraded to Medical College was lacking NHM programme implementation.

Critical Care Services

Critical care services were available at DH, with online registration, oxygen supply for all beds, 24x7 availability of critical care testing and care, identification of red and yellow beds, provision for isolation beds, and separate rooms for plaster and observation.

PICU/NICU

The NICU was under direct supervision of a paediatrician and his team of staff nurses. However, the staff nurses were not yet fully trained to handle NICU cases in the absence of a paediatrician. The paediatrician reported that it will take another six months to fully operationalize the NICU

Blood Bank

There was a provision for blood transfusion for severe anaemia at the CHC FRU and DH levels.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

Laundry services were outsourced in all the hospitals. SOPs have been formulated for laundry, but a detailed SOP was required for proper functioning. Most facilities do not have mechanized laundry and instead have three washing machines with a capacity of 7.5 litres each.

Dietary and Kitchen Services

Diet for all patients was provided as per JSSK guidelines and was outsourced.

JHARKHAND

Emergency Services

Emergency services were available with designated triage areas and clear demarcation for red, yellow, and green zones. The red zone was equipped with essential emergency equipment. However, ECG machines were unavailable in the emergency department, and ECGs were conducted only through an on-call technician. Critical cases, such as myocardial infarction (MI) and stroke, were referred to MGM Hospital, located 8 km away. Patients in the emergency room were reportedly stabilized and shifted within 6-12 hours, but delays in transferring patients from the emergency to the wards were noted, often due to bed unavailability. Some patients had remained in the emergency department for up to three days due to full occupancy in wards.



Intensive Care Unit (ICU) and High Dependency Unit (HDU)

ICU services in district hospitals were largely non-functional due to a lack of ventilators, trained staff, and essential drugs. The HDU at SDH Ghatshila was underutilized, with no trained intensivists, and reliance on general medical officers with limited critical care expertise. Medical gas pipeline systems were inadequate, and emergency drugs like inotropic agents were inconsistently available.

Operation Theatre

The modular operation theatre at District Hospital Sahibganj was well-equipped, featuring a functional ventilation system with laminar airflow and adherence to infection control guidelines. However, challenges included inconsistent power backup, requiring regular generator maintenance. The lack of a dedicated biomedical waste storage facility near the OT area posed contamination risks. The Newborn Stabilization Unit (NBSU) within the OT was non-functional at the time of inspection.

Labour Delivery Recovery (LDR) Complex

LDR rooms at SDH Ghatshila and Urban CHC Mango were well-maintained, featuring curtains for privacy and newborn care corners. However, at CHC Potka, neonatal resuscitation equipment, including ambu bags and masks, was either unavailable or disorganized. The labour room had outdated radiant warmers, and hygiene concerns were noted. Registers for labour cases and outcomes were maintained in some facilities but lacked uniformity.

Special Newborn Care Unit (SNCU)

At Sahibganj District Hospital, the SNCU had 12 functional beds and was equipped with radiant warmers, phototherapy units, and syringe pumps. The unit had a 15% reduction in neonatal mortality over the past year and admitted 40-50 newborns per month. However, space constraints, inconsistent infection control, inadequate staff training, and incomplete documentation were identified as key challenges. At SDH Ghatshila, the SNCU was functional with a dedicated Kangaroo Mother Care (KMC) room for mothers, supporting newborn nutrition and infection control.

The Newborn Care Corner (NBCC) at few facilities, including CHC Potka, lacked essential neonatal resuscitation equipment, such as different-sized masks and warmers, compromising immediate newborn care. The Newborn Stabilization Unit (NBSU) within the OT at District Hospital Sahibganj was non-functional, affecting the care of at-risk newborns post-surgery.



Blood Bank

In East Singhbhum district hospital, blood bank was well maintained.

Mechanised Laundry

There was lack of mechanized laundry services in East Singhbhum district.

KARNATAKA

Emergency Services

The emergency departments in the District Hospitals (DH) of both districts were well-equipped with triaging facilities, continuous oxygen supply, and multipara monitors. The emergency trays were well-stocked with essential drugs and consumables such as anti-rabies vaccine (ARV), anti-snake venom (ASV), defibrillators, and CPR cum intubation trays. However, in DH Ballari, despite the availability of job aids and standard operating procedures (SOPs) for the management of snake bites, medical officers in the emergency department lacked awareness of ASV use protocols.

At the Sub-District Hospital (SDH) Siruguppa in Ballari, the functional STEMI program was noted, with Tenecteplase available for emergency pre-referral administration under virtual specialist guidance. A common challenge across both districts was the inadequate availability of human resources.

HDU/ICU

The HDU/ICU at DH Dakshina Kannada was constructed under the Smart City Project and was well-equipped, with single entry/exit points, continuous oxygen supply, and multipara monitors. The hospital had separate ICUs for obstetric and neonatal care (Lady Goshen), surgical, and medical cases. However, the surgical ICU was located far from the OT complex, leading to logistical challenges in patient management.

In DH Ballari, the ICU had similar infrastructure, with nine ventilator beds, though occupancy was low (<20%) at the time of the visit. At SDH Siruguppa (Ballari), the eight-bed ICU/HDU was monitored via a tele-ICU system linked to DH Ballari. The unit was staffed with one medical officer and three nurses, but its layout did not comply with critical care guidelines. The ICU had recorded 179 admissions over the past three months, with a 75.4% recovery rate, 16.2% referrals, and 8.4% leave against medical advice (LAMA).



Operation Theatre

At the District Hospitals, most of the OTs were modular, state-of-the-art units equipped with Heating, Ventilation, and Air Conditioning (HVAC) systems, ensuring high infection control standards. While zoning was implemented in most OTs, some facilities lacked unidirectional flow due to older infrastructure. The SDH OTs were well-maintained, but at the district level, connectivity between the OT and surgical ICU was limited, requiring logistical improvements for post-operative patient transfer.

Labour Delivery Recovery (LDR) Complex

All labour rooms were functional, with dedicated handwashing areas, trained staff and availability of essential supplies were noted, such as adequate LDR beds, fetal monitoring devices and labour tables as per delivery load. An exemplary Labour-Delivery-Recovery (LDR) complex was observed in the aspirational block CHC Kampli (Ballari) with good infrastructure, staff and protocols in place.

Additionally, the state had introduced innovative labour and delivery tables designed to support postpartum care by allowing mothers to breastfeed comfortably after delivery. Birth companions were being allowed in delivery rooms, and interaction with beneficiaries showcased their satisfaction with the services.

Special Newborn Care Unit (SNCU)

SNCU facilities across the districts were MusQan certified, well-equipped with triaging facilities, and linked via Nagu-Magu ambulance services. The SNCU at RH Talia had in-house lab facilities, referring only complicated cases.

In Ballari, SDH Siruguppa had an NBSU, and DH Ballari had an SNCU.

Midwifery Initiative

The State has recently launched the Midwifery Initiative with a total of four institutes supporting the program. The Vani Vilas Hospital Bengaluru is a National Midwifery Training Institute, whereas three other state training institutes are the Cheluvamba Hospital, Mysuru, Vanivilas Hospital, Bengaluru, and the Belagavi Institute of Medical Sciences, Belagavi.

PICU/NICU

The PICU at Wenlock Hospital was well-resourced, with a single entry/exit point, continuous oxygen supply, well-maintained ventilatory equipment, and round-the-clock paediatrician availability through a PPP model.

In Ballari district, an NHM-supported NICU was available at Ballari Medical College and Research Centre (formerly VIMS). The NICU had 60 beds (30 each for inborn and out-born), a 10-bed step-down unit, 15 ventilators, and centralized oxygen supply. However, the NICU faced a shortage of staff nurses, with only 30 nurses available.

Blood Bank

Blood bank established by Indian Red Cross working inside the premises of the hospital which give transfusion support to needy patients in the hospital.

Mechanized Laundry/Central Sterile Supply Department (CSSD)

The mechanized laundry and CSSD in the higher



facilities of Ballari district had adequate autoclave and sterilization protocols in place. The CSSD for the OT in the SDH Siruguppa was located within the OT complex itself. Testing for sterilization failure was done as per protocol, and no cases of failure were reported in the last few months, as per records.

Dietary and Kitchen Services

At the DH Ballari, in-house kitchen services were available, with adequate infrastructure for meal preparation, though separate stores were not available for dried, sun-dried, and wet products. Infection prevention protocols were in place for staff. The food was served through trolleys, and a feedback mechanism was in place.

MADHYA PRADESH

High Dependency Unit (HDU)/ Intensive Care Unit (ICU)

The district hospitals had functional HDU and ICU. DH Rewa has an 18-bed ICU with six beds reserved for cardiac patients under NP-NCD and a 17-bed HDU with centralized oxygen. DH Balaghat operates a 15-bed ICU, with reserved beds for palliative care and oncology cases, admitting an average of 200 patients per month. Critical cases were being referred to Medical College, Jabalpur. However, PM CARES ventilators remained unused due to missing connectors, which were unavailable statewide.

Operation Theatre (OT)

DH Balaghat has two OTs (Major and Ortho OT), well-equipped with zoning protocols, and HVAC systems. Newly installed laparoscopy set was available at the major OT.

Labour Room

Labour rooms at both DHs were well-maintained, with 24x7 electricity, air conditioning, geysers, and attached toilets. Standardized registers (Delivery, Referral, Partograph, Safe Birth Checklist) were properly maintained. CH Jawa had only two traditional labour tables, despite 250-300 deliveries per month, and lacked modern threefold labour tables. Labour room disinfection was inadequate due to the absence of a fumigator, and swab cultures were not sent for analysis.



Newborn Care Services (NBCC, NBSU, SNCU)

DH Balaghat had a high-case-load SNCU, equipped with 26 radiant warmers, 12 phototherapy units, two neonatal ventilators, and one bubble CPAP. However, one ventilator had been non-functional for over two weeks. The facility maintained separate sections for inborn, outborn, and step-down care neonates. The attached KMC area lacked proper beds or recliners, providing only sitting desks for mothers. Infection control and space optimization need improvement.



PICU/NICU

DH Balaghat had a 10-bed PICU facility, with all beds well-equipped and continuous oxygen supply. The facility had only two ventilators, out of which one was non-functional for the last six months due to a spare part issue. The available critical care equipment included two ventilators, one defibrillator, one HFNC, and four Bi-PAP machines.

Dietary and Kitchen Services

A well-maintained kitchen was functional at DH Balaghat. Diet services were provided free of cost for all in-patients. A diet chart was available and displayed in the kitchen.

MAHARASHTRA

High Dependency Unit (HDU)/ Intensive Care Unit (ICU)

DWH Akola has a 5-bed HDU, with 4 beds having continuous oxygen supply. The average length of stay was 5-7 days, with a 3:1 nurse-to-bed ratio and the presence of intensivists. No ICU facility was available. SDH Murtizapur lacks both ICU and HDU services. Obstetric ICU/HDU services need to be introduced to strengthen maternal critical care.

Operation Theatre (OT)

DWH Akola has 2 major OTs and 1 minor OT, with a C-section rate of 56% and an operation cancellation rate of 0.22%. Each surgeon performs an average of 15 LSCS surgeries per month. DH Murtizapur has 3 OTs (2 major – Eye and Obstetrics, and 1 minor), with a C-section rate of 18.46% and an operation cancellation rate of 18.69%. Each surgeon performs 2-9 surgeries per month. C-arm machines were unavailable, affecting orthopedic surgeries.

Special Newborn Care Unit (SNCU)

DWH Akola operates a 48-bed SNCU and a 20-bed MNCU, admitting 306 inborn and 58 outborn newborns per month. The bed occupancy rate was 87.23%, with an 86% successful discharge rate. KMC was provided in 49.5% of LBW cases, with a 0.9% mortality rate and 9.7% referral rate. The SNCU/MNCU was MusQan-certified. The labour room was renamed Navjaat Shishu Aagman Kaksh.

Labour Delivery Recovery (LDR) Complex

SDH Sindhudurg's labour room was state-certified for SUMAN and meets LaQshya eligibility criteria. However, with only 60 deliveries per month, it falls below the certification benchmark due to the absence of ICU services, leading to referrals for high-risk pregnancies (HRPs). Hirkani Kaksha (breastfeeding rooms) have been introduced at all healthcare levels as a best practice.

RH Akola was led by a gynaecologist but handles only normal deliveries and minilap procedures. C-sections, HRPs, and MTP cases were referred due to the lack of an anaesthetist, paediatrician, and blood storage unit. Despite a delivery load of 25-30 per month, the absence of a Newborn Stabilization Unit (NBSU) results in referrals for sick and LBW newborns.

DWH Akola was a women-only hospital, with a new MCH wing under construction that will include LDR facilities. The labour room follows all standard protocols, and PoC tests were conducted. Birth companions were allowed.

At SDH Murtizapur, the MCH wing was housed in the same building as NBCU. The labour room was fully functional with sufficient labour tables. However, the hospital lacks SNCU and MNCU services, instead operating a Newborn Stabilization Unit to support immediate neonatal care.

Midwifery Initiative

The state midwifery training institute was situated in DWH Akola. The training of participants will commence next year with a batch of 30 students. Currently, five midwifery educators were under training. The initiative focuses on promoting physiological births with minimal interventions, respecting

the mother's choices regarding birth companions and positions, and ensuring dignity through respectful maternity care (RMC).

PICU/NICU

NICU and PICU facilities were not available.

Blood Bank

No blood bank was reported at WCH, Kudal, Sindhudurg.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

At DWH Akola, CSSD was functional at the center, but there was no linkage between CSSD and mechanized laundry. At DH Murtizapur, an autoclave facility was available, consisting of one horizontal autoclave with an 8-10 drum capacity and one vertical autoclave with a 2-drum capacity.

Dietary and Kitchen Services

At DWH Akola, dietary services were outsourced, and the kitchen was situated in a separate building with all facilities. A total of 6,795 dinner meals were served in the last month. An Ayush Garden has been developed near the kitchen area. At DH Murtizapur, dietary services have been outsourced for three years, and the kitchen was located in a separate building with all necessary facilities.

MIZORAM

Emergency Services

Emergency services were available at both DH Lunglei and DH Kolasib but required further strengthening. Triage areas were not properly demarcated as per emergency guidelines. DH Lunglei had a separate emergency entrance with clear signage, while DH Kolasib was temporarily functional in the Eye Hospital building due to ongoing construction of a new 100-bed DH. Oxygen supply was reliant on cylinders, as the centralized medical gas pipeline system was non-functional in both DHs. Critical gaps included a lack of pediatric ambubags, pediatric masks, and gastric lavage tubes in DH Lunglei. Additionally, gas stoves and LPG cylinders were kept in the emergency area, posing safety risks. Patient privacy was inadequate in DH Lunglei's emergency department.

High Dependency Unit (HDU)/ Intensive Care Unit (ICU)

Neither DH Lunglei nor DH Kolasib had ICU services. DH Lunglei had an HDU, but critical care services were absent in DH Kolasib. The new DH under construction in Kolasib does not plan for ICU services, which was a significant gap given the region's difficult terrain and road conditions. Oxygen cylinders were available, but there was no centralized supply. Critical equipment and drugs were present, though an intensivist was not available, with MD Medicine managing cases at DH Lunglei.

Operation Theatre (OT)

DH Lunglei had three functional OTs catering to General Surgery, Orthopaedics, Maternity, and Ophthalmology, performing 628 major surgeries from April to October 2024. In DH Kolasib, only LSCS and Orthopaedic surgeries were conducted, as the district lacked a General Surgeon and ENT specialist. Though an Eye Specialist was posted, no eye surgeries were conducted due to a lack of confidence, causing a backlog of cataract surgeries since 2023. Zoning of the OT was maintained with designated protective, clean, sterile, and disposal zones.

Labour Room

DH Lunglei's Labour Room and Maternity OT were LaQshya certified, but neither district hospital had a separate MCH wing or followed the LDR concept. DH Lunglei had only one oxygen cylinder shared between the labour and postnatal rooms, and the suction apparatus was non-functional. DH Kolasib reported 572 institutional deliveries (April–September 2024), including 72 C-sections, but only 23.2% of mothers stayed for 48 hours post-normal delivery, and 53% for 72+ hours post-C-section. Home deliveries remain prevalent in remote areas due to difficult terrain and lack of transport. Comprehensive lactation services were not fully functional, and staff nurses required additional training.

Newborn Care Services (NBCC, NBSU, SNCU)

DH Lunglei had a 7-bed SNCU, MusQan certified, with triaging areas, critical care equipment, and trained staff (1 Pediatrician, 7 Nurses, 5 Cleaning Staff, 1 DEO). 7 radiant warmers and phototherapy machines were available, though one warmer was non-functional and under repair. KMC and breastfeeding areas were demarcated with privacy ensured, and newborn care was provided under JSSK entitlements.

In DH Kolasib, SNCU and NBSU were unavailable. A KMC room with four radiant warmers was used for very sick newborns. Though sufficient radiant warmers were available, optimal resource utilization was lacking. Staff training in neonatal care was pending. Infant and child deaths were reported, but discrepancies were found in audit records, particularly concerning age and admission dates. CDR was not being conducted consistently.

PICU/NICU

The PICU was reported functional in Lunglei district hospital.

Blood Bank

Blood banks were functional in both District Hospital Lunglei and Kolasib. Blood donation camps were conducted regularly, and a record of issued and collected units was maintained. In DH Kolasib, the blood bank was enrolled under the Haemovigilance Program of India until June 2026. However, the license of the blood bank was nearing expiration (December 2024), and the renewal process was underway. A backup refrigerator was recommended for surplus blood storage.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

Laundry services were outsourced at both the visited district hospitals.

Dietary and Kitchen Services

In-house dietary services were available at both the district hospitals. Dedicated and clean food distribution trolleys were available.

ODISHA

Labour Room

Labour rooms across facilities were well-maintained with adequate supplies of essential and emergency drugs. LaQshya certification had been obtained for some facilities, ensuring adherence to quality standards. Birth companions were allowed to provide emotional support during deliveries.

Newborn Care Services (NBCC, NBSU, SNCU)

Sambalpur district had a 14-bed SNCU with high bed occupancy and referral rates. However, there were no fixed referral criteria for sick newborns. Facilities were equipped with Newborn Stabilization Units (NBSUs), Newborn Care Corners (NBCCs), and essential neonatal equipment. Mothers received counselling on breastfeeding, danger signs, and Kangaroo Mother Care (KMC).

Prompt referral of sick newborns was ensured to Medical College in both districts. No child deaths were reported in the past year, and free treatment for sick infants was implemented under the JSSK scheme.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

Laundry services were available in all public healthcare facilities through outsourced mode under state specific “Nirmal Scheme”

RAJASTHAN

Emergency Services

Emergency services were available 24x7 at all secondary care facilities, with patient footfall ranging from 100-350 per day. However, triaging systems were absent at SDH and CHCs, except at the Hybrid facility in Sikar, which had a structured system. Common cases included accidents, dog and snake bites, poisoning, and medicolegal cases. Equipment such as stretchers and wheelchairs were available but poorly maintained. Most emergency rooms lacked dedicated beds and multipara monitors. Waste disposal was not compliant with Biomedical Waste Protocol, and sterilization protocols were not followed due to staff unawareness. Staff had not received recent training in emergency management, and LAMA rates at Bharatpur Hybrid Facility were 15-18%.

High Dependency Unit (HDU)/ Intensive Care Unit (ICU)

ICUs were well-established at DH Sikar and Bharatpur, with 20 beds, 10 ventilators, 4 defibrillators, and 6 multipara monitors. However, not all ICU beds were ventilator-supported. HDU was observed in Bharatpur DH. The average ICU stay was 3-4 days and in HDU, 1-2 days. The nurse-to-bed ratio was 1:4, and there was no dedicated intensivist at Bharatpur Hybrid Facility. Dedicated ICU staffing was absent, with doctors providing on-call coverage. Isolation facilities were unavailable. ICU charges were Rs. 200/day but free for BPL, senior citizens, and BHAMASHA cardholders.

Operation Theatre (OT)

OTs with proper zoning were functional at Sikar Hybrid Facility and DHs but not at CHCs and SDHs in Bharatpur. DH Sikar and Bharatpur had four functional OTs for Emergency, Ortho, OG, and ENT surgeries. Common procedures included cataract surgeries, C-sections, hydroceles, and family planning operations. HVAC systems were absent in all functional OTs. At Bharatpur SDH, specialists (anaesthetists, gynaecologists, and surgeons) were available, but the OT was non-functional. One of the CHCs visited in Bharatpur had well-equipped OTs but no surgeons.

Labour Delivery Recovery (LDR) Complex

The LDR concept was not implemented in the state. MCH wings were established at Hybrid Facilities, but Sikar's MCH was located 3 km away from DH. MCH was 100 bedded hospital and had 10 specialists including Obstetrician & Gynaecologists (OBGY), Paediatrician and 1 Anaesthesiologist etc. The monthly delivery load was 450 in MCH wings.

LaQshya certification was obtained at DH Sikar, but Bharatpur's MOT was non-functional due to a lack of OBGY specialists. C-section load was 115-120 per month in MCH Sikar. Birth companions were not allowed.

Maternal Death Review (MDR) committees were formed and reviewed cases. Biomedical waste management at CHCs/SDHs in Bharatpur was inadequate, and labour rooms had rusted labour tables, stacked junk, and stained sheets. Drop-back services under JSSK were not provided.

Newborn Care Services (SNCU, NBCC, NBSU)

Sikar had a 30-bed SNCU, and Bharatpur had a 24-bed SNCU, with triaging, critical equipment, and a 90% bed occupancy rate. Antenatal corticosteroids and Kangaroo Mother Care were provided for preterm and LBW infants. Centralized oxygen supply was absent in Sikar but available in Bharatpur.

No dedicated medical officer (MO) was assigned to SNCU, with paediatricians providing on-call emergency duty. OPD-hour newborn care was managed solely by staff nurses. Out born deaths

were higher, and no Institutional Child Death Review (CDR) committee was formed. Infection control measures were inadequate, and staff were not trained.

Midwifery Initiative

Midwifery Led Care Units were not found in the DH across the districts.

Blood Bank

Both the District Hospitals in Rajasthan have functional blood banks, which act as mother banks to other facilities in the districts. Around 80% of blood donations were from replacement donors, while 20% were from voluntary donation drives organized by various community and faith-based organizations. The District Hospital Sikar was the only government Blood Component Separation Unit (BCSU) in the district, catering to transfusion services for Sikar and adjoining districts. The Blood Centre Sikar has received the Best Performance Award for the last three consecutive years from the State Government.

TTI testing by both ELISA and rapid testing was available, and the blood bank functions 24x7. Blood was collected from donors on a voluntary basis. The average monthly blood collection was approximately 500 packs, and 94-96% of the collected blood underwent component separation.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

Central Sterile Supply Department (CSSD) was not established at the visited health facilities. The instruments were sterilized at their respective wards/departments/clinical areas.

There were no in-house laundry facility in both the districts and the services were outsourced to vendors. Washing machines were also available with the health facilities. No Linkages were reported between Laundry and CSSD to ensure wear & tear of clothes, and knowledge of staff on disinfection was found inadequate. Record keeping mechanisms were poor.

Dietary and Kitchen Services

In District Hospitals (DH) Sikar and Bharatpur, kitchen services were outsourced to a vendor operated by the Red Cross Society. Patients paid INR 10 per meal, and attendants paid INR 1 per meal. A feedback mechanism was in place, conducted telephonically through IVRS, along with a feedback register. Infection prevention protocols such as hand hygiene and use of PPE were being followed. The Annapurna Rasoi Scheme provided affordable meals, where the government subsidized INR 12 per meal, reducing the patient's cost to INR 8 per meal. At CHC/SDH level, dietary services were provided by self-help groups. Nutritional Rehabilitation Centres (NRCs) at DH Bharatpur had well-equipped kitchens.

TRIPURA

Emergency Services

In urban settings, triaging boards were observed, but a consistent and standardized implementation of triaging was lacking. In rural settings, no formal triaging system was found at CHCs. However, both urban and rural facilities had continuous oxygen supply and multipara monitors, and essential patient equipment.

Operation Theatre (OT)

OT zoning was observed only at the State Hospital, while it was absent at CHCs. Unidirectional flow of materials and HVAC systems were not consistently implemented. The State Hospital had multiple OTs, whereas CHCs generally had only one. The C-section rate was high across the state. The State Hospital conducted an average of 30 major and 32 minor surgeries per month, approximately 5 surgeries per surgeon per week, while CHCs recorded 5 major and 10 minor surgeries per month.

High Dependency Unit (HDU) / Intensive Care Unit (ICU)

The ICU had a single entry/exit point with a continuous oxygen supply. However, no dedicated Obstetric ICU (OICU) was available in the state. An intensivist was present for ICU care, with a doctor-to-bed ratio of 1:8 and a nurse-to-bed ratio of 1:5. The ICU, located only at the State Hospital, was equipped with oxygen and ventilator beds, and essential medications and equipment were available in the HDU.

Labour Delivery Recovery (LDR) Complex

LDR rooms were available at both the State Hospital and CHCs, but dedicated LDR beds and a formal triaging system were absent. Essential amenities such as handwashing areas, dedicated staff, point-of-care test kits, and adequate labor tables were in place.

Special Newborn Care Unit (SNCU)

The SNCU was MusQan certified and had a high bed occupancy rate (92.64%), with an average of 18 inborn and 20 out born admissions. 77.27% of neonates were successfully discharged, with 16.23% transferred from the step-down ward. The SNCU at the state-run IGM hospital primarily admitted inborn neonates, with a smaller proportion of out born admissions. Free ambulance referrals were provided for out born cases.

All Low Birth Weight (LBW) babies received Kangaroo Mother Care (KMC). Antibiotic use was 80%, while mortality stood at 2%. The Late Admission Mortality Rate (LAMA) was 0%, reflecting timely referrals and effective interventions. The referral rate was 4.5%, mainly for surgical cases. The nurse-to-bed ratio was 1:4. The SNCU was equipped with 20 oxygen beds and 4 ventilator beds. A statewide equipment repair and maintenance agreement was in place, ensuring all major equipment was mapped and labeled. 90% of medicines were provided free of cost to patients.

Midwifery Initiative

The state has not yet identified a State Midwifery Promotion Initiative (SMPI). Additionally, no dedicated training programs for midwifery have been conducted.

PICU/NICU

A Paediatric Intensive Care Unit (PICU) or Newborn Intensive Care Unit (NICU) was functional at the state hospital, but such specialized facilities were not available at Community Health Centres (CHCs). The PICU was equipped with ventilators, oxygen-supported beds, and other critical care equipment. A single entry/exit point for patient flow was in place, and a paediatrician was available round-the-clock. However, there was no direct access to a Mother and Newborn Care Unit (MNCU). The unit provides continuous oxygen supply and has round-the-clock paediatric services.

Key performance indicators for the PICU include an Average Length of Stay (ALOS) of 7.65%, a Bed Occupancy Rate (BOR) of 56%, and a discharge rate of 66.66%. All low birth weight (LBW) babies receive Kangaroo Mother Care (KMC). The unit has 10 oxygen beds and 2 ventilator beds.

Blood Bank

Blood banks was not available at present at CHC while the State Hospital has obtained the necessary licenses and authorizations for blood banks.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

The state lacked a mechanized laundry service. A mixed approach was observed, with institutions utilizing a combination of in-house laundry facilities and partial contracts with external laundry services. There was no central sterilization unit, and autoclaves were utilized within individual departments for sterilization purposes. However, Sigma-loc indicators, which are crucial for validating sterilization effectiveness, were not consistently observed. Additionally, no records of sterilization failures were documented, and standardized clinical protocols for sanitation and sterilization procedures were not found within the hospitals.

Dietary and Kitchen Services

Dietary services were provided in-house. The state hospital serves meals twice daily for 285 beds, while the CHC caters to 20 beds. Expiration registers were not observed, but the food stock appeared fresh during the inspection. The infrastructure at both facilities was deemed satisfactory, with designated areas for receiving and distributing meals. Infection prevention protocols were being adhered to. However, no formal feedback mechanism was found in any of the visited hospitals to assess patient satisfaction with the food services.

UTTAR PRADESH

Special Newborn Care Units (SNCUs)

The state's Special Newborn Care Units (SNCUs) face severe overcrowding, with occupancy rates reaching an alarming 179%. The shortage of beds and inadequate infrastructure compromises neonatal care, increasing risks for newborns requiring specialized treatment. Overcrowding also places additional pressure on healthcare workers, affecting the quality of services.

SNCU facilities also faced a significant staff shortage. Rotational staff lacked the capability to operate medical equipment, impacting effective neonatal care. Additionally, SNCU/NBSU facilities reported high LAMA rates and poor referral tracking.



PICU/NICU

A well-equipped 25 bedded Mini PICU was well equipped but underutilized in DH Kushinagar. However, rotational staff lacked the capability to operate medical equipment in the Paediatric ICU (PICU), despite the availability of equipment in the Mini PICU. Additionally, the Mini PICU at CHC Kaptanganj was handling a higher caseload with three bedded capacity.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

It was observed that CSSD was not used for dental procedures at District Hospital, Agra, rather a rusted autoclave machine was being used.

UTTARAKHAND

Emergency Services

Emergency care in the state was poorly organized, with weak referral linkages, transport availability, and response times. Response time for ALS/BLS ambulances was 12.50 minutes in urban areas and 23.32 minutes in rural areas. Utilization was highest for pregnancy-related services and RTA cases.

At DH Bageshwar, half of the emergency room was being used as storage space, affecting patient management. No triaging or zoning was established, and intra-hospital linkages were weak. While DH Dehradun and CHC Shaiya had SOPs in place, CHC Raipur and SDH Vikasnagar had compromised SOPs.

Operation Theatre (OT)

At DH Bageshwar, zoning and SOPs were compromised, with no dedicated spaces for trolley change, apron change, dirty corridor, or microbiological sampling. False ceilings and formaldehyde fumigation were used, both of which are not recommended. The TSSU lacked proper segregation of sterile and unsterile articles. OTs at CHCs were poorly maintained and were primarily used for family planning procedures in camp mode. At SDH Vikasnagar, protocols were compromised, and fungal growth was observed on OT walls.

Intensive Care Unit (ICU) & Critical Care Services

Critical care services were weak and poorly managed. At DH Bageshwar, ICU infrastructure was available (oxygenated beds, monitors, ventilators, and essential equipment) but underutilized due to staff shortages, lack of training, and irrational staff postings (ICU-experienced staff were deployed in emergency and other departments). There was no Central Sterile Supplies Unit (CSSU) in DH, affecting infection control. Mechanized laundry had limited equipment, worked in constrained spaces, and had compromised protocols.

Newborn Care Services (SNCU, NBCC, NBSU)

At Mahatma Gandhi Hospital Dehradun, the SNCU was located 1 km away from the maternity wing, affecting coordinated maternal-newborn care. SNCU Bageshwar faced HR shortages, including the absence of a paediatrician, impacting 24x7 functionality. SNCU at SDH Vikasnagar reported a 32% LAMA rate, raising concerns about service quality. Safe abortion services were available only at DHs and select CHCs with obstetricians.

Midwifery Initiative

States was also planning Midwifery led care unit to be started at DH Dehradun.

Blood Bank

Blood bank services were available at DH Bageshwar but not at DH Dehradun, which has a Blood Storage Unit (BSU). The voluntary donation camps were organized in partnership with Police, bank, NGOs etc. They collect about 40 to 50 units per camp, yet uses replacement donor (60,372 donors in FY 2023-24) while utilizing services. The main consumer of blood in DH was for severe anaemia management. The bank uses e-raktkosh portal, and reports were generated. Eight units were discarded in October 2024 in Bageshwar.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

There was no Central Sterile Supplies Unit in DH. The Mechanized laundry has limited equipment, works within space constraints and has protocols compromised.

Dietary and Kitchen Services

Diet support service for inpatient facilities was outsourced in both Districts. In Bageshwar, kitchen was found to be in shabby condition with no dedicated space for keeping food items. No diet chart was seen.

WEST BENGAL

Critical Care Services

In South 24 Parganas, Critical Care Units (CCUs) were well maintained at Diamond Harbour GMCH. The CCMIS software was effectively used, and medicines, consumables, and equipment were available as per norms. Triage was followed at casualty, and healthcare teams were proactive, with good subject knowledge and adherence to infection control practices.

Facilities were clean and well-maintained indoors, but building maintenance and waste management required improvement. Colour-coded bins were available for BMW segregation, but periodic training on updated protocols was needed. Signages were available, but pictorial and color-coded directional signages at strategic locations were recommended.

In Medical Colleges, hybrid CCUs and General CCUs were functional.

Emergency services

Across Rural Hospitals (RHs) and SDHs, gross space constraints and inadequate triaging were observed in emergency departments. Delayed repair of critical equipment was noted in multiple facilities across both districts, affecting emergency care efficiency.

Operation Theatre (OT)

All OTs were well-equipped, and zoning was followed in most OTs except for Gynaecology OT in SDH. The number of surgeries, including Eye, ENT, General, and Obstetrics, was optimal.

HDU/ICU

Both the sub district hospitals had well functional 4 bedded and 6 bedded HDUs with adherence to technical protocols.

Newborn Care Services (SNCU, NBCC, NBSU)

In South 24 Parganas, Special Newborn Care Units (SNCUs) were well maintained, with standard treatment protocols followed. SNCU Bed Occupancy Rate (BOR) was 115.48%, and successfully discharged cases stood at 91.4% (2024-25). LAMA was low (0.4%), while mortality was 5% and referrals stood at 3.1%. Antibiotic usage was 21%. Triage beds, human resources, and equipment were available, but fire safety norms needed regular monitoring. MusQan activities were not implemented.

In Malda district, space constraints in SNCUs were severe, contributing to a high neonatal death rate. Overcrowding limited effective newborn care, requiring urgent infrastructural expansion.

PICU/NICU

A 12 bedded paediatric Intensive Care unit was functional with 16 beds in Malda District.

Blood Bank

It was observed that the license of the blood bank at Malda Medical College and SDH Chanchal had expired in 2020 and 2022, respectively. There was a high patient load at tertiary care facilities, indicating the need for strengthening blood bank services.

Mechanised Laundry/Central Sterile Supply Department (CSSD)

CSSD and mechanized laundry were not available at SDH facilities.

Dietary and Kitchen Services

Dietary services were available, but the infrastructure was not as per Government of India norms and were FSSAI certified.

SUBCATEGORY 2: TO UNDERSTAND THE GAP IN IMPLEMENTATION OF RMNCH+A, RBSK, RKSK, SUMAN, PMSMA (E-PMSMA), JSSK, NLEP, NTEP, ETC.

KEY OBSERVATIONS:

1. FAMILY PLANNING

- A basket of choice was available at most secondary care facilities, yet stock-outs of Inj. MPA in Bihar and IUCD in Haryana were reported. Antara uptake improved in Assam but remained low in Chhattisgarh due to compliance issues.
- While sterilization services were present, male sterilization was inadequate across Rajasthan, Mizoram, and West Bengal. Odisha showed an increase in the uptake of newer contraceptives like Antara and Chaya, while Tripura faced challenges with unavailability of PTK and Ezy pills.
- Despite trained staff, PPIUCD and PAIUCD were underutilized in Assam, and retention of PPIUCD insertions was low in Chhattisgarh. Acceptance was particularly low in Jammu & Kashmir. Laparoscopic sterilization services were restricted in Assam, and fixed-day sterilization was inconsistent across Chhattisgarh and Odisha. In Gujarat and Chhattisgarh, shortages of NSV, minilap, and interval IUCD kits hindered service provision. Himachal Pradesh maintained tubal ligation services.
- Awareness initiatives such as Saas Bahu Sammelans were absent in Bihar, and Saarthi vehicles were non-operational. Karnataka lacked the Sugam model, which was implemented in many secondary care facilities across Tripura and Odisha.
- While separate counseling rooms were available in Himachal Pradesh and Haryana, and Rajasthan, they were missing in Madhya Pradesh, limiting privacy and effective counselling services.
- Comprehensive abortion services were generally available across the secondary care facilities visited in states, yet post-abortion IUCD insertion was low in Karnataka. Assam's district hospitals provided MMA, MVA, and D&C, but private ultrasound services in Chhattisgarh led to increased out-of-pocket expenses.
- JSSK and JSY entitlements were timely provided across secondary care facilities in Bihar, Chhattisgarh, Odisha, and Rajasthan. Delayed payments were reported in Madhya Pradesh with high OOPE for diagnostics.
- Records were well maintained in most of the states however, records showed inconsistencies, with discrepancies between manual stock registers and FPLMIS in Haryana, missing facility registers in Himachal Pradesh, and incomplete documentation in Madhya Pradesh.

2. MATERNAL HEALTH

- Labour rooms were generally functional and well-equipped in most states, with LaQshya certification observed in Assam, Himachal Pradesh, Tripura, and Maharashtra. Facilities were SUMAN notified in Arunachal Pradesh, Assam, Bihar, Maharashtra, Tripura, and Odisha. However, gaps were noted in states like Arunachal Pradesh (absence of midwifery-led care units), Gujarat (infection control lapses), and Jharkhand reported poor labor room monitoring and privacy violations.
- HRP tracking mechanisms were found in Gujarat with critical feedback loops for follow-up, Odisha with operational HRP cards and monitoring app, and Rajasthan (82.08% ANC coverage with structured monitoring). However, gaps existed in Bihar (poor HRP management planning), Chhattisgarh (HRP list not shared with PHCs/CHCs), and Haryana (lack of separate HRP line listing at CHCs).
- States like Assam had labor room workforce trained in AMTSL and newborn resuscitation. In Himachal Pradesh, the staff was yet to be trained on Dakshata, while Jharkhand exhibited poor

staff knowledge on labor complications.

- Institutional deliveries were high in states like Assam, Gujarat, and Himachal Pradesh. However, high C-section rates were reported in Karnataka (50-60%) and Arunachal Pradesh (25%), while Madhya Pradesh had low emergency LSCS rates which was linked to absence of BEmOC-trained MOs. Some states, such as Gujarat and Maharashtra, faced high referral rates for complicated cases due to inadequate FRU staffing.
- Well-functioning NBSUs and SNCUs were present in Assam, Maharashtra, and Gujarat, but Arunachal Pradesh lacked ventilatory support and proper triaging. Partographs, safe birth checklists were available in most of the facilities. However, in Mizoram and Jharkhand, maternal and newborn care was inadequate due to gaps in partograph use and availability of essential neonatal equipment.
- PMSMA sessions were regularly conducted in states like Assam, Bihar, Chhattisgarh, and Odisha. However, Mizoram did not observe PMSMA days, and Jharkhand lacked e-PMSMA camps. Himachal Pradesh recorded ANC registrations only on PMSMA days, limiting timely tracking.
- Essential drugs and diagnostics were widely available in most of the states, with no reported stockouts. However, shortages of IFA and calcium supplements were noted in Jharkhand, while Gujarat's UCHC labor rooms lacked essential drugs like magnesium sulfate.
- Birth companion policies were implemented in states like Arunachal Pradesh, Karnataka, and Maharashtra. However, issues of privacy violations in labor rooms were noted in Gujarat and Jharkhand. Karnataka also reported cases of OOPE.
- The MaNTrA app in Uttar Pradesh successfully tracked over 61 lakh deliveries, improving surveillance of intrapartum care.

3. CHILD HEALTH

- Functional Newborn Care Corners (NBCCs), Newborn Stabilization Units (NBSUs), and Special Newborn Care Units (SNCUs) were available in most states like Gujarat, Rajasthan, and Odisha, but gaps in equipment and HR shortages were prevalent across the visited facilities.
- NICUs were well-equipped and functional in states like Tripura, while NBSUs were either non-functional or under-equipped in Jharkhand and Mizoram. SNCUs in states like Himachal Pradesh and Uttarakhand were either under construction or located away from maternity wards, affecting service delivery.
- Shortages of paediatricians, trained nurses, and specialists were a common challenge, particularly in Haryana, Jharkhand, and Uttarakhand. Many states lacked training in key areas such as resuscitation, NSSK, SBA, and IYCF, impacting neonatal care quality. Training gaps in AMTSL, PPH, and eclampsia management were observed in states like Chhattisgarh.
- Routine immunization services were well managed in states like Bihar, Karnataka, and Himachal Pradesh. Model immunization centers were operational in Bihar, while Karnataka ensured 100% immunization coverage.
- Kangaroo Mother Care (KMC) was actively practiced in Gujarat and Odisha, but gaps in training were observed in some states.
- Many facilities lacked essential newborn



trays, resuscitation protocols, and KMC spaces, as seen in Arunachal Pradesh and Himachal Pradesh.

- CLMC were well functioning and equipped in Rajasthan, Tripura, Odisha, missing in Himachal Pradesh.

4. MATERNAL AND CHILD DEATH REVIEW AND RESPONSE

- Maternal death reviews were conducted in several states, including Haryana, Karnataka, Tripura, Mizoram, Rajasthan, and Uttar Pradesh, and Odisha to enhance monitoring and reporting. In Arunachal Pradesh, both maternal death reviews, and child death investigations were being conducted, but records were not uploaded to the MDSR and MPCDSR portals.
- Jharkhand's MPCDSR system was ineffective, with no proper maternal and perinatal death reviews being conducted.
- Child death reporting and audits were weak in Chhattisgarh, with significant underreporting in HMIS and MPCDSR compared to SRS estimates. Tripura established an expert committee for infant death audits, demonstrating a structured review process. Haryana reported 263 child deaths, but detailed CDSR audit findings were missing.
- Newborn death audits were conducted in Arunachal Pradesh, but records or meeting minutes were not maintained, impacting accountability.
- Several states, including Assam, Bihar, Gujarat, Himachal Pradesh, Jammu & Kashmir, Maharashtra, Madhya Pradesh, Uttarakhand, and West Bengal, either had limited reporting available or require further strengthening of maternal and child death audits to improve surveillance and intervention strategies.

5. UNIVERSAL IMMUNIZATION PROGRAMME (UIP)

- Most of the states including Karnataka, Bihar, Tripura, and Odisha demonstrated strong immunization coverage with well-maintained cold chain systems, adherence to immunization schedules, and proper vaccine handling.
- Bihar, Haryana, Chhattisgarh, Odisha, and Madhya Pradesh maintained proper cold chain mechanisms with functional eVIN/UWIN systems for vaccine tracking and storage management.
- ANMs and healthcare providers in several states, such as Rajasthan, Tripura, and Odisha, were well-trained on immunization protocols, birth dose administration, and microplanning. However, gaps in training on AEFI management were noted in states like Jharkhand and Haryana.
- Rajasthan and Madhya Pradesh reported challenges in immunizing migrant laborers and nomadic groups, contributing to dropouts. Additionally, Aadhaar-linked OTP issues led to delays in U-WIN data entry in Madhya Pradesh.
- While AEFI registers were available in some states (Tripura, Haryana), awareness and documentation were poor in states like Bihar and Jharkhand, indicating the need for better training and reporting.
- Some states, such as Madhya Pradesh, faced challenges like BCG vaccine shortages and lack of power backup for cold chain equipment, affecting immunization service continuity.

6. CHILD NUTRITION

- Nutrition Rehabilitation Centers (NRCs) were operational across states including Karnataka, Odisha, Tripura, Himachal Pradesh, and Maharashtra. Odisha reported high recovery rates (90%) and proper weight gain before discharge.
- Few states, including Bihar, Haryana, and Assam, reported low NRC bed occupancy (20-25%), poor

mobilization of SAM children, and weak post-discharge follow-up, affecting long-term recovery. Rajasthan reported weak referral linkages for SAM children and poor coordination between healthcare levels, leading to gaps in service delivery.

- Arunachal Pradesh, Rajasthan, and Karnataka faced challenges in screening for SAM, anaemia, and birth defects.
- Jharkhand and Haryana reported essential staff shortages, unhygienic conditions, and poor infection control in NRCs. Arunachal Pradesh had a non-functional NRC due to HR shortages, and Assam lacked a Nutritionist-cum-Counselor.
- Maharashtra implemented the Hirkani Kaksha (breastfeeding rooms), while Odisha had well-equipped NRCs with IEC materials. AIIMS Raipur in Chhattisgarh served as a Centre of Excellence for Nutrition.



7. RASTRIYA BAL SWASTHYA KARYAKRAM (RBSK)

- DEICs were operational in Karnataka, Maharashtra, Jammu & Kashmir, Rajasthan, and Odisha, supporting referrals and specialized care. Karnataka demonstrated strong coordination between DEICs and Mobile Health Teams (MHTs), ensuring regular school and AWC screenings.



- States like Bihar, Tripura, and Mizoram reported non-functional DEICs due to HR and infrastructure gaps. Jharkhand's DEICs were underutilized, functioning more as pediatric OPDs than referral centers.
- Assam ensured RBSK screening for all newborns before discharge from SNCUs. Haryana's MHT screened over 18,000 children, but key vacancies were reported for Optometrist, Psychologist. Rajasthan and Himachal Pradesh conducted routine screenings and referrals, though DEICs were

absent in some districts.

- Many states, including Madhya Pradesh, Chhattisgarh, and Maharashtra, faced staffing shortages affecting specialized services. Maharashtra's DEIC had accessibility issues like split floors without an elevator.
- Mizoram's annual visits to orphanages, care homes, and NGOs for 4D screenings were a notable initiative. Maharashtra's SDH had a child-friendly play area near ANC rooms, supporting child engagement during maternal check-ups.
- Inconsistent referral pathways and poor treatment follow-ups were reported in Jharkhand and Mizoram, affecting service continuity and treatment outcomes for screened children.

8. RASTRIYA KISHOR SWASTHYA KARYAKRAM AND ADOLESCENT FRIENDLY HEALTH CLINIC (AFHC)

- Arunachal Pradesh, Assam, Himachal Pradesh, Karnataka, Maharashtra, Odisha, and Madhya Pradesh had operational Adolescent Friendly Health Clinics (AFHCs). Notably, Odisha's Sharda Clinics and Himachal's Nayi Disha Kendra were well-equipped with trained counselors, medical officers, and essential commodities.
- Madhya Pradesh's Umang Clinics encouraged open discussions through the Khul Ke Puchho, Khul Ke Jano initiative. Odisha implemented a peer education program, and Maharashtra incorporated yoga sessions for adolescent mental well-being.
- Assam and Odisha provided school-based services, with outreach activities covering topics like nutrition, substance abuse, and high-risk behaviors. Odisha also ensured biweekly outreach to AWCs. However, community linkages in Karnataka were weak despite active school visits.
- Bihar's Yuva Clinic was nonfunctional, and the School Health Programme under Ayushman Bharat was absent. Rajasthan lacked dedicated AFHC spaces at secondary facilities, and Haryana's AFHC at DH functioned without a female counselor. Poor awareness led to underutilization of AFHC services in Jharkhand.
- AFHCs in Odisha and Himachal Pradesh provided free sanitary napkins, whereas Haryana lacked them. Jharkhand reported high teenage pregnancies and anemia despite IFA supplementation, with AFHCs being underutilized due to poor community awareness.
- Maharashtra reported increasing cases of adolescent diabetes and hypertension, alongside parental concerns over mobile addiction. Assam recorded a high number of teenage pregnancies among AFHC walk-ins.
- Gaps in Referral and Community Linkages: Karnataka had strong referral linkages to tertiary care but weak community engagement.
- Rajasthan's AFHC services were provided through routine OPDs due to the absence of dedicated spaces. AFHC in Haryana lacked essential staff and commodities at CHC and SDH levels. IEC materials and signages were available across most of the facilities visited, however, improvement was needed across Karnataka.

9. NATIONAL TUBERCULOSIS ELIMINATION PROGRAMME (NTEP)

- Maharashtra has achieved 100% TB case notification on the Nikshay portal, with improved treatment adherence and high payouts under the Nikshay Poshan Yojana. Rajasthan has 840 registered Nikshay Mitras, ensuring food support and monitoring.
- Himachal Pradesh's fast-tracking of TB patients using special cards at DH Shimla and Maharashtra's PDCA (Plan-Do-Check-Act) approach for private sector TB notification demonstrates effective strategies.
- Arunachal Pradesh, Tripura, and Mizoram have also made progress, with 33 and 24 Panchayats,

and 18 villages have been declared TB-free respectively declared TB Mukta with TB supporters assigned to all TB patients.

- Jharkhand, Bihar, and Karnataka have active DBT payments for TB patients, though gaps in timely disbursement and integration with Nikshay remain in some states. Uttarakhand has verified 87% of bank details for DBT. Karnataka's DBT system is not integrated with Nikshay, leading to discrepancies in recorded payments. West Bengal faces challenges due to TB patients lacking bank accounts, delaying DBT disbursements.
- Bihar has identified gaps in follow-up sputum examinations and TPT implementation. In Mizoram, sputum examination rates are below the elimination threshold.
- Haryana lacks a dedicated DRTB ward and faces CBNAAT cartridge shortages. Tripura's X-ray machines are non-functional, requiring patients to travel at their own expense. Rajasthan observed missing designated cough corners and inadequate ventilation in labs.
- Several states, including Bihar, Chhattisgarh, Tripura, and Rajasthan, have functional CBNAAT/TrueNAT facilities. Himachal Pradesh has efficient sample transport through ASHAs, postal services, and health workers. Maharashtra also has tele-radiography units, ensuring short turnaround times. Madhya Pradesh reported delays in sample transportation (2-12 hours), lack of cold chain maintenance, and improper sterilization. Some Jharkhand facilities had non-functional CBNAAT machines, affecting case detection.
- Mizoram lacks a medical officer at the District TB Centre, impacting implementation. Jharkhand has inconsistent Nikshay updates across districts, and Haryana lacks district-level TB death analysis.

10. NATIONAL LEPROSY ERADICATION PROGRAM (NLEP)

- Odisha, Haryana, and Rajasthan have shown a decline in leprosy prevalence with effective case management and completed treatments. Odisha has achieved low prevalence in 14 districts and maintained disability rates under 2%.
- States like Odisha, Chhattisgarh, and West Bengal actively conducted case detection campaigns, identifying new cases and ensuring treatment initiation. Jharkhand's LCDC detected over 121 cases, and surveillance is ongoing in Arunachal Pradesh.
- Nikusht 2.0 and Nikusht Aushadi are operational in Arunachal Pradesh for case tracking. Jharkhand, Chhattisgarh, and Himachal Pradesh have ensured sufficient MDT stocks, with case entries recorded in Nikusht.
- Odisha led in disability management with 170 Reconstructive Surgeries (RCS), while Chhattisgarh and Rajasthan provided physiotherapy, MCR footwear, and self-care kits for patients. However, gaps observed in Arunachal Pradesh and Tripura.
- Haryana and Chhattisgarh demonstrated strong IEC implementation, while Odisha actively worked on reducing stigma. However, Madhya Pradesh and Tripura faced gaps in health worker training, affecting case detection and treatment adherence.
- Weak suspected case identification in Madhya Pradesh, lack of mass screening in Tripura, and inadequate Post-Exposure Prophylaxis (PEP) coverage in Haryana and Tripura indicate gaps in preventive efforts. Jharkhand faced logistical issues in treatment kit distribution.

11. NATIONAL PROGRAMME FOR CONTROL OF BLINDNESS AND VISUAL IMPAIRMENT (NPCBVI)

- Haryana, Odisha, Rajasthan, and Karnataka demonstrated progress in cataract surgery programs. Karnataka achieved 8,500 out of its 12,000 annual targets by October 2024, while Odisha completed 1,610 surgeries.
- Haryana and Rajasthan reported integration of school based screenings with the RBSK and RKSK

programs, respectively, ensuring early identification and free spectacles distribution for children with refractive errors. West Bengal's Chokher Alo initiative mandated universal eye screening.

- Karnataka reported mobile ophthalmic units and tele-ophthalmology in multiple districts, while outreach screening with NGO collaboration was observed in Rajasthan and Maharashtra. Odisha reported systematic outreach screening for cataract and refraction errors.
- Haryana and Rajasthan also reported distribution of free glasses to children and presbyopic patients. Maharashtra displayed IEC materials at facilities to raise awareness.
- Arunachal Pradesh reported inconsistent services in blindness control programme due to irregular availability of ophthalmologist. In similar lines, Jharkhand reported lack of a staff nurse in the eye ward, and Gujarat's reported unavailability of an optometrist in SDH. In Madhya Pradesh shortfall of ophthalmic assistants was highlighted during the visits.
- Limited diagnostic facilities in Maharashtra and Madhya Pradesh were identified as factors hindering comprehensive eye care. Jharkhand and Tripura reported weak follow-up mechanisms for cataract surgeries. Additionally, underutilization of donated eyes was linked to reduced eye donation.



12. NATIONAL PROGRAM FOR HEALTH CARE OF ELDERLY (NPHCE)

- Status of NPHCE implementation varied across states. Regular geriatric OPD clinics were found functional alongside general OPD services in most of the places, but separate IPD wards were not available. In Bihar, the National Programme for Health Care of the Elderly (NPHCE) had not been initiated at any level, with elderly clinics and wards either non-existent or inactive. Awareness among healthcare workers regarding elderly care was lacking, and IEC efforts for the programme were inadequate in most of the states.

13. PRADHAN MANTRI NATIONAL DIALYSIS PROGRAMME (PMNDP)

- PMNDP was reported operational in most of the states providing free of cost dialysis services including medicines and diagnostics to all beneficiaries through NHM and State Insurance scheme mainly at the secondary care facilities. Separate machines for seropositive patients were available in Odisha and Rajasthan.

- In most of the states the dialysis units run in PPP mode. Peritoneal dialysis facilities were only available in Uttarakhand & Mizoram.
- The state of Arunachal Pradesh had signed MoU with Sir Ganga Ram Hospital, New Delhi for review of dialysis patients, training and assistance in renal transplant.
- Except Mizoram, ABHA IDs were not generated at the dialysis center which hindered the seamless integration of dialysis services into the broader healthcare system.
- In Madhya Pradesh Erythropoietin was included in the state EML, the facility in-charge was indenting the erythropoietin on monthly basis from the DH drug store and was providing it to dialysis patients free of cost.
- In Tripura and Himachal Pradesh Nephrologist visited the facility regularly and also was available to patients through teleconferencing.
- In the state of Jharkhand, the facility caters to patients holding Below Poverty Line (BPL) cards or Ayushman Bharat cards by offering free dialysis services. Despite this effort to enhance accessibility, several critical gaps in the infrastructure and service delivery were observed during the visit, which require immediate attention.

14. NATIONAL ORAL HEALTH PROGRAMME (NOHP)

- Dental services were available in all states, primarily at the secondary level, but only basic care was provided, with no access to dental X-rays. Most states had vacant dental hygienist posts, except for Chhattisgarh and Haryana. Oral cancer screening and referral of suspected cases needed strengthening at secondary care facilities. In Jammu & Kashmir, Dentists were positioned at secondary care facilities; however free of cost services were not provided for all dental services.

15. NATIONAL TOBACCO CONTROL PROGRAMME (NTCP)

- All states had district Tobacco Cells, but COTPA implementation was stricter in Chhattisgarh and Jharkhand. Regular awareness campaigns needed strengthening at the community level for effective program implementation.

16. NATIONAL MENTAL HEALTH PROGRAMME (NMHP)

- The District Mental Health Programme was not fully functional in most states except Karnataka, where proper patient follow-up and psychiatrist availability at DH were ensured. The Tele-MANAS platform remained underutilized due to low awareness and accessibility, except in Karnataka. In Chhattisgarh, targeted interventions were conducted every Friday, with a trained staff nurse providing counseling, mainly for substance abuse (alcohol) and exam-related stress and anxiety.

17. NATIONAL PROGRAMME FOR PALLIATIVE CARE (NPPC)

- The programme was not effectively implemented, with limited knowledge and awareness among healthcare workers across the observed facilities. No separate palliative care wards were available, though designated IPD beds were assigned.
- In Madhya Pradesh, an online platform was developed for rehabilitation and nursing services, and state-level staff training was conducted. Some CHCs and SDHs had round-the-clock availability of painkillers, including Tramadol, but dedicated palliative care counselling services were lacking, relying instead on doctors and nursing staff.

18. NATIONAL VIRAL HEPATITIS CONTROL PROGRAMME (NVHCP)

- Facility staff had low Hepatitis B vaccination coverage in most of the states except Rajasthan and Chhattisgarh.
- Screening and follow-up for Hepatitis B among pregnant mothers were inadequate in multiple states, with positive cases referred to DH/SDH for delivery.
- Chhattisgarh had a treatment center at the district hospital with HBsAg testing and antiviral drugs, while Madhya Pradesh offered HBV/HCV testing, treatment, and follow-up.
- In Chhattisgarh and Rajasthan, biomarker and viral load samples were sent to medical colleges for testing.

19. NATIONAL PROGRAMME FOR PREVENTION AND CONTROL OF NON-COMMUNICABLE DISEASES (NP-NCD)

- NCD clinics were functional in most states, actively screening for diabetes and hypertension, but patient follow-up was poor. Comprehensive cancer screening was largely unavailable, except in Chhattisgarh, Haryana, Mizoram, and West Bengal, where cervical cancer screening was limited to secondary-level facilities. Rajasthan and Haryana demonstrated good coordination between NOHP and NP-NCD for oral cancer screening and treatment. The NP-NCD portal was not functioning well in most states, with no real-time data entry.
- While Hypertension and Diabetes screening was reported across most of the states, screening of cancers is yet to be initiated as envisaged. Role of NCD clinics in population-based screening was also missing, where there was no follow up mechanisms observed across states. Continuum of care approach is yet to be established in NCD care.

20. NATIONAL RABIES CONTROL PROGRAMME (NRCP):

- In Rajasthan and Assam, Anti-Rabies Vaccine (ARV) was available at PHCs and above, while Anti-Rabies Immunoglobulin (ARIG) was administered at CHCs and higher facilities.
- Madhya Pradesh faced a shortage of Anti-Rabies Vaccine. IEC on rabies prevention was inadequate in most states. Healthcare providers had knowledge gaps in managing animal bites.

21. NATIONAL VECTOR BORNE DISEASE CONTROL PROGRAMME (NVBDGP):

- The program was effectively implemented in malaria-endemic areas of Madhya Pradesh, Mizoram, and Jharkhand, with no reported deaths from malaria or dengue.
- Annual prevention calendars and dedicated response teams were in place. Regular screening for malaria, chikungunya, and dengue was conducted in most endemic states. However, in West Bengal, documentation related challenges were observed i.e. poor record maintenance and unavailability of micro plans..

22. OTHERS

- The National AIDS Control Programme was available at secondary care facilities, with treatment at district hospitals and referrals for positive pregnant women. The NACP data portal was not fully functional in most states, and post-exposure prophylaxis medicines were reported unavailable in Gujarat. In Arunachal Pradesh, OST for IDUs was provided at the district level, and awareness and testing for vulnerable groups were conducted. However, the ART centre at DH was non-functional.
- Iodine testing services were conducted in endemic areas of Jharkhand under the National Iodine

Deficiency Disorders Control Programme (NIDDCP), but other components were not implemented, and IEC efforts were insufficient.

- Under the National Programme for Prevention and Control of Fluorosis, water testing for fluoride levels was conducted in Chhattisgarh, Jharkhand, and Uttar Pradesh, but further measures were needed.
- The National Programme for Prevention and Control of Deafness was effectively implemented in Karnataka, with ENT surgeries being conducted. However, staff training on early identification of deafness was inadequate.
- Under the National Sickle Cell Anaemia Elimination Mission, Odisha implemented mixed screening methods, established prenatal diagnosis centres, and provided hydroxyurea treatment. Karnataka lagged in screening due to a shortage of test kits, while West Bengal had screening mechanisms at both primary and secondary levels.



KEY RECOMMENDATIONS

- Ensure uninterrupted contraceptive availability through efficient stock management while expanding and implementing initiatives like Saas Bahu Sammelans and Saarthi Vehicles to improve accessibility and awareness.
- Strengthening of midwifery-led care units, improved infection control in labor rooms, and addressal of high C-section rates through regular audits and skill-building for emergency LSCS is required.
- States/UT to enhance newborn care training for healthcare staff, ensure robust cold chain management, and improve AEFI reporting mechanisms to strengthen immunization safety.
- Optimization of AFHCs with proper staffing and privacy, expansion of peer education programs is needed. Targeted interventions to be undertaken to address the rising burden of adolescent NCDs.
- To strengthen TB elimination efforts, DBT payments needs to be streamlined through Nikshay, ensure proper follow-up of sputum tests, and enhance access to diagnostics such as CBNAAT and X-rays for early detection and treatment.
- The states should ensure monitoring of PMNDP program activities to ensure effective implementation of dialysis services. a dedicated Nodal Officer at the State and District level may be identified with assigned responsibility to undertake periodic reviews and ensure that PMNDP portal is updated regularly.
- The District Mental health programme needs to be implemented with decentralization of diagnostic facilities. All Antipsychotic drugs need to be stored and dispensed as per the recommended

guidelines. IEC activities in local language should be undertaken. Tele MANAS Toll-free number must be displaced across the health facilities.

- The state need to Strengthen mechanisms for regular monitoring and supervision of NACP activities, including active case finding, follow-up of HIV-positive individuals, and ensuring continuity of care at the district level.
- Elderly and Palliative care to be strengthened across facilities, including capacity building of healthcare workers. Monthly Shivar and provision of Rs.5000/AAM/month shall be leveraged for mobilization of specialist for consultation in elderly care and other services. All district hospitals need to have palliative care centers and Morphine availability to ensure seamless pain management.
- The states need to be ensure that facilities are made Elderly/ especially abled friendly in line with IPHS guidelines. Programme needs to cascade down with decentralized services to reduce OOPE and ensure optimum Health care seeking by the elderly. screening camps for elderly at the community level in remote and difficult to reach areas should be organized focusing on geriatric care.
- The physiotherapy units at the healthcare facilities need to have Digital Physiotherapy machines than the manual machines to provide better services as well as advance care to the patients also saving the time of the staff to cater to more patients.
- The states to ensure Stringent implementation of COTPA act 2003 especially focusing on child related sections. More awareness among the tribal people for the ill effect of tobacco through wellness activities, community based platforms and school level activities need to be undertaken.
- Dental care services needs to be ensured across the secondary care facilities with functional equipment and skilled HR.
- To strengthen the implementation of the NCD programme the state should ensure screening of all population 30 years and above. Patient cards should be provided to each patient to facilitate treatment and follow-up care. A robust referral and tracking system should be established to ensure that patients diagnosed with complications during screenings are referred promptly to higher-level facilities. Use of NP-NCD Portal should be ensured for follow-up and tracking.
- Comprehensive Cancer screening under the NCD programme is to be ensured across facilities.
- The states should strengthen Case based surveillance for vector borne diseases in the endemic areas.
- States need to effectively implement the relevant components of National Programme for Climate change and Human health.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH:

a. RMNCH+A

- Labour rooms had essential equipment, drugs, and birth companion policies, but LDR concepts and midwifery-led care units were missing. Safe delivery checklists and partographs were being used at the facilities.
- High C-section rates (25%) were observed. Under the CM Arogya Yojana, Rs. 11,000 were provided for LSCS deliveries. Few of the facilities were SUMAN notified. Abortion services in the state are inconsistent and not regularly available.
- NBSUs were functional but lacked ventilatory support, triaging, and follow-up care for discharged newborns. Mothers had a designated ward to stay in NBSU.
- NBCCs were functional, but essential arrangements like newborn trays, resuscitation protocols,

and KMC facilities were missing. Staff lacked training in NSSK and IMNCI but demonstrated essential newborn care skills.

- SNCU were available but not constructed as per guidelines. Newborn death audit was conducted, but records or minutes were not maintained. Also, details were not uploaded to the MPCDSR portal.
- Screening for SAM and anemia was inadequate, and IFA syrup and tablets were unavailable. Facilities were equipped with digital hemoglobinometers and Vitamin A. Also, the staff needed training in IYCF, MAA, AMB. NRC at DH Longding was non-functional due to HR shortages.
- Mobile Health Teams were active but faced logistical challenges due to inadequate transport and accommodation funds. Screening for birth defects and developmental delays was satisfactory, with effective referral mechanisms.
- DEIC at Longding was functional and operated well with good referral mechanism and follow up in place. However, DEIC was absent in West Siang.
- MDR was conducted with records maintained but not uploaded to the MDSR portal. Child death investigations were carried out, but ASHAs and ANMs lacked awareness of CDR notification procedures.
- RKSK program was implemented in 6 districts across the state. DH Longding had a functional AFHC clinic.

b. NTEP

- NAAT available; drug-resistant cases were being referred due to inadequate facilities. Limited availability of IEC. 33 Panchayats in West Siang were recognized as 'TB Mukta Panchayats' in 2023.

c. NLEP

- Surveillance was ongoing for seven cases; one active under treatment. Nikusht 2.0, Nikusht Aushadi operational. SPARSH campaign was conducted, but IEC was lacking, and rehabilitation services were partially available.

d. NPCBVI

- Services were inconsistent due to the irregular availability of an Ophthalmologist, with OPDs managed by optometrists and two nurses in the absence. Cataract surgeries were being performed, but the supply of free spectacles was inadequate, as state-procured stock had been unavailable for the past 1–2 months.

e. NPHCE

- Under this program, physiotherapy services were provided to the elderly patients at DH Aalo (West Siang).

f. PMNDP

- The services were operated on a PPP model in the state. The PMNDP portal usage was around 84%.
- In West Sing District (DH Aalo) the HD center had 03 machines while these were missing in Longding district. Monthly water endotoxin checks, and



quarterly viral marker assessments were not conducted as required. The remaining 16 districts had no dialysis centers and were linked with the existing functional units.

- The state had an MoU with Sir Ganga Ram Hospital, New Delhi for review of dialysis patients, training and assistance in renal transplant which is a novel concept.

g. NOHP

- The district hospitals, and CHCs had dental surgeons and functional dental chairs. However, the services were not free.

h. NPCCHH

- Under the program, the District Environment Health Task Force was created and all health facilities had designated Nodal Officers for Climate Change.
- Training had been provided to Medical Officers (MOs) on diagnosing and managing Heat-Related Illnesses (HRI) and Acute Respiratory Infections (ARI), including surveillance.
- In terms of Green Climate Resilient health facilities, 65 out of 205 PHCs, CHCs, and DHs had solar panels, 119 had replaced non-LED lights with LED, and 55 had rainwater harvesting structures.



i. NTCP

- The state faces challenges with alcohol, substance abuse, and tobacco-related health problems. To address this, State Tobacco Control Enforcement Committees had been formed. Regular IEC activities and awareness campaigns were conducted, especially in schools.

j. NPPCF

- The prevalence for Goiter and IDD was less than 1% in the state. Regular salt samples testing was being done in the state. Schools' surveys were conducted to screen for goiter. IEC activities to create awareness about the regular consumption of iodized salt in prevention and control of IDD was in place.

k. NMHP

- The service was not satisfactory. DMHP was functional in only five districts in the state. While the state had set up a TELEMANS cell, its awareness was reported very low.

l. NPNCD

- Oral cancer screening or clinical breast examination was not being done at the DH due to unavailability of specialist. Screening camps were conducted once a month. No Cardiac Care Unit was established.

m. Others

- Under the National AIDS Control Programme (NACP), provisions for Opioid Substitution Therapy (OST) for Injecting Drug Users (IDUs) were available at the district level, along with regular awareness and testing initiatives targeting vulnerable groups such as TB patients and IDUs. Project staff also conducted home visits to People Living with HIV (PLHIV) to ensure continued care. However, there were gaps in service delivery, including the non-functional ART center at DH Aalo and the lack of an operational data portal for NACP at both CHC and DH levels. The need for establishing ART and Link ART centers at these facilities was identified to strengthen HIV care and treatment services.
- Under the National Rabies Control Program (NRCP), the district health teams conducted mass awareness campaigns on rabies, dog bites, and their prevention and treatment. Despite these efforts, critical gaps in the availability of essential medical supplies were observed, as both the anti-rabies vaccine and rabies immunoglobulin were either unavailable or out of stock at the CHC and DH in the West Siang district. Addressing these shortages is essential to ensuring timely and effective rabies treatment.

ASSAM**a. Family planning and abortion services**

- At the District Hospital, uptake of contraceptive methods like Antara injections had improved, though follow-up compliance remains low.
- PPIUCD and PAIUCD insertions were underutilized across all facilities. Laparoscopic sterilization services was limited to camp-based approach performed by external surgeons. The rate of PPIUCD insertions was approximately 30%.
- Comprehensive abortion services were available at the District Hospital, offering MMA, MVA, and D&C.

b. Maternal Health

- The visited District and Civil Hospitals were LaQshya certified as well as SUMAN notified, and were equipped with a fully functional labor room, and NBSU. Antenatal and postnatal wards were also observed as well-maintained. Post partum stays adhered to recommended durations—48 hours for normal deliveries and five days for caesarean section but was not being followed at SDH.
- The knowledge of the labor room staff on AMTSL, newborn resuscitation, and other emergency services was satisfactory.
- OT at the visited CHC was non-functional due to lack of trained specialists. Gaps in staff training, particularly in ultrasound use and emergency obstetric care, were observed across all centers.
- PMSMA services were being offered on the 9th day of each month, with an average attendance

of 25-30 patients per month.

- Free ultrasonography services were provided through in-house facilities.

c. Child Health

- Districts were equipped with SNCU staffed by trained personnel. NBSU in both the districts were non-operational attributed to absence of trained MOs and pediatric specialists.
- RBSK screening for all new-Borns was conducted prior to their discharge from the SNCUs in each district. DEIC was nonfunctional in one of the districts.

d. Child Nutrition

- Well-equipped NRC was observed as functional in the state. However, challenges like low bed occupancy rate, non-mobilization of SAM children by MHTs, the absence of a Nutritionist-cum-Counsellor, and poor post discharge follow-up were reported as implementation challenges.

e. Adolescent Health:

- AFHC was operational at DH. Services including IEC materials, school visits, and outreach on topics like nutrition, substance abuse, and high-risk behaviors were being provided. Most walk-ins' cases involved cases of teenage pregnancies.

f. NPHCE

- The program had not been initiated at any level in the district, including the District Hospital, CHCs, or SDHs. Geriatric clinics and wards were either non-existent or inactive across the healthcare facilities visited.

g. PMNDP

- Services were delivered through a PPP mode with Apollo Hospitals, ensuring free drugs and diagnostic services for dialysis patients. The dialysis facility at the District Hospital, Kaimur, was found to be satisfactory, providing essential treatment free of cost.

h. NOHP

- Dental specialists and facilities were available at the CHC level. However, the uptake and utilization of services remained limited, highlighting the need for improved awareness and accessibility.

i. NMHP

- Mental health services were available only at the District Hospital with limited capacity. The position of a psychiatrist remained vacant, leading to a lack of specialized mental health care. The Tele-MANAS platform was underutilized, indicating gaps in awareness and accessibility. There was a need to expand mental health services to the block and community levels to improve access.

j. NVHCP

- Screening for viral hepatitis was available only at the District Hospital. The vaccination status of facility staff against Hepatitis B was poor. Coverage for Hepatitis B screening among pregnant mothers was limited, with inadequate follow-up, highlighting the need for strengthened maternal screening and care.

k. NPNCD

- NCD clinics were operational at the District Hospital, CHCs, and SDHs for screening and managing diabetes and hypertension. However, patient follow-up was poor. Identified NCD patients were provided with a minimum one-month supply of free drugs, ensuring basic continuity of care.

Screening for oral, breast, and cervical cancers was not observed at the visited facilities, indicating gaps in comprehensive cancer screening. IEC materials related to NCD programs were adequately available.

BIHAR

a. Family Planning

- At the District Hospital, uptake of contraceptive methods like Antara injections had improved, though follow-up compliance remains low.
- PPIUCD and PAIUCD insertions were underutilized across all facilities. Laparoscopic sterilization services was limited to camp-based approach performed by external surgeons. The rate of PPIUCD insertions was approximately 30%.
- Comprehensive abortion services were available at the District Hospital, offering MMA, MVA, and D&C.

b. Maternal Health

- Institutional deliveries were being conducted at DH and CHCs. However, a significant number of home deliveries were reported.
- Gaps were apparent in tracking of HRPs with no well-defined plan for systematic management of HRPs.
- Issues were reported with delayed ANC care attributed to delayed ANC registration, incomplete MCP cards.
- PMSMA was being conducted at DH, SDHs, and CHCs. JSY and JSSK payments were reported to be made on time across facilities.

c. Child Health

- Routine immunization services were regular, model immunization center operational at CHC.
- Significant gaps observed in growth monitoring across facilities.
- DEIC was nonfunctional in the districts visited. Coverage and the quality of RBSK facilities need to be monitored.
- NRC was underutilized with an average bed occupancy of 20%.

d. Universal Immunization Program

- Effectively implemented across the assessed facilities with well-trained staff. Micro plan and logistics were adequately available, and consistent updates on eVIN. Cold chain equipment was available and functional, with regular temperature monitoring.
- Lack of awareness about (AEFI) was observed and AEFI registers were either unavailable or not updated.

e. Adolescent Health

- AFHC- Yuva clinic, was nonfunctional at the assessed facility. The School Health Programme (SHP) under Ayushman Bharat was not seen to be implemented in the district.

f. NTEP

- CB-NAAT was available at CHCs.
- While Direct Benefit Transfer (DBT) payments for tuberculosis patients were being processed,

gaps were noted in the timeliness of DBT disbursements and the universalization of DBT.

- The drugs were available and timely dispensed to patients. However, follow up sputum examinations were inconsistent, TPT was lacking, inconsistent home visits by STS were identified as gaps.

g. NPHCE

- The program had not been initiated at any level in the district, including the District Hospital, Community Health Centres (CHCs), or Sub-District Hospitals (SDHs). Geriatric clinics and wards were either non-existent or inactive across the healthcare facilities visited.

h. PMNDP

- The dialysis facility available at the District Hospital, Kaimur, was found to be satisfactory. Free-of-cost services were available for patients, ensuring access to essential dialysis care.

i. NOHP

- Dental specialists and facilities were available at the CHC level. However, the uptake and utilization of these services remained limited, highlighting the need for improved awareness and accessibility.

j. NMHP

- Mental health services were available only at the District Hospital with limited capacity. The position of a psychiatrist remained vacant, leading to a lack of specialized mental health care. Additionally, the Tele-MANAS platform for mental health support was underutilized, indicating gaps in awareness and accessibility for mental health consultations. There was a need to expand mental health services to the block and community levels to improve access.

k. NVHCP

- Screening for viral hepatitis was available only at the District Hospital. The vaccination status of facility staff against Hepatitis B was poor. Coverage for Hepatitis B screening among pregnant mothers was limited, with inadequate follow-up, highlighting the need for strengthened maternal screening and care.

l. NPNCD

- NCD clinics were operational at the District Hospital, CHCs, and SDHs for the screening and management of diabetes and hypertension. However, patient follow-up was poor. Identified NCD patients were provided with a minimum one-month supply of free drugs, ensuring basic continuity of care. Screening for oral, breast, and cervical cancers was not observed at the visited facilities, indicating gaps in comprehensive cancer screening programs. Information, Education, and Communication (IEC) materials related to NCD programs were adequately available at the facilities visited.

CHHATTISGARH

a. Family Planning:

- Eligible couple registers were maintained, and a basket of contraceptive choices was available at all levels.
- Most MOs and staff nurses were trained in PPIUCD/IUCD, but retention of PPIUCD need improvement. Fixed-day sterilization was unavailable in some districts, and NSV, minilap, and interval IUCD kits were lacking due to provider shortages.
- IEC materials were missing in key areas, though FP corners and condom boxes were in place, and community awareness was good, with concerns about teenage pregnancies in tribal areas. Newer

contraceptives like Chhaya and Inj. Antara need better promotion.

- Medical abortion was provided, but USG services from private facilities were observed as main reason for beneficiaries incurring OOPE. MVA/EVA were found underutilized, and second-trimester MTP was unavailable due to unavailability of gynaecologist.

b. Maternal Health:

- HRP list was not shared with PHC/CHC, leading to poor tracking and ANC services. Essential maternity services, including counselling, KMC, and respectful care, birth companion, were being provided at facilities.. Partograph was available at most facilities, but safe birth checklist was not observed across all facilities. PMSMA was being conducted on the 9th and 24th of every month.
- 51/222 facilities were SUMAN notified. USG services were limited, thus causing OOPE for beneficiaries. There was a felt need for strengthening of intra-facility monitoring.
- MDSR committees were formed, and reviews were being conducted but there was no action plan being developed. MPCDSR portal was not being used for MDR.
- JSSK was well implemented with entitlements displayed, but grievance redressal was found lacking; JSY payments were regular but occasionally reported as being delayed, primarily due to missing documents.

c. Child Health:

- HBNC & HBYC visits were conducted by (ASHA) Mitani, and NBCC was functional at all delivery points with necessary equipment. NBSU was operational at CHCs but has poor admission rates due to a lack of dedicated staff, while the DH NBSU needs upgrading to an SNCU. SNCU in DH Jashpur functions with trained staff but does not qualify for MusQan due to its location away from maternal wing. No DEIC at district hospital.
- NRCs had high bed occupancy, but retaining SAM children for full recovery was a challenge, and follow-up was poor. Although AIIMS Raipur served as a Centre of Excellence for Nutrition, but the state did not have a dedicated paediatric Centre of Excellence.
- Many SNs in labour rooms lack training in SBA, DAKSHTA, NSSK, and resuscitation protocols, affecting newborn care. Knowledge gaps existed in AMTSL, PPH, and eclampsia management. Pediatricians were absent in NBSUs, and some dedicated staff lacked training.
- Comprehensive newborn screening was lacking at all delivery points.
- Child death reporting was poor, with underreporting in HMIS and MPCDSR compared to SRS estimates.

d. Immunization and Nutrition

- Immunization, cold chain, alternative vaccine delivery arrangements, training in AEFI and training through e-VIN was observed in visited districts.

e. NTEP

- TrueNAT machines and sputum microscopy were available at CHCs and DHs.
- Active TB case detection through MMUs was not observed. Facilities were actively using Ni-kshay Aushadhi

f. NLEP

- States had a high leprosy burden; district Gariyaband reported 44 cases, while Jashpur reported 4 patients under treatment.
- Cases were mainly diagnosed by NMA, MDT is adequate, 13 disability cases listed in Jashpur, and

4 eligible for RCS.

- Gariyaband's CHC Devbhog had a physiotherapy unit, while Jashpur reported patients being treated at facilities and severe cases being referred to RLTRI, Raipur after initial treatment.
- Case entries were done on Nikusth. IEC materials were well displayed at district and facility levels in both states.

g. NPCBVI

- Cataract and glaucoma treatment were being provided, but retinal disease, trachoma, and trauma care were lacking in the district.
- In Jashpur, an Ophthalmic Assistant manages cases under NPCBVI, with cataract detection done via basic vision tests. Slit-lamp examination is unavailable, and retinal issues are suspected based on history. Tonometry for glaucoma is available, but trauma care is limited to primary management. Weekly outreach camps screen for visual impairment.
- Separate registers were not being maintained for cataract blindness and visual impairment.

h. NPHCE

- The Siyan Jatan clinic was initiated by the state for elderly care every Wednesday. Physiotherapy units were functional; however, ramps and wheelchairs for elderly patients were unavailable. Medical Officers needed training in geriatric healthcare. RHOs periodically visited bedridden elderly patients at home, ensuring outreach services.

i. PMNDP

- Two dialysis units were operational—one at the District Hospital and another at the CHC in Devbhog. The bed occupancy rate was nearly 150%, indicating high demand for dialysis services.

j. NOHP

- Well-maintained dental units were available, but there was no provision for dental X-rays. The post of dental hygienist remained vacant in Jashpur. Services like root canals, fillings, extractions, scaling, and sterilization were provided at the District Hospital and CHC in Devbhog.

k. NPCCHH

- A state-level governing body was constituted, along with a multi-level task force and a state-level EHC. A district-level multi-sectoral task force was also formed. A mortality register was available at the center, but data on suspected case mortality and death line listing were missing. No training was provided on air pollution-related diseases, and no IEC materials were displayed on climate-related health risks such as heat strokes.

l. NTCP

- Compliance with COTPA was observed, with all healthcare facilities displaying "No Tobacco" and "Tobacco-Free Area" signage. State- and district-level coordination committees had been formed to ensure implementation.

m. NPPCF

- Devbhog block in Gariyaband was affected by high fluoride levels in drinking water, underscoring the need for mobilizing clean drinking water from alternative sources. Activities under the program were required to address fluorosis concerns.

n. NMHP

- District Mental Health Units were functional, and a counseling center was available. Targeted interventions were conducted every Friday, and one staff nurse was trained in counseling services. Most identified cases were related to substance abuse (alcohol), followed by stress and anxiety due to exams. However, the follow-up of identified patients was poor.

o. NPPC

- A dedicated OPD for palliative care was not available, but services were provided during regular OPD and emergency visits. Basic logistics were available, and staff nurses and medical officers counseled patients; however, none were trained in psychosocial interventions or psychoeducation. IPD beds were available for palliative care, but there was no separate ward.

p. NVHCP

- A treatment center was established at the District Hospital, where HBsAg testing and antiviral drugs were available. Biomarker and viral load samples were sent to Ambikapur Medical College for analysis. Immunoglobulin was unavailable at the District Hospital. Around 50% of the staff in Jashpur were vaccinated against Hepatitis B.

q. NPNCD

- In Gariyaband, the District Hospital had space for an NCD clinic and a daycare center, but no NAFLD interventions were observed, whereas in Jashpur, NAFLD interventions were present despite the absence of designated NCD clinic space. Under NCD-Plus, CHC Kansabel recently conducted NP-NCD screening for the entire population. Cervical cancer screening was available at the District Hospital.
- At the CHC level, NCD clinics lacked dedicated space, though diabetes and hypertension protocols were in place. The NP-NCD portal was present but faced technical issues. Jashpur had active health promotion activities, including IEC displays, tobacco cessation, and dietary modifications. STEMI and stroke cases were referred to the District Hospital, but there was no provision for chronic kidney disease management.

GUJARAT**a. Family Planning:**

- Comprehensive abortion care and fixed day sterilization services were provided at secondary-level facilities. However, NSV and MTP services were not provided at SDH despite available resources.

b. Maternal Health:

- Critical feedback loop for tracking High-Risk Pregnancies (HRP) existed, ensuring follow-up by PHCs, ANMs, and ASHAs.
- Well-functioning MLCU at DH Vadodara and SDH Mandvi; 254 out of 496 deliveries at DH conducted in MLCU.
- High patient load at district hospitals/medical colleges due to lack of 24x7 delivery points and preference for private facility was observed.
- Low night LSCS rate in Vadodara; 30% LSCS rate at SDH Mandvi, with more emergency than elective cases.
- Labour room at UCHC had infection control gaps, inadequate privacy, and lacked essential drugs like magnesium sulfate.

c. Child Health

- Critical feedback loop for tracking High-Risk Pregnancies (HRP) existed, ensuring follow-up by PHCs, ANMs, and ASHAs.
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d. NTEP

- TB patients were being admitted in the general ward of SDH- high risk of infection.

e. NPCBVI

- Optometrist unavailable at the SDH. Under-utilization of donated eyes resulted in decreased eye donation.

HARYANA**a. Family Planning:**

- Full basket of contraceptive choices available at DH and SDH, with occasional stock out of Inj. MPA & IUCD; sterilization services available at DH and SDH but not at CHC; low PPIUCD uptake at CHC.
- Separate area for abortion care, includes OPD and counselling room available at DH.
- Manual stock registers did not match FPLIMS data. IEC material were displayed at the facility.

b. Maternal Health

- SUMAN volunteer not identified, and USG lab services were limited to 9 AM - 3 PM at DH.
- PMSMA second round conducted on 10th/ 23rd of every month.
- HRP monitoring was actively conducted at SDH, while CHC lacked separate HRP line listing.
- Facilities followed safe birth protocols, including partograph use and essential drug administration.
- Maternal death audits were conducted as per protocol, IEC materials were displayed, but awareness of SUMAN remained low.

c. Child Health

- Pediatrician unavailable; NBCC functional with round-the-clock nursing staff, but no private breastfeeding area or MusQan certification. IYCF-trained staff and a lactation management center were lacking, and Family Participatory Care services existed but were not well understood.
- Palwal reported 263 child deaths (Apr–Oct 2024), but CDSR audit details were missing, though maternal and child death audits were conducted at all facilities.

d. Universal Immunization Program

- Staff demonstrated good awareness of immunization protocols, vaccine handling, and cold chain management, with regular UWIN and EVIN entries.
- Birth doses were provided, and vaccines were verified per VVM checks, but unopened and opened vials were stored together. AEFI registers and kits were available, but staff lacked training on proper documentation.
- SDH administered Td vaccines to 13,073 adolescents, while CHC Sondh functioned only as a storage point without outreach immunization.

e. Child Nutrition

- DH NRC had low occupancy (25%) and an 81% discharge rate with protocol gaps in diet, SAM treatment, and counselling.
- Staff shortages led to misutilization, and essential equipment and medicines were missing.

f. RBSK

- DH NRC had low occupancy (25%) and an 81% discharge rate with protocol gaps in diet, SAM treatment, and counselling.
- Staff shortages led to misutilization, and essential equipment and medicines were missing.

g. Adolescent Health

- District Adolescent Health Committee were not formed; AFHC clinic functional but lacks a female counselor.
- Essential supplies available, except sanitary pads. AFHC services absent at CHC and SDH.

h. NTEP

- CBNAAT machines were available but faced cartridge shortages. DH lacks a DRTB ward, referring patients to medical colleges.
- Chemoprophylaxis coverage is 58%, and 18 TB deaths were reported, but district-level analysis was missing.
- Treatment support centers operate weekly, with updated Nikshay records, though adverse events were not documented. Digital X-ray films were not provided to patients.

i. NLEP

- Leprosy cases dropped from 21 last year to 8 (all multibacillary) in 2024-25.
- Slit Skin Smear testing was available at DH. No PEP was administered in the community. All 2023-24 patients completed treatment, with most cases referred via CBAC by ASHAs through MOs in PHCs.

j. NPCBVI

- The Ophthalmology Department handled 170-180 OPD cases daily. It collaborates with RBSK for refraction and squint screening.
- Cataract was the most common surgery. Cashless cataract surgeries were available at Prabha and ABLE Charitable Hospitals, while complex cases were referred to tertiary centers.
- From Jan-Oct 2024, 2602 children were screened, 1103 had refractive errors, and 259 received free glasses, along with 677 presbyopic patients.

k. NPHCE

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l. PMNDP

- Dialysis services were outsourced, and separate dialyzers were maintained for sero-positive patients. Essential records and water quality parameters were well-maintained.

m. NOHP

- Dental facilities were operational with dental surgeons and hygienists providing preventive counseling. Coordination between NOHP and NP-NCD for oral cancer screening was effective.

n. NPCCHH

- The state had respiratory specialists and climate-related response equipment, but the DH team was unaware of the governing body, task force, or environmental health cell. IEC materials were not displayed.

o. NTCP

- The tobacco cessation center was functional at DH Palwal, managed by a psychiatrist and clinical psychologist. Poor follow-up due to psychologists' outreach work. Tobacco-Free Educational Institutions (ToFEI) was implemented.

p. NMHP

- DMHP was not fully functional. Basic psychotropic drugs were available, but IEC activities were inadequate, and staff were unaware of the TeleManas helpline.

q. NPPC

- Implemented only in DH Bharatpur, with IPD beds available. Morphine and Tramadol were stored securely, but no home-based palliative care was provided.

r. NVHCP

- Positive patients were referred to tertiary care for treatment due to a lack of physicians at DH. Viral load tests were outsourced, and HBsAg screening was conducted during antenatal visits. HBIG was unavailable at secondary care levels.

s. NP-NCD

- NCD clinics screened for diabetes, hypertension, and cancers, but stroke, NAFLD, and CKD screenings were not conducted. Data entry on the NP-NCD portal was not in real-time, and a patient follow-up mechanism was lacking.

HIMACHAL PRADESH**a. Family planning**

- At CHC: Interval IUCD insertion was done by ANMs, but facility registers were missing.
- DH provided MTP and family planning services, including tubal ligation. DH Shimla offered family planning services, counseling in ANC, PNC wards, and the labor room. Spacing methods and a condom box were available, but the latter was not placed in a visible, accessible area. Family

planning registers were maintained, and MTP, tubal ligation and NSV were conducted.

b. Maternal health

- ANC registrations were recorded monthly in MCH registers only on PMSMA days (9th of every month); others were registered in general OPD.
- Civil Hospital Tuna Devi was declared a delivery point but had a very low caseload (Aug: 4, Sep: 0, Oct: 1), with most preferring medical colleges. No gynecologists were posted in Civil Hospitals/ CHCs in Hamirpur; normal deliveries were conducted by Medical Officers. CHCs primarily conduct normal deliveries, largely managed by midwives.
- Labour room and maternity OT in the visited district hospital were LaQshya certified. DH had a dedicated MCH wing and conducted 15-20 deliveries daily, with 25-30% C-sections. Privacy concerns were observed, with pregnant women waiting in the veranda and twin bed-sharing due to space constraints. DH entertained birth companion policy under Respectful Maternity Care, but no SUMAN activities had been undertaken.
- Air-lifting services were available for emergency deliveries. DH lacks services for CLMC, MAA, IYCF, and NRC. At CHC, staff was not oriented to the basic MCH and other national programs.
- No MDR or CDR reviews had been conducted in recent years, though a committee exists.
- High risk pregnancies were being monitored monthly on a fixed date and on the other DH, they were being referred to IGMCH.
- Early initiation of breastfeeding within an hour of delivery was practiced, with limited IEC material displayed.
- MO and Staff Nurse had not gone through Dakshata training and midwifery had not taken SBA training since last 10-12 years.

c. Child health

- Newborn Care Corners (NBCC) existed only in DHs; other facilities only have warmers in OT.
- DH Shimla's SNCU was under construction, currently functioning as an NBSU with limited equipment and only two pediatricians. Critical newborns were referred to IGMCH or Kamla Nehru Hospital.
- Pediatric and neonatal ICUs were unavailable at DH Shimla.
- Routine vaccination services were well-managed, including for migrant and left-out children, though some records were missing due to a lack of Aadhaar-linked phone numbers.
- Cold chain maintenance was in place, but one deep freezer was non-functional due to expired maintenance contracts.
- NRCs were functional in the state.

d. Adolescent health

- Nayi Disha Kendra (NDK) served as an Adolescent Friendly Health Clinic, well-equipped with a medical officer, junior psychiatric resident, counselor, medical social worker, and IEC materials.
- Free condoms, sanitary napkins, and a private washroom facility were available. Cases were referred from OPD, schools, colleges, and Anganwadi centers.
- CHCs under RSKS conducted monthly Adolescent Health (AH) Days, including WIFS distribution, HB and sugar testing, and awareness sessions on tobacco use.
- TD vaccines were administered in schools under the supervision of lady health supervisors.

e. RBSK

- The district lacks a District Early Intervention Centre (DEIC) as per norms. RBSK-MHT in CHC conducted routine screenings in Anganwadis (156) and schools (151), referring 4D cases to IGMCH. Data was updated on the RBSK portal and recorded in screening and referral registers.

f. NTEP

- The Program is well-implemented, with notable practices like cough-syrup surveillance and routine TB testing in IPD. DOTS is provided weekly by pharmacists.
- IEC materials are sufficient. Sample transport for TrueNAT/CBNAAT is managed by ASHAs, health workers, and postal services. Fast-tracking of TB Patients using special cards was being practiced at DH Shimla.

g. PMNDP

- Services were operational through PPP-mode at DH Hamirpur free of cost to the BPL beneficiaries and other through HIM CARE state insurance scheme. All the patient's data was recorded on the PMNDP portal.
- The Nephrologist visited the centre on a monthly basis as well as being available through tele-consultation. However Peritoneal dialysis services were not available at DH

JAMMU AND KASHMIR**a. Family Planning**

- Basket of choice and sterilization services available. PPIUCD was promoted but acceptance was low.
- MTP services were present.

b. Maternal Health

- Maternal & Child health audit and review meetings were not being conducted at DH level.
- Comprehensive lactation management centers were non-functional.

c. Child Health and Nutrition

- NRC was not established, and child malnutrition management was done by paediatrician. Intensive SAM services were not available.
- DEIC was Functional with adequate staff availability.

d. NPHCE

- The state is having a separate Elderly Care Ward with dedicated IPD beds. In addition, a separate Palliative Care Ward is available with dedicated beds though palliative care services were not available. Trauma and Burn Injuries: services are available and treated in DH.

e. NHMP

- Under MHCA Act, 2017, J&K has notified The State mental Health Rules. Formation of State Mental Health Authority and Mental Health Review Boards not done yet. Proposal is submitted to the government.

f. NPNCD

- Under NPPCD, Programme is operational but due to limited equipment surgeries are not being done. Screening camps at field level are not conducted. Audiometry services are present. Hearing aid is prescribed.

JHARKHAND

a. Family Planning

- Basket of choice available. However, privacy concerns, such as open placement of condom boxes were observed. Willingness for sterilization remained low. Certain contraceptive options, including PPIUCD and permanent methods, were not consistently discussed or offered.
- Gaps in record-keeping, stock management, and follow-up care were noted, particularly for programs like Antara, PPIUCD, IUCD, and Chhaya, while the absence of job aids and the Sugam model affected the quality of counseling.

b. Maternal Health

- Line listings of HRPDs were available. No evidence of follow-up during ANC and PNC visits. E-PMSMA camps were not conducted.
- Gaps included: Inadequate antenatal care, poor documentation, MCP card not updated, essential tests were not being conducted, and severe shortages of essential supplements like IFA and calcium due to supply chain delays. High-risk pregnancy follow-ups and structured birth planning were lacking.
- Labor room monitoring was weak, with partographs and Safe Childbirth Checklists missing or improperly used, and essential labor management equipment either unavailable or non-functional. Privacy violations during labor, lack of birth companion counseling, and poor staff knowledge on labor complications further compromised maternal care.
- Despite specialist availability, essential services like C-sections and IUCD insertions were not provided. Additionally, the MPCDSR system was ineffective, with no proper maternal and perinatal death reviews conducted, leaving critical cases unaddressed.
- Labor rooms and OTs lacked infection control measures, zoning, and microbiological surveillance, posing high infection risks for mothers and newborns.
- High rates of C-sections and inadequate training for labor management staff.

c. Child Health

- Newborn care services were inadequate, with a lack of breastfeeding support, poor resuscitation knowledge, and shortages of essential equipment.
- NBSUs and NBCCs were either non-functional or lacked necessary facilities, impacting immediate newborn care.
- Essential newborn screenings, IEC materials, and follow-up mechanisms for SNCU-discharged newborns were absent.
- DEIC facilities were underutilized, functioning as parallel pediatric OPDs rather than referral centers for RBSK cases, with inadequate physiotherapy and specialized psychological services. Staffing shortages and incorrect portal entries further compromised service delivery.

d. Immunization

- Immunization services were generally well-managed with proper vaccine storage, temperature monitoring, and adherence to the open vial policy, but major gaps included poor AEFI management knowledge, lack of due lists, and missing AEFI registers.
- While the E-VIN system was functional, U-WIN system usage required further training.

e. Nutrition

- While NRCs were well-managed and functional as per guidelines, with knowledgeable professionals, critical WASH gaps, lack of room heaters, breastfeeding spaces, unhygienic food, and lack of proper therapeutic feeding was reported.

- Infection control was poor (rat stool found in kitchen), with inadequate mosquito nets in an endemic region. Admission, discharge, and follow-up protocols were weak, and staff required training in newborn care, resuscitation, and documentation.

f. Adolescent health

- High rate of teenage pregnancies, and anaemia was reported among adolescents despite IFA supplementation.
- Adolescent Friendly Health Clinics (AFHCs) were poorly implemented, underutilized, and lack community awareness

g. NTEP

- TB testing was conducted using AFB, and CBNAAT; CBNAAT was non-functional at some facilities.
- Most of the facilities had adequate availability of anti-TB drugs and well-trained lab professional.
- NIKSHAY updates were inconsistent in East Singhbhum but regularly maintained in Sahibgan.
- DBT of Rs. 500 was being provided to the beneficiaries.

h. NLEP

- Screening followed 3 cardinal signs, with SSS at district hospitals; drug kits were available, but treatment kits were dispensed from different facilities.
- LCDC (Sept 2024) detected more than 121 cases in districts, all under treatment.

i. NPCBVI

- At DH East Singhbhum, an eye specialist and ophthalmic assistant manage the program, but the specialist was underutilized, and no staff nurse is available in the eye ward. Poor follow-up mechanism for cataract surgery.
- Cataract surgeries were conducted locally, while complex cases were referred to tertiary centers, limiting the program's scope.
- At some facilities, ophthalmology services were provided by an optometrist and a medical officer, with the medical officer handling most OPD services.

j. NPHCE

- Limited to district hospitals with dedicated beds and a shared physiotherapy unit. Equipment remained unused due to space constraints.

k. PMNDP

- Dialysis services were available but lacked ABHA ID integration. Sahibganj hospital had only two machines in a damp facility, raising infection risks.

l. NOHP

- Basic dental services were available at the district hospital, but no X-ray facilities or CHC dental units existed.

m. NTCP

- Tobacco Cessation Centre was non-functional, but counseling and outreach activities were conducted. IEC materials were displayed.

n. NPPCF

- Fluorosis management funds in Pakur were undisbursed, and water testing records were unavailable.

o. NMHP

- Services were limited to a small OPD at the district hospital, with no inpatient care or CHC/PHC

services despite high patient loads.

p. NP-NCD

- NCD screening and referrals were functional, but specialist support and documentation were inadequate.

q. Others

- NVBDCP: Malaria and filariasis cases were detected, but outreach was inadequate. Hydrocoele surgeries lacked anesthetist oversight.
- Rabies Vaccination: Available with proper refrigeration and administration.
- Iodine Deficiency Disorders: IEC materials were available, but active implementation was lacking.

KARNATAKA

a. Family Planning

- Basket of choice available, but the Sugam model was absent, and IEC materials available but lacked creativity.
- Staff were trained in temporary and permanent family planning methods, with efficient service delivery and well-maintained follow-up records.
- Comprehensive Abortion Care was available with dedicated specialists and proper equipment, but post-abortion IUCD insertion was suboptimal due to gaps in provider training and awareness.

b. Maternal and Neonatal Health

- The maternal health infrastructure in secondary care facilities was well-developed, with a model LDR complex at CHC.
- Labour rooms were functional, well-equipped, and staffed, with birth companions allowed and beneficiaries expressing satisfaction. However, informal payments were reported resulting in OOPE.
- C-section rates were high (50-60%). Preference for elective C-sections were reported.
- Maternal death reviews were conducted, with most deaths linked to delayed referrals, particularly from Andhra Pradesh.

c. Child Health

- Newborn Care Corners with radiant warmers and trained staff were functional in all labor rooms. NBSU was nonfunctional in Ballari district despite available resources.
- 100% immunization coverage and adequate vaccine availability was reported. Adequate availability of vaccines and AEFI kits, and open vial policy was being followed.
- DEICs were well-coordinated with MHTs under RBSK, with essential HR in place. RBSK MHTs followed micro plans, regularly visiting schools and AWCs, and submitting reports.

d. Nutrition

- The NRC at VIMS Medical College was well-functioning, with 20 beds, an in-house kitchen, adherence to SoPs, and NHM-supported staff.
- Most tertiary care NRC admissions came from PICU, highlighting missed early detection of severe malnutrition in the community.
- The NRC at SDH Siruguppa lacked dedicated staff, a separate kitchen, and round-the-clock operations, leading to inadequate inpatient admissions.

e. Adolescent Health

- Functional Sneha Kendra (AFHCs) was well-equipped with commodities, records, and educational materials, with trained counselors providing AFHS-compliant services. Strong referral linkage to tertiary care but community linkages remained weak despite school visits.
- IEC displays and signages needed improvement at all levels.

f. NTEP

- DBT payments for TB patients were processed through Sewa Sindhu and Khajane 2, but lack integration with the Ni-Kshay portal, leading to non-updated payment records.
- Enrollment of Ni-Kshay Mitras under PMTB MBA had improved, though food support was only available for patients. Scope for improved usage of NAAT for diagnosis.

g. NPCBVI

- The state had 9 govt and 40 non-govt eye banks. Mobile ophthalmic units were operational in 28 districts with few having and tele-ophthalmology units. Collaborations involving medical colleges and NGOs for screening and free spectacle distribution were reported.
- Secondary care facilities provided basic ophthalmic care and cataract surgeries, with Ballari achieving over 8,500 of its 12,000 annual cataract surgery targets by October 2024.

h. IDSP

- Large number of Scrub typhus cases were reported in Dakshin Kannada.

MAHARASHTRA**a. Family Planning**

- Antara contraceptive had good community acceptance, with patients visiting CHC for all doses. CHC had a functional OT with two tables, used for tubectomy and emergency evacuations.

b. Maternal and Neonatal Health

- SUMAN certified labor room, and ICUs were absent- high referral of HRPs. Facility faces challenges with LaQshya certification due to low delivery numbers.
- Midwifery services were available at some facilities and birth companion allowed.
- NBSU existed at the facilities, but significant infrastructure gaps include the absence of ICU, SNCU, MNCU, and BSU at various facilities, leading to high referrals for high-risk pregnancies (HRPs) and neonatal care.
- A well-functioning Women and Child hospital was available in the state. Labour room and OT to certified under LaQshya or SUMAN although it fulfills the criteria adequately. IFA tablets were available along with Ferric Ammonium Citrate in the syrup form.
- Some facilities were FRUs but lack essential staff like obstetricians, pediatricians, and anesthetists, limiting their capacity to manage complicated cases.
- PMSMA was conducted on the 9th of every month.
- NRCs were operational with dedicated staff.
- Good practices include Hirkani Kaksha (breastfeeding rooms), renaming labor rooms to Navjaat Shishu Aagman Kaksh (labour room), Ayush gardens, IEC models for nutrition awareness, and regular LSCS/referral audits.

c. Child Health and RBSK

- The DEIC services were functional in observed districts. Infrastructure gaps existed like services split across floors without an elevator, making access difficult. Therapy units lack separate rooms, essential equipment, foam flooring, and a dedicated play area for children.
- Frequent visits for therapy added out-of-pocket expenses for families.
- Critical vacancies, including Optometrist, Audiologist, Speech Therapist, Pediatrician, and Data Entry Operator, affect the delivery of specialized services.
- Good practice: A child-friendly play area near the ANC room at SDH provided recreational space for children accompanying mothers for check-ups.

d. Adolescent Health

- Adolescent health issues were addressed every Monday at SDH by two counselors and support staff.
- Parents were more concerned about mobile addiction than academics.
- NCDs like diabetes and hypertension were emerging among adolescents. Yoga sessions were conducted for mental well-being.

e. NTEP

- True NAAT and tele-radiography units (PPP mode) were functional with short turnaround times. 100% TB cases were recorded in the Nikshay portal, and treatment adherence is manually monitored.
- DR-TB patient numbers had reduced; all previously diagnosed cases completed treatment. TB notification rate had improved, with 100% UDST and high Nikshay Poshan Yojana payouts.
- Best Practice: PDCA (Plan-Do-Check-Act) technique was used to improve private sector TB notification and TMP certification in Gram Panchayats.

f. NLEP

- KUSUM: Tribal area screening by ASHA

g. NPCBVI

- Limited diagnostic facilities at SDH, available only for cataracts and refractive errors. High success rate of cataract surgeries performed at government facilities was reported. IEC was displayed at the facilities.
- Regular ophthalmic outreach services, with RBSK aided school children.

MADHYA PRADESH**a. Family Planning**

- Basket of choice was available, sterilization and PPIUCD preferred over other modern contraceptives. Fixed-day sterilization services were available at the CHC.
- Staff had limited knowledge regarding MPA doses and side effects. Separate counselling rooms were unavailable. Discrepancies were observed in the PPIUCD and delivery registers.
- Incomplete Consent Forms and no training on documentation of DBT linked schemes.

b. Maternal Health

- Although basic facilities were available in the Labour Room, Infrastructure gaps persisted, including the absence of septic labor rooms, Obstetric ICUs, and proper sterilization practices. STPs were not followed in the LR.
- Registers were maintained, case sheets, partograph, Safe Birth Checklist, etc., were available. Equipment issues, such as non-functional ventilators and blood storage units, along with poor instrument sterilization and outdated labor tables, impact service quality.
- Delayed JSSK payments, and high out-of-pocket expenses for diagnostics were reported.
- BEmOC-trained MOs were unavailable. Deliveries carried out by staff nurses. Emergency LSCS rates were low.

c. Child health

- Key maternal and child health programs, including Dastak Abhiyan and SAANS, were being implemented with IEC materials and community-level campaigns, but gaps remained in pneumonia screening and newborn care services.
- While infrastructure such as DEIC, NRC, and NBCCs was available, underutilization, staff shortages, and equipment gaps like missing phototherapy machines and non-functional radiant warmers impacted service delivery.
- SAM child identification and newborn screening for birth defects were inadequate, with weak referral mechanisms and inconsistent reporting from primary and secondary healthcare facilities.
- RBSK services were affected by severe HR shortages, with only 23 out of 27 Mobile Health Teams functional.
- CDR meetings had been inactive for over a year, impacting data monitoring and quality

d. Universal Immunization Program

- The immunization wheel was being utilized by healthcare staff.
- The district vaccine store was well-managed with proper labeling and IEC materials, but a BCG vaccine shortage and lack of power backup for ILRs at facility levels were noted.
- Cold chain management was effective with digital monitoring via e-VIN. Real-time U-WIN entry was being done, though data entry faced delays due to Aadhaar-linked OTP issues.
- While staff were well-trained and implementing the Open Vial Policy, errors in injection technique and improper vaccine storage at session sites were observed.

e. Adolescent Health

- Umang Clinics designed with the theme 'Khul ke Puchho, Khul ke Jano' to encourage open conversations and awareness.
- Dedicated space, equipment and commodities, IEC present in the clinic, sanitary pad dispensation machine was functional.

f. NTEP

- TB drugs and sample transportation facilities were readily available.
- Delays in sample transport (2–12 hours) and lack of cold chain maintenance were observed, with only one sputum sample collected per patient and improper sterilization and packaging practices. Samples transported via NGO.
- Gaps in staff training, lack of awareness of guidelines, and issues in NIKSHAY ID creation led to disrupted sample collection and case tracking, affecting TB diagnosis and follow-up.

g. NLEP

- Leprosy diagnosis and MDT treatment were available with adequate drug supply, but disability management services needed strengthening.
- Suspected case identification was weak due to gaps in ANM and ASHA training, absence of suspect case registers, and lack of referrals from the field.
- Medical Officers lacked training and awareness of leprosy identification and treatment protocols.

h. NPCBVI

- The state effectively leveraged the PPP model for cataract surgeries, achieving high rankings in performance. Digital platforms like WhatsApp were utilized for IEC and consultations, enhancing outreach and coordination.
- While school-based eye care initiatives were well-maintained, challenges included a shortage of ophthalmic assistants and delays in equipment procurement.
- Also, diagnostic services for cataract, glaucoma, retinal diseases, and diabetic retinopathy were unavailable.

MIZORAM**a. Family Planning**

- Basket of choice available but sterilization services were limited to females with low uptake. Male participation is low.
- Staff were trained in IUCD insertion, PPIUCD, MPA injection, and contraceptive counselling, with counselling models and IEC materials well-maintained.
- Record-keeping for family planning services was systematic, though community-based contraceptive distribution and updated eligible couple registers were lacking.
- Comprehensive abortion care, including MTP services with necessary equipment and reporting formats, was functional at DH.

b. Maternal Health

- Four ANC coverage- 59%, 15% deliveries conducted at home. C-section and USG services available, partograph was being used.
- Maternal death reviews were being conducted.
- PMSMA days were not being observed, along with missing OBGYN and gynecological services at the CHC.

c. Child Health and RBSK

- No functional NBSU/ SNCU at CHC, hence cases were referred to DH.
- The state had functional DEIC in one of the observed districts offering therapy and screening.
- The RBSK program faced challenges in service delivery across the state due to gaps in infrastructure, specialist availability, and essential medicines, with some districts lacking functional DEICs and NRCs, leading to high rate of referrals to higher center.
- MHTs were functional but lack of systematic referral and treatment pathways limits the program's impact.
- Innovative approach: Annual visits to orphanages, care homes, and NGOs for 4D screenings.

d. NTEP

- Treatment supporters were being assigned to all the TB patients. No medical officer at DTC, and limited fund flow was affecting the smooth implementation of the NTEP program led to delays in service delivery, reagent supply, and honorarium payments for treatment supporters.
- The state had made progress in TB elimination, with 18 villages being declared TB-free, but monitoring gaps existed due to the absence of MOTCs at the block level.
- Sputum examination rates remained below the required threshold for the elimination phase, and TB preventive therapy coverage was low.

ODISHA**a. Family Planning and abortion care**

- Basket of choice available, with increased uptake of newer contraceptives like Antara and Chaya. Essential contraceptive supplies, including IUCD and PPIUCD kits, were available, but Minilap kits were missing.
- PPIUCD insertion rates were 10-15%, and fixed-day sterilization services were not observed at higher-level facilities.
- Family planning services had trained counselors, timely incentives, and well-maintained records with adequate counseling aids. Sugam model was displayed.
- Comprehensive Abortion Care was available with trained professionals. Medical boards were established to address pregnancies beyond 24 weeks.

b. Maternal Health

- High-risk pregnancies were tracked using an app, with HRP cards issued for regular monitoring to reduce maternal mortality with cases referred to medical colleges.
- Facilities were SUMAN-notified facilities providing services as per the citizen charter, with regular PMSMA sessions conducted.
- EmONC services aligned with MNH guidelines, with Kelly's pads used for blood loss measurement and well-maintained labor rooms stocked with essential drugs.
- LaQshya certification had been achieved in some facilities, birth companions were allowed in labor rooms, and partographs were maintained.
- Maternal death surveillance software was in use. Free JSSK entitlements were available.
- Under MAA program, ANM/Nurses/Doctors lacked training in lactation support and management, and Lactation Management Centers (CLMC/LMU) were partially available.

c. Child Health

- Kangaroo Mother Care (KMC) rooms and breastfeeding corners with adequate privacy were available, but not all healthcare workers were trained in KMC.
- SNCU had high occupancy and referrals to medical colleges, but no fixed criteria for referring sick newborns. Facilities were equipped with NBSUs, NBCCs, and essential equipment, with mothers receiving counseling on breastfeeding, danger signs, and KMC care.
- Free services for sick infants were provided under JSSK.
- The District Early Intervention Centre (DEIC) under RBSK offered adequate services with referrals to tertiary care for specialized treatment.

d. Universal Immunization Program

- The open vial policy was implemented across all facilities, with service providers knowledgeable about full immunization, AEFI, and vaccine logistics. Functional E-VIN machines were monitored by pharmacists. Frontline workers had access to immunization due lists.
- Vaccines were properly stored with VVM status and date/time markings, and District Task Forces on Immunization hold regular meetings.

e. Nutrition

- NRC was available with 80% and a recovery rate of more than 90%. The average stay was around 20 days, with an average weight gain of 5gms per kg body weight per day for three days before discharge. The NRC is well-equipped with adequate IEC materials.

f. Adolescent Health

- AFHCs (Sharda clinics) were operational. Equipped with trained medical officers and counselors, offering outreach services twice a week in schools and Anganwadi Centres (AWCs).
- A peer education programme was implemented. Free sanitary napkins were provided to adolescent girls.

g. NLEP

- Odisha's leprosy prevalence rate had declined with 14 districts achieving a rate below 1 and 20 districts maintaining a Grade 2 disability rate under 2%.
- Active case detection through campaigns and surveillance led to 8,396 new cases in 2023-24 and 3,143 up to September 2024, with Multi-Drug Therapy provided and 170 RCS surgeries conducted.
- Effective implementation of NLEP with case detection and beneficiaries receiving necessary treatments. Efforts were directed towards reducing stigma and raising awareness.

h. NPCBVI

- Outreach screening for cataract and refraction errors was being conducted with identified individuals referred to DH for further management.
- A total of 1610 cataract surgeries had been successfully conducted as of September 30, 2024, in the State.

RAJASTHAN**a. Family Planning**

- Basket of choice was available. Condom boxes were installed in OPD areas, privacy was ensured. Beneficiaries preferred Antara over Condoms and oral contraceptive. PPIUCD insertion and Male sterilization were found unsatisfactory.
- Staff were trained and informed about IUCDs and modern contraceptives. Laparoscopic services were provided with the help of private agencies.
- FPLMIS was being utilized for regular reporting.
- Abortion services, trained medical practitioners, and reporting formats were available.

b. Maternal Health

- Delivery caseload was well distributed across primary and secondary healthcare facilities, with

high-risk and complicated cases referred to higher centers. The number of C-sections was low due to infrastructure and trained HR constraints at CHC/SDH.

- ANC checkups were regularly conducted, with 82.08% of registered women receiving four checkups. High-risk pregnancies were identified and monitored, and PMSMA was organized in both districts. MAMTA card and Prasooti case Sheet (Admission Ticket) were being distributed.
- Facilities had adequate drugs, diagnostics, and essential supplies, including pregnancy testing kits, IFA tablets, and corticosteroids, with no stockouts reported. Partographs and safe birth checklists were used in labor rooms, but Midwifery Led Care Units were absent in district hospitals.
- The PMMVY scheme was being implemented. JSSK food services were good quality but insufficient quantity. Respectful maternal care was provided, including privacy, informed services, referral transport, and meal provision. Maternal death reviews were conducted, but action points for improvement were lacking.
- 8 maternal deaths were reported in one of the districts due to postpartum hemorrhage and shock. Very few facilities were notified under SUMAN, and IEC materials were insufficient in healthcare facilities. 'Yashoda' DMCH promoted exclusive breastfeeding.

c. Child Health

- Functional Newborn Care Corners (NBCCs) were established in all secondary care facilities, with designated NBSU units at CHCs and SNCUs at district hospitals. Round-the-clock trained staff nurses and medical officers were available in NBSUs, and IEC materials were displayed at delivery points.
- None of the facilities visited, except one in Sikar, were MusQan-certified.
- NRC was operational 24/7 in DH Sikar and RCH Bharatpur, with an average length of stay between 9-11 days. Facilities had well-equipped kitchens, and individualized diet charts were prepared for admitted patients.
- The CLMC was located in the Medical College catering to 30-35 mothers on a daily basis. The center was well-equipped with breast pumps, deep freezers, and pasteurization infrastructure, ensuring high safety and quality standards.
- The DEIC was functional and well equipped in one of the observed districts, conducting regular screenings and referrals.

d. Universal Immunization Programme

- District Task Force Meetings on Immunization (DTFI) were conducted in both visited districts, ensuring coordinated efforts in immunization activities.
- High immunization coverage, well-maintained MCP cards, adherence to microplans, and ANMs' awareness of vaccination schedules were observed across districts.
- Birth dose vaccination (OPV, BCG, Hepatitis B) was practiced at all delivery points, with mapping of facilities for zero-dose and Penta-1.
- Challenges in immunization were noted among marginalized groups (migrant laborers, nomads, women), contributing to dropouts.
- The E-VIN system was functional at all facilities, with sensors and temperature records maintained twice daily.

e. RBSK

- RBSK was effectively implemented across the observed districts with regular screening and referral.

f. Adolescent Health

- No dedicated space for AFHC at secondary facilities, establishment under process. Services were provided through routine OPDs and no dedicated counsellor.

g. NTEP

- CBNAAT, and TrueNat were available at observed facilities. 840 Nikshay Mitras registered. Free diagnostic and treatment facilities were available.
- Monitoring services were satisfactory, effective implementation of Nikshay Poshan Yojana.
- Designated cough corners were missing in the observed facilities. Most of the labs didn't have adequate ventilation, or facilities for slide microscopy.

h. NLEP

- Leprosy case management at SDH/DH levels was effective, with low prevalence observed in the visited districts.
- Cases of PB and MB were detected in the district. Single Dose Rifampicin (SDR) was administered, MCR footwear and self-care kits provided.

i. NPCBVI

- Vision charts, IEC displayed in OPD. MO conducts screening of general OPDs and referral cases.
- RKSK team conducted screening and provided spectacles at school.
- Cataract surgeries camps organized with help of NGOs, while surgeries were being conducted at facility.

j. NPHCE

- Implemented only at DH Bharatpur with basic rehabilitation equipment available; weekly geriatric OPD non-functional elsewhere.

k. PMNDP

- Functional dialysis unit only at DH in PPP mode; updates on PMNDP portal delayed due to ABHA ID unavailability.

l. NOHP

- Dental clinics were available at CHC Bhusavar, SDH Weir, and DHs; good coordination with NP-NCD for oral cancer screening.

m. NTCP

- District Tobacco Control Cell, DLCC, and 22 enforcement squads constituted; physical challan booklets available at facilities.

n. NMHP

- DMHP not fully functional; mental health services available at DH Bharatpur, but IEC activities and awareness on Tele MANAS helpline lacking.

o. NPPC

- Implemented only at DH Bharatpur; palliative IPD beds available, but no home-based palliative care provided.

p. NVHCP

- No stockouts for diagnostic kits; Anti-HCV biomarker testing unavailable at Medical College Sikar; referral mechanism in place.

q. NP NCD

- NCD clinics functional, opportunistic screening for cancers initiated, VIA implementation weak due to reagent shortage.

TRIPURA**a. Family Planning**

- The Sugam model was installed, focused on post-partum sterilization, sterilization case booklet maintenance.
- Basket of choice was unavailable with absence of PTK and Ezy pills, inadequately trained staff, not familiar with FP-LMIS portal, lack of essential service delivery registers, delay in compensation to beneficiary for sterilization, limited display of IEC material.
- Abortion services were available with functional EVA equipment, MMA drugs and MTP reporting formats.

b. Maternal Health

- Pregnancy testing kits, MCP cards, safe motherhood booklets, and clean toilets near the delivery room were available.
- Facilities were SUMAN notified, and LaQshya certified. PMSMA days were regularly conducted.
- Maternal deaths were reported and reviewed, and audits were conducted. Blood transfusion services were available.
- Gaps were reported including inconsistent maintenance of HRP line listing and follow-up, lack of testing kits for HIV and Syphilis, limited access and high cost of USG. Some facilities were not utilizing partographs, safe birth checklists, and surgical checklists. High cost of USG, staff shortages, partial implementation of respectful maternity care reported.

c. Universal Immunization program

- MCP cards were available, ANMs were aware of vaccination schedule, vaccine storage and handling were proper, significant number of adolescents immunized with Td vaccine, AEFI registers maintained, ToT for MR conducted, functional cold chain equipment, no incidents reported of stockouts.

d. Child Health

- NICU was well equipped and functional with trained staff. Newborn screenings for birth defects were being conducted. CLMC was established, and IEC was displayed.
- An expert committee was established to audit infant deaths.

e. RBSK

- DEIC was available but nonfunctional. HR and essential items were unavailable.

f. NTEP

- CBNAAT was available, 24 Panchayats were declared as TB Mukta, 279 Nikshay Mitras, X Ray machine was nonfunctional, patient had to travel and bear the expenses.

g. NLEP

- Inadequate dispense of MDR and PEP treatment. Five Surveillance, Supervision, and Support (SSS) activities were conducted. Mass screening had not been conducted, MCR footwear unavailable. Cases were referred to medical college for diagnosis.

h. NPCBVI

- Cataract surgeries were conducted, but inadequate follow-ups were reported.

UTTAR PRADESH

- The MaNTrA app had successfully tracked over 61 lakh deliveries across 5,593 facilities, enhancing surveillance of intrapartum care. Several facilities were not LaQshya certified.
- MDSR was in place, identifying key causes of maternal deaths. Strengthening systemic analysis and follow-up actions can improve outcomes.
- Fragmented IT systems limited comprehensive monitoring of high-risk pregnancies, delaying timely interventions.
- Administrative inefficiencies slow JSY fund disbursement, reduced financial support for pregnant women. Streamlining payments is essential.
- Under the National Programme for Prevention and Control of Fluorosis ample water testing for the fluoride concentration was being done in state.
- NCD clinics were functional. Screening camps are conducted but there is no provision of Cervical screening. Patient follow-up is poor.

UTTARAKHAND

a. Family Planning

- Safe abortion services were available at DH and a few CHCs.

b. Maternal Health

- HRPs were identified as DH/SDH but referred to medical colleges attributed to poor blood transfusion, and HDU/ICU services.
- RMNCHA+N referrals were handled mainly by DH and a few CHCs

c. Child Health

- Pediatric HDU/ICU was not functional at DH due to HR unavailability.
- SNCU was situated away from the maternity wing, hampering services. SNCU at one of the SDH reported 32% LAMA rate.

d. NTEP

- Under Nikshay Poshan Yojana, 87% of bank details were verified across the observed districts.

e. PMNDP

- The services were being provided at the DH under the PPP mode. The services were free for Golden Card, Ayushman Card, Antodaya Card and Aadhar card holder of domicile state. Recently peritoneal dialysis was also started.

WEST BENGAL

a. Family Planning

- Gaps were noted in contraceptive services, male sterilization, MTP services, and laparoscopic sterilization.

b. Maternal Health

- Labour room infrastructure was well-organized, but ANC and PNC wards were inadequate in RH and SDH. Pregnant women often arrived in full dilation. However, referrals for ANC in labor had

declined due to improved RCH services.

- Respectful maternity care was practiced, with no out-of-pocket expenses for RMNCH+A services and adequate essential drug supplies were available.
- Micro plans for Routine Immunization were in place. Teenage pregnancy and anemia were prevalent in certain areas.
- SNCU space was insufficient, with a high neonatal death rate and a high caesarean section rate in one of the districts.

c. Child Health

- Real-time monitoring through the 'Jatak Seva' portal for Visible Birth Defect (VBD) screening within 48 hours of birth was being utilized. Birth certificates were issued to all newborns before discharge at designated facilities.

d. NTEP

- Treatment adherence to Tuberculosis through DOTS was high. Malnutrition was prevalent among TB cases, and the lack of bank accounts was a barrier to timely DBT.

e. NLEP

- Active case findings were being done in both districts.

f. NPCBVI

- State's 'Chokher Alo' initiative mandated universal eye screening. A government eye bank was available for cornea collection. The ophthalmology unit at CHC displayed an inventory of spectacles for presbyopia, and an NGO was supporting the program.

g. NPHCE

- 10 beds were allotted under NPHCE. Physiotherapists, IEC, and weekly OPD for geriatrics were available at SDH Chanchal. IEC material was properly displayed at public health facilities.

h. PMNDP

- An 8-bedded dialysis unit was operational at the Medical College in PPP mode, with a nephrologist visiting once a month. Only hemodialysis services were provided in PPP mode.

i. NOHP

- Dental OPDs were operational with experienced dentists and dental chairs at secondary care facilities. However, conservative dental care (RCT/Filling) was absent at secondary care facilities.

j. NPCCHH

- Malda district had an action plan for climate change. In South 24 Parganas, LED bulbs were used, and health facilities were mercury-free. IEC materials were displayed at primary and secondary health facilities visited.

k. NTCP

- TCC unit under NTCP was available only at Malda Medical College. IEC materials were displayed at primary and secondary health facilities visited.

I. NPNCD

- NCD clinics were operational mainly for screening Hypertension, Diabetes, Oral, Breast, and Cervical Cancer at all visited secondary healthcare centres.
- The NP-NCD portal was not used; instead, the Simple app was used in rural settings and the HWC portal at U-HWCs. Ischemic Stroke management was being done via neuro telemedicine (Hub & Spoke model) in South 24 Parganas.

m. Others

- NVBDCP: Record maintenance was poor in the districts. In Malda district, the micro plan for kala-azar and diagnostics were not available.
- NPPCD: Specialists such as ENT, audiometric assistants, and audiologists, along with an audiology room at Chanchal SDH, ensured comprehensive ENT services. However, record maintenance for ENT services at Chanchal SDH needed improvement.
- National Sickle Cell Anaemia Elimination Mission: IEC materials for sickle cell anaemia screening were displayed at visited primary and secondary health centres in Malda district.



CATEGORY 2: MEDICINES AND DIAGNOSTICS

SUBCATEGORY 1: FREE DRUGS SERVICE INITIATIVE (FDSI)

NATIONAL OVERVIEW

The Ministry of Health and Family Welfare (MoHFW) is committed to ensure the accessibility of essential medicine free of cost in public health facilities. Dispensing of free medicines at public health facilities will improve healthcare access and directly reduce the Out-of-Pocket expenditure (OOPE) of patients. To achieve this goal, the National Health Mission implemented the Free Drugs Service Initiative (FDSI) in 2015.

According to the NHA 2021-2022, the share of OOPE in Total Health Expenditure (THE) declined by 24.8 percentage points, from 64.2% to 39.4%, while Government Health Expenditure's (GHE's) share rose by 19.4 percentage points, from 28.6% to 48%, between 2013-14 and 2021-22. This inverse trend reflects the positive impact of public health programs on improving healthcare quality. Medicines contribute a major portion of OOPE.

The Ministry of Health and Family Welfare (MoHFW) has been conducting the Common Review Mission (CRM) to assess the implementation and progress of various health programs including FDSI, identify challenges, and ensure the effective utilization of resources. The CRM also facilitates collaborative discussions with stakeholders to ensure alignment with health policy goals, enhance the quality-of-service delivery, and provide on-ground recommendations for improving the health system's efficiency and outcomes.

The observations, major findings, and recommendations from the Free Drugs Service Initiative assessment across 19 states/UTs are summarized below.

KEY OBSERVATIONS

- States such as Uttar Pradesh, Chhattisgarh, Assam, Bihar, Gujarat, Haryana, Karnataka, Jharkhand, Maharashtra, Odisha, Madhya Pradesh have not aligned their notified Essential Drugs Lists (EDL) with the IPHS Essential Medicines List (EML).
- Some states, such as Uttarakhand and Rajasthan, have well-aligned EDLs with the IPHS EML, ensuring the availability of essential medicines. However, in states like Uttar Pradesh and Bihar, gaps exist, leading to inconsistencies in medicine availability at different levels of healthcare.
- States like Uttar Pradesh, Chhattisgarh, Assam, Bihar, Gujarat, Haryana, Karnataka, Jharkhand, Maharashtra, Odisha, Rajasthan, Madhya Pradesh, Uttarakhand & West Bengal have implemented centralized procurement and distribution mechanisms, leading to better availability of medicines.
- States like Bihar, Odisha, Uttar Pradesh, Uttarakhand experience frequent stockouts due to delays in procurement and distribution. Inefficient demand forecasting and lack of cyclical indenting further exacerbate medicine shortages.
- Most of the states are having lack of dedicated storage spaces and / or these storage facilities are not of acceptable standards. Additionally, several have improper disposal of expired drugs resulting in an increased wastage and risk of dispensing errors.
- States such as Karnataka, Uttarakhand, Uttar Pradesh have Procurement delays due to long lead time and ineffective demand forecasting resulting in frequent medicine stockouts, affecting service delivery at PHCs and CHCs.
- There is Inadequate training on inventory management, drug indenting, and prescription practices leading to inefficient supply chain execution at health facilities in states like Himachal Pradesh and Uttarakhand.
- States like Uttarakhand, Uttara Pradesh are not having any last mile delivery plan for distribution of medicines at Primary health care facilities. In many instances, the staff of these facilities have to spend their own finances to collect the medicines.

KEY RECOMMENDATIONS

- Alignment of EDL with IPHS EML – States/ UTs should ensure their notified EDL is aligned with the IPHS EML to maintain consistency and availability of essential medicines at all levels. State needs to undertake regular audits ensure the same.
- Strengthening DVDMS or State specific LMIS – Implement robust inventory management systems like e-Aushadhi, DVDMS, and e-Niramaya up to the SHC-AAM level. Manual indenting through Google Sheets should be phased out, and systematic indenting with forecasting and real-time stock tracking should be ensured.
- Ensuring Proper Storage & Expired Drug Management – Dedicated storage spaces for medicines, including active storage, cold storage, quarantine areas, and NOAQ (Not of Acceptable Quality) areas, should be set up. Stock registers may also mention rake numbers for easy access. Expired drugs and consumables should be identified and disposed of as per protocol to prevent dispensing errors and storage issues.
- Minimizing Stockouts & Improving Procurement Efficiency – Lead time for drug procurement and distribution should be reduced by streamlining supply chain processes, ensuring cyclical indenting, and conducting periodic demand forecasting to prevent supply shortages. Effective utilization of DVDMS or similar platforms must be prioritized for improving medicine availability. Facilities need to rationally estimate medicine demand to avoid wastage. e-Aushadhi or existing digital platforms may be leveraged to manage near-expiry drugs through the transfer management system for optimal utilization.
- Enhancing Cold Chain & Vaccine Management – Cold chain infrastructure should be strengthened with proper monitoring of temperature-sensitive drugs. Staff should be trained on eVIN for effective vaccine stock management.
- Capacity Building & Training of Healthcare Staff – Regular training on inventory management, forecasting, drug indenting, storage protocols, and prescription practices (generic name usage, FEFO, LASA) should be conducted for relevant healthcare personnel.
- Improving Digital Connectivity for Real-time Monitoring – Internet connectivity at all healthcare facilities should be improved to enhance the functionality of LMIS and DVDMS, reducing discrepancies between portal data and actual stock availability.
- Strengthening Quality Assurance & Local Procurement Mechanisms – Locally procured medicines must undergo stringent quality checks, and uniform labelling (e.g., “Govt. Supply – Not for Sale”) should be ensured to reduce pilferage and ensure compliance with regulations.
- Regulatory Compliance: Ensure proper storage and handling of narcotic, psychotropic, and Schedule H1 medicines as per the Drugs & Cosmetics Act.
- Formulary Development: Develop a Standard Treatment Guideline (STG) linked formulary to guide the healthcare providers in prescribing and dispensing medicines appropriately.
- Narcotic drugs (controlled substances) need to be stored in locked cupboard or in a safe place to which only limited authorised persons have access.
- There is poor coordination between procurement, warehousing and distribution teams, which adversely impact the efficiency of the supply chain.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- State has notified the EDL for all categories of health facilities. However, only 21.6% of the drugs listed in the EDL were available at District Hospitals (DHs).

- EDL medicines were supplied from the State Warehouse based on indents and Local procurement was also carried out by the District Medical Officer through a tendering process.
- No system was in place for quality control of locally purchased drugs. There was no proper mechanism for disposing of expired drugs, conducting periodic stock verification, or monitoring the temperature of thermo-sensitive drugs.
- The District Drug Warehouse was well-ventilated and illuminated, with adequate space and storage shelves for medicines. Power backup was available.
- Use of DVDMS was limited due to poor network connectivity. Procurement of drugs was not planned systematically.
- Stocking of medicines for hypertension and diabetes management was inadequate. There was no cyclical indenting process, leading to frequent stockouts. The average lead time for supplies from district medical stores to health facilities was 15 days.

ASSAM

- The state has notified the EDL for all healthcare facilities. During the CRM visit, the state reported the total number of medicines in the State EML as: DH – 272, SDH – 272, CHC – 272. The EDL and real-time availability were displayed at all visited healthcare facilities.
- Facilities submit indents based on consumption data to the district headquarters. The Directorate of Health Services (DHS) compiles, analyses, and approves the consolidated requirements. The National Health Mission (NHM) Assam verifies the request and allocates the budget. The Assam Medical Services Corporation Limited (AMSCCL) procures medicines through limited tenders. Suppliers deliver medicines to District Drug Warehouses (DDWHs). DDWHs distribute drugs to facilities based on indent and consumption
- The DVDMS is used for stock maintenance and indenting. The platform is implemented at all levels of facilities. The average delivery time from order placement to healthcare facilities is 14 days.
- The State EDL is not fully aligned with IPHS EML. Some essential medicines are missing, leading to shortages. Storage facilities maintain buffer stock, updated bin cards, and follow First Expiry, First Out (FEFO) principles. Standard Operating Procedures (SOPs) for expired drug disposal are followed.

BIHAR

- Essential Drugs List: The state has notified a facility-wise EDL, which includes 456 medicines for DH against 381 in the IPHS EML, 314 for SDH against 318 in IPHS, and 310 for CHC against 300 in IPHS. Under the FDSI, all medicines were labelled with expiry dates, and no expired drugs were found during the visits.
- At the DH level, most essential medicines were available, but Injection Magnesium Sulphate was missing at the secondary healthcare level, and drug lists were not displayed in most facilities. Anti-Rabies Vaccine (ARV) and Anti-Snake Venom (ASV) were available at the APHC level. NCD medicines were accessible at all levels, ensuring a 30-day drug supply for continuity of care. However, the availability of anti-malarial drugs was inconsistent across the visited facilities.
- Procurement & Supply Chain - The e-Aushadhi supply chain management portal has been implemented up to the AAM-SHC level, ensuring a streamlined supply chain from the state to district warehouses through the e-Aushadhi. The lead time for drug receipt is within a week of order placement. While free drugs were available at most healthcare facilities, some essential medicines were out of stock, highlighting the need for streamlined and continuous monitoring of drug supply. Drug indentation and management occur through e-Aushadhi, with centralized procurement and distribution. However, stock-out medicines were not updated timely on the e-Aushadhi portal, leading to discrepancies between portal records and actual stock availability

in stores.

- Drug warehouse - The DH drug store requires several improvements to enhance functionality and safety. Cracked walls were observed in multiple areas posing risk of seepage during the rainy season, potentially damaging stored medicines and supplies. The floor requires repairs to maintain a clean and safe environment, while cartons of medications need proper organization for efficient access and management. Additionally, the facility needs revamping to ensure pest control, temperature and humidity regulation, and overall maintenance. Proper storage and arrangement of drug cartons will improve functionality, accessibility, and overall efficiency of the drug store.
- Visited facilities were not found compliant against IPHS norms in terms of drugs.

CHHATTISGARH

- Essential Medicines List- Free drug stock was displayed at the facility, with 196 medicines available at DHs against the 381 IPHS EML and 63 at CHCs against the 300 in IPHS EML.
- Procurement & Supply Chain- At secondary-level facilities, indenting was managed through the Drug Distribution and Management Information System by Chhattisgarh Medical Service Corporation Limited (CGMSC). Dedicated storage spaces were available at all visited facilities. No stockout days were reported, and buffer stock was maintained at all levels.
- Quality Assurance and Drug warehouse - No expired drugs were found in CHCs or DHs. Drugs were prescribed using generic names in adherence to Standard Treatment Guidelines. The LASA and FEFO drugs were properly labelled and stored separately in all visited PHCs and SHCs.
- Inventory management of medicines - Drugs were maintained as per LASA and FEFO guidelines in NQAS-certified facilities. However, internet connectivity issues affected the functionality of DVDMS at DHs.
- Chhattisgarh is having own state specific LMIS, which is integrated with central dashboard up to AAM-PHCs.

GUJARAT

- Expired drugs and consumables were found in some hospitals. Jan Aushadhi Kendras supplied 18% of the State EDL, but emergency drug procurement in Vadodara lacked proper labelling, increasing pilferage risks. UHID numbers were not used for pharmacy dispensing, affecting treatment tracking.
- Near-expiry drugs at DH/SDH levels are managed through CHC redistribution, but updates are irregular. Quarantined drugs take 1–3 months for quality checks, delaying availability. Expired medicines occupy large storage areas, with 15 truckloads discarded but more remaining. Injection vials / ampoules storage rooms lacked temperature control, and warehouse infrastructure issues included non-functional fire alarms, faulty wiring, poor lighting, and security lapses.
- Sick cell screening is conducted for adolescents, school-going children, and ANC cases. Referrals are made to the Sick Cell Disease Centre (SCDC), where hydroxyurea is administered.

HARYANA

- The state has notified a facility-wise EDL. However, none of the visited facilities had all medicines as per the EDL. At the CHCs, 84 medicines out of 300 were available.
- The Haryana Medical Services Corporation Limited (HMSCL) acts as the central procurement agency for drugs and vaccines. Decentralized procurement is managed via DPMU till AAM-PHC level.

- Non-Availability Certificate (NAC) is issued only after three months of stockout, delaying local purchases and causing prolonged shortages. Essential family planning drugs like Inj. MPA and IUCDs were unavailable during the visit.
- Drugs were arranged alphabetically, with expiry dates clearly displayed. The visited facilities were not integrated with DVDMS. Instead, the state-specific DPMU portal was used for procurement and stock management.

JAMMU & KASHMIR

- At the CHC level, medicines are adequately available, and DVDMS is functional. However, at the DH level, only 34% of drugs from the state EDL are available (146 out of 422). DVDMS is fully operational at the central warehouse but is only partially implemented below the district level. A Central Procurement Agency is in place, ensuring e-tendering processes are followed.

JHARKHAND

- Commonly prescribed drugs were available, but no facility had the availability as per complete EDL. Medications were within expiry dates, and expired drugs were segregated for disposal. At DH East Singhbhum, pharmacy registers were well-maintained, except for the missing stock register.
- DVDMS was used for supply management, but procurement was not as per rules. E-Aushadhi entries did not match stock records. At CHC, a clerk with minimal pharmaceutical knowledge managed the pharmacy. Stock records were missing, and 800 morphine sulphate injections lacked proper documentation. Similar issues were noted at UPHC and PHC visited facilities.
- FDSI was implemented with free drug entitlements displayed. LASA drugs were labelled separately but indenting and procurement gaps led to inefficiencies. E-Aushadhi was underutilized, and staff lacked data. Tramadol injections were dispensed in OPD, raising regulatory concerns. Improvements in compliance, data management, and drug handling are needed.

KARNATAKA

- Most facilities had 90% availability of essential medicines. The EDL was displayed in the local language at both urban and rural facilities.
- The DVDMS has been implemented in both urban and rural areas up to the AAM-PHC level. Pharmacists actively used the DVDMS portal for identification and procurement of medicines and were aware of its functionalities. However, the turnaround time from indenting to medication delivery could extend up to 2 weeks. Higher institutions demonstrated efficient medicine supply management by utilizing near-expiry counters and online inventory management systems.
- The majority of facilities had dedicated storage spaces for medications, quarantine supplies, and expired medicines. Drugs were stored in special storage areas with properly labelled shelves.
- Up to 50% of supply shortages were caused by supply chain disruptions, impacting patient care.

MADHYA PRADESH

- State has notified facility wise EDL the availability of medicines in the State EDL varies across healthcare facilities. At DHs, all 381 medicines listed in IPHS are available, while SDHs have 226 medicines available against the required 318, and CHCs have 190 medicines against the IPHS standard of 300.
- At the district drug store, 22 drugs had stock-outs in the past year, indicating supply chain gaps.

The District Vaccine Store was well-managed, but BCG vaccine shortage was observed. Anti-Rabies Vaccine availability was insufficient.

- Random drug sampling for quality testing was conducted. A three-month buffer stock was maintained with proper indenting. Daily entries of dispensed drugs are essential for better forecasting and stock control.

MAHARASHTRA

- State has facility wise EDL for all levels of facilities. At DH 102 medicines are available in state EDL against IPHS EML (381), 102 state EDL is available against 318 in IPHS EML for SDH, and 91 state EDL is available against 300 in IPHS for CHC level.
- Inventory management of medicines: Maharashtra is DVDMS (e-aushadhi) state and has integrated its e-aushadhi portal till SHC-AAM.

MIZORAM

- The availability of medicines across primary and secondary care facilities remains a challenge, with significant gaps between the State EDL and the IPHS EML.
- At secondary care facilities, FDSI faced shortages due to a limited State EDL, low supplier participation, and logistical constraints. The State EDL includes fewer medicines than the IPHS EML, leading to high out-of-pocket expenses for patients.
- Procurement and supply chain processes rely on multiple IT platforms, with DVDMS being used for inventory management. However, medicines are sometimes procured locally and manually entered into the system, leading to inefficiencies. The central drug warehouse is in poor condition, used for other supplies, and lacks quality testing facilities. Despite 232 medicines being available at the warehouse, only 63 are part of the Free Drug Service Initiative (FDSI).
- In aspirational blocks, medicine shortages persist, with expired drugs found in all visited facilities. Weak indenting and distribution strategies result in underutilization of DVDMS, further affecting medicine availability.
- Drug stock-outs and discrepancies between DVDMS and the revised EML remain critical issues. Although NCD drug supplies were regular, limited supplier participation and high transportation costs continue to impact procurement. The absence of a quality testing system and reliance on manual tendering processes further weaken the supply chain. Transport vehicles remain underutilized due to poor road conditions and maintenance costs, affecting last-mile delivery. Persistent medicine shortages force local purchases, increasing out-of-pocket expenses for patients.

ODISHA

- The state has notified facility-wise EDL and has achieved 75% availability of essential drugs across all levels of public health facilities. However, the currently notified state EDL for CHCs have 202 medicines, SDHs have 205 medicines, and DHs have 219 medicines against the IPHS EMLs.
- Additionally, the State has also included the MMA drug kit (combo pack) in its EDL.
- Odisha State Medical Corporation Ltd. (OMSCL), which serves as a central procurement agency, is responsible for procurement of drugs and vaccine in the State.
- During the facility visits, it was observed that some medicines available in the stock were expired.
- Inventory management of medicines through 'e-Niramaya' software was in place which deals with

the management of stocks up to the PHC Level.

- Storage – During the visit at the facilities it was observed that vaccines were stored and handled properly, with correct placement on ice packs, visible vaccine vial monitors (VVMs), and labelling of open vials with date and time.
- Sickle Cell Anaemia - In Odisha, approximately 5.35 lakh people have been affected by Sickle Cell Disease (SCD). As of October 2024, out of all the screened individuals, 88,415 cases were diagnosed positive with the disease. Out of the 88,451 people with SCD 34,416 had started hydroxyurea treatment. Furthermore, the State has established centres for prenatal diagnosis and treatment with hydroxyurea is available at various healthcare levels.

TRIPURA

- Free Drug Supply & Procurement System - All drugs are provided free of cost at all healthcare levels, with 70% centrally procured and 30% locally purchased. The state operates its own SCMS to manage drug supply and inventory. However, drug availability is inconsistent, with no fixed pattern for monitoring stockouts. The FDSI medicine list and stock details are not displayed at facilities, and procurement is done only when required, without proper forecasting.
- Inventory & Storage Management - Drug distribution counters exist but are not integrated with DVDMS. Inventory management is poor, with a hybrid system of software & ledgers being used. There is no separate storage for high-risk drugs, LASA, psychotropics, or narcotics. Medicines are procured based on demand, rather than scientific forecasting. Storage conditions are inadequate, with no temperature monitoring and no designated areas for expired or quarantined stock.
- Central Warehousing & Quality Control - The central drug warehouse handles procurement and distribution, supplying drugs for national programs and hospitals. Districts collect drugs monthly, and the central warehouse maintains a 24-hour lead time. While quality checks are conducted, temperature control is inadequate, and there is no proper mechanism for expired drug returns. The state has notified its EDL for different levels of facilities, however further optimization is needed to align with national standards i.e. IPHS.

RAJASTHAN

- Rajasthan has notified the EDL for all categories of health facilities. During the CRM visit, the state reported the total number of medicines in the State EDL as follows: DH: 645 medicines, SDH: 645 medicines, and CHC: 551 medicines. Approximately 70-80% of the essential medicines were available at health facilities in the visited districts. The list of essential medicines, as per state policy, was displayed in all secondary-level health facilities.
- Drug warehouses have been constructed. However, they lack properly designated storage areas for different types of drugs, including active dry storage, quarantine storage, cold storage, NOAQ (Not of Acceptable Quality) area, and a designated unloading/incoming area.
- e-Aushadhi was implemented at all levels for indenting and tracking drug consumption. While OPD drug consumption was recorded, there was no mechanism to capture IPD drug usage.
- Storage: There was no proper mechanism for storing, monitoring, or disposing of expired drugs. Staff were unaware of the expired drug policy.

UTTAR PRADESH

- The State EDL is not aligned with IPHS EML, leading to the unavailability of many recommended medicines, including psychotropic drugs, at health facilities. Medicine shortages and poor inventory

management affect patient care, with pharmacists unaware of stock-out rates and expiry disposal processes. Narcotic drugs were found stored in open spaces at CHCs, and only 54 out of 84 EDL-recommended medicines were available at AAM level. Essential drugs like E-pills, Medical MTP kits, and TB medicines were out of stock at several delivery points and PHC AAMs.

- Storage conditions at district warehouses were poor, with unhygienic spaces, improper utilization, and weak cold chain management. FEFO practices were not followed, pest control was inadequate, and essential safety measures like fire safety equipment and CCTV surveillance were missing. At Kushinagar warehouse, medicines were stored on the floor, mould was found on some medicines, and rabies vaccines were stored outside the cold chain. Routine monitoring of storage and distribution was lacking, and poor coordination between procurement, warehousing, and distribution teams further weakened the supply chain.
- DVDMS was used only for indenting, with other critical features like stock management and expiry tracking not in use.

UTTARAKHAND

- Free Drug Scheme has been in place since 2019, with a facility-wise EDL covering 700 drugs and 270 surgical items. Centralized procurement is done through e-Aushadhi, while the CMO has authority for local purchases in emergencies to prevent stockouts.
- DVDMS was implemented up to SHC-AAM level, but it was not utilized at this level in the visited districts.. In Bageshwar, DVDMS was operational only at the DH level, with limited medicine supply to SHC-AAMs. No NCD medicines were found to be dispensed at SHC-AAM in Bageshwar, forcing patients to collect medicines from PHC, CHC, or DH.
- The state has three drug warehouses located in Dehradun, Roorkee, and US Nagar. The Dehradun warehouse serves as the central hub for distributing vaccines and medicines to all districts. Additionally, each of the 13 districts has a CMO-CMSD warehouse within a government-owned building. Procurement follows a centralized process, with provisions for local procurement in emergencies.

WEST BENGAL

- In secondary care facilities, drug availability ranged between 33-73% compared to the EDL. Reasonable price medicine shops within or near health facilities provided medicines at a subsidized cost (55-76%). Maternity care in both districts had adequate essential and emergency drugs, ensuring no out-of-pocket expenses for RMNCH-A services.
- The CCMIS software was used for inventory management, ensuring medicines, consumables, and equipment were available as per norms. However, drug storage was improper, with high humidity and poor segregation of medicines and disinfectants. In South 24 Parganas, 179 essential medicines were available at SDH against the 396 drugs listed in the EDL.

SUBCATEGORY 2: FREE DIAGNOSTIC SERVICE INITIATIVE

The 'Free Diagnostics Service Initiative' (FDSI) programme was launched in July 2015 by the Ministry of Health and Family Welfare, Government of India, under the National Health Mission (NHM) with the aim to provide accessible and affordable pathological and radiological diagnostic services closer to the community, which in turn reduces the Out-of-Pocket Expenditure (OOPE). The revised guidelines were launched in 2019 with an expanded range of diagnostics at all levels of public health facilities: 14 tests at Sub Centres (SCs), 63 tests at Primary Health Centres (PHCs), 97 tests at Community Health Centres (CHCs), 111 tests at Sub-District Hospitals (SDHs), and 134 tests at District Hospitals (DHs).

FREE DIAGNOSTICS SERVICES IMPLEMENTATION:

- A. Laboratory service has been implemented in all 19 visited States/UTs. Out of these 19 states, 8 states have implemented the FDSI in mixed mode (Arunachal Pradesh, Assam, Jharkhand, Himachal Pradesh, Madhya Pradesh, Maharashtra, Tripura, Uttarakhand) and 11 states through in-house mode (Mizoram, West Bengal, Rajasthan, Bihar, Chhattisgarh, Jammu & Kashmir, Odisha, Uttar Pradesh, Gujarat, Karnataka, Haryana).
- B. CT scan service has been implemented in all 19 visited states. Out of these 19 states, 14 have implemented the CT scan services in PPP mode (Bihar, Himachal Pradesh, Uttarakhand, Madhya Pradesh, Rajasthan, Odisha, Assam, West Bengal, Maharashtra, Uttar Pradesh, Tripura, Jharkhand, Karnataka, Haryana), and 5 states have implemented it through other means (Arunachal Pradesh, Mizoram, Chhattisgarh, Jammu & Kashmir, Gujarat).
- C. Tele-radiology (tele-reporting of X-rays) has been implemented in 10 out of the 19 states visited. These are, Bihar, Himachal Pradesh, Jammu & Kashmir, Rajasthan, Maharashtra, Uttarakhand, Uttar Pradesh, Assam, West Bengal, and Tripura.



KEY OBSERVATIONS

- Availability of diagnostic tests as per the FDSI guidelines 2019 was found to be low in the states of Maharashtra, Gujarat, and Bihar, and satisfactory in Madhya Pradesh, Himachal Pradesh, Odisha, Haryana, Uttar Pradesh, Uttarakhand, Chhattisgarh, Assam, Rajasthan, Karnataka, West Bengal, J&K, Jharkhand, Tripura, Arunachal Pradesh, and Mizoram.
- Availability of sample transport was observed in Karnataka, Madhya Pradesh, and Uttarakhand while it was lacking in other states.
- Availability of reagents and consumables was adequate in Rajasthan, J&K, Haryana, Himachal Pradesh, and Chhattisgarh while it was lacking in other states.
- Diagnostic services were provided free of cost in all the states except in Mizoram, Tripura, Uttarakhand, and J&K (where a user fee was approved by the State).
- Tele-radiology services were mostly out-sourced, and were found to be satisfactory (Turnaround Time was within 24 hours).
- External Quality Assurance System (EQAS) was implemented for lab tests only in the states of Madhya Pradesh and Mizoram at the District Hospital (DH) level.
- For secondary level facilities, there is a need to strengthen the diagnostic capabilities of the CHCs across the States. The range of in-house services across the secondary level facilities were quite limited.

KEY RECOMMENDATIONS

- The availability of equipment, and diagnostic services needs to be as per IPHS-2022 and EDL. The availability of diagnostic services for specific conditions where their endemicity or high prevalence have been identified need to be prioritized.
- Availability of TB diagnostic services need to be ensured across the levels of care.
- States need to ensure that facilities display the list of services provided and available for the patients.
- States are encouraged to fully utilize the IPHL funds to enhance the diagnostic infrastructure to meet the IPHS standards. States who have initiated the upgradation process may target its timely completion and operationalization of the IPHLs.
- Similarly, funds under PM-ABHIM and 15th Finance Commission may be utilized to strengthen the diagnostic labs and disease surveillance capabilities of the CHCs and the DHs.
- Essential diagnostic equipment, including CBC counters (cell counters), semi-automatic biochemistry analyzers, Syphilis test kits, and Hepatitis C test kits must be made available at the CHCs to not only enhance the diagnostic capabilities at the secondary level but also reduce the burden on higher-level facilities. The DHs should be equipped commensurately to support the management of critical and complex cases.
- Supply of reagents and consumables must be regularized to reduce the dependence on RKS or any untied funds for procurement. It is crucial to fully utilize the existing diagnostic tools and expand testing capabilities.
- Outsourcing of diagnostic services to private providers need to follow only after a gap-analysis. It is recommended to out-source only high-cost low volume tests while strengthening the in-house capacity for delivering all low-cost high volume tests. States may consider gradually phasing out of out-source services by simultaneous strengthening of in-house diagnostic capabilities.
- States need to institute adequate checks against irrational testing prescriptions, especially for the out-sourced services under the FDSI.
- Hub and spoke model of free diagnostic services may be strengthened by linking the facilities with medical colleges. This would also ensure the availability of doctors/ specialist at the Hubs.
- Teleradiology services may be implemented, wherever feasible, to enhance diagnostic capacities. Equipment for imaging diagnostic services must be AERB certified.
- States may strengthen or implement Laboratory Management Information System (LMIS) at CHCs and other facilities to improve diagnostic management and record maintenance. The implementation of UHID numbers for lab sample management must be prioritized, and protocols for Turnaround Time (TAT) and sample transportation should be established and monitored.
- States may strategize and integrate disparate IT applications for patient care. Electronic health records may be linked with laboratory systems, pharmacy software, and hospital information management systems.
- States need to ensure that patients have access to their test reports in commonly accessible media.
- Adherence to Internal Quality Assurance Systems (IQAS) and External Quality Assurance Systems (EQAS) must be mandated for lab tests to ensure accuracy and reliability.
- The practice of levying user fees for diagnostic services need to be reconsidered, given the provisions under FDSI intend to mitigate OOPE incurred by the patients. States should strive to ensure that the diagnostic services should be made available free of cost to all beneficiaries. State practices adversely affecting the treatment seeking behaviour of patients need to be addressed.
- States need to strengthen the facilities to also commensurate treatment capabilities with the

diagnostic services. OOPE due to patient referrals for treatment need to be addressed.

- Capacity building of relevant HRH for FDSI need to provide systematically for improving internal process and quality of testing.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

User charges were levied for diagnostics and lab tests both at the level of DH and Community Health Centres (CHCs). The services were free of cost for the Ante-Natal Care (ANC) beneficiaries. The district hospitals had two labs – a Public-Private Partnership (PPP) lab operationalized under the Free Drugs Service Initiative (FDSI) and an in-house lab. Approximately 25 paid tests were provided through the in-house lab, while 46 tests out of 134 under the PPP arrangement were provided through the PPP mode. The report turn-around time was within 6-8 hours. Critical test results were alerted to the patient and the treating doctor.

The X-ray machines were found non-functional in the visited facilities, and the patients were referred to private clinics. Electrocardiogram (ECG) and Computed Tomography (CT) scan services were available as in-house services in some facilities. The CT scan unit was certified by the Atomic Energy Regulatory Board (AERB). The facilities charged Rs. 500 for a head scan, Rs. 1,500 for a chest scan, Rs. 1,000 for an abdomen scan, and Rs. 200 for an ECG.



ASSAM

The primary healthcare facilities provided essential lab tests in-house, while the secondary level facilities followed a hub and spoke model. FDSI was implemented in a hybrid mode – in-house and PPP mode. As per the State's EDL, CHC-FRU provided 54 in-house and 47 PPP tests, SDH provided 61 in-house and 47 PPP, and DH provided 63 (in-house) and 47 PPP tests. Advanced diagnostic testing was outsourced to PPP service provider. Supervision of private services needed attention. Interactions with the beneficiaries revealed high OOPE incurred by them on availing services. Diagnostic services for HIV and STDs were available, but patients had to be referred to the medical colleges for availing treatment.

BIHAR

Around 5-6 point-of-care diagnostics were available at APHCs. The diagnostics lists were not displayed in most of the facilities visited. Most of the laboratories in the visited facilities in Gaya were operational and conducted rapid diagnostic tests for common ailments, ensuring timely and accurate patient

diagnoses. However, routine diagnostic facilities for Lymphatic Filariasis (LF) were not observed at any of the health facilities visited.

CHC Diagnostic Labs were equipped with semi-auto biochemistry analysers, TruNAATs, and X-ray machines, but were underutilized due to reagent shortages. District Hospital Diagnostic Labs functioned relatively better with sufficient HR, conducting 60–70 tests per day. In an effort to meet IPHS norms, the installation of a fully automated analyser was in progress at the time of the visit.

The districts did not have Block Public Health Units (BPHUs) or Integrated Public Health Laboratories (IPHLs), which adversely affected the number of tests available and also disease surveillance capabilities of the Integrated Health Information Platform (IHIP).

CHHATTISGARH

Most of the visited facilities displayed the list of diagnostic tests. However, most of them provided these tests for a nominal user fee. The number of diagnostic tests provided through the Community Health Centres (CHCs) was around 67, which is less than the recommended Essential Diagnostics List (EDL) for CHCs. Sick cell solubility tests and the HPLC tests were available at the AAM-PHCs, even in tribal areas.

The supply of reagents was managed by the Chhattisgarh State Medical Service Corporation. The availability of reagents and consumables at the facilities was observed to be as per requirement for the available tests.

GUJARAT

The state was using the state corporations and health grants for diagnostics and equipment. Diagnostic supplies were routed through the Regional and District Drug Warehouses to the facilities across the levels of care. However, irregularities in the supply of reagents and consumables led to reliance on Roji Kalyan Samiti (RKS) untied funds for procurement.

In Vadodara, staff highlighted concerns regarding lab services being outsourced at the CHC level, as it affected service delivery and timely reporting of investigations. Pathological services provided through a PPP arrangement were observed to be efficient. Human Resource (HR) gaps were observed in the number of lab technicians against the requirement as per Indian Public Health Standards (IPHS) norms in a few facilities. The availability of critical POC kits like HBsAg, HIV and Syphilis in labour rooms needed attention.

The absence of a Logistics Management Information System (LMIS) at the CHCs contributed to inefficient diagnostic management and record maintenance by the staff. The Unique Health Identification (UHID) numbers were not followed for lab sample management. The maintenance of Turnaround Time (TAT) records and adherence to protocols for sample transportation were not followed. Internal Quality Assurance System (IQAS) and External Quality Assurance System (EQAS) were not implemented for lab tests.

HARYANA

FDSI is implemented at the district level through an in-house model. However, the number of tests provided in some of the visited District Hospitals (DHs) and Sub-District Hospitals (SDHs) was less than 50% of the notified tests under the State's Essential Diagnostics List (EDL) (e.g., 71 out of 134; 42 out of 134). Microbiology tests were not being performed in the DH diagnostic lab.

Though one of the visited DHs had received approvals for establishing an integrated public health lab, the process of upgradation had not been initiated till the visit. So far, the space has been identified, and a fully automated biochemistry machine (XL-640) has been made available in the laboratory. Further, equipment procurement was in process through the Haryana Medical Services Corporation Limited, the nodal agency for procurement of medicines and equipment. Reagents and consumables are indented through the e-Upchaar portal and collected from the warehouse located in District

Gurugram. In case reagents and consumables are unavailable, a NAC is generated, allowing the DH to purchase them locally with the help of Swasthya Kalyan Samiti (SKS) funds.

The DHs had designated staff for diagnostic lab services, including 1 Pathologist, 1 Microbiologist, 6 Lab Technicians, and 1 Data Entry Operator. The report Turnaround Time (TAT) ranged from 1-6 hours and was available online as well as on the e-Upchaar portal. The CT scan patients were provided with both a film and a report. However, X-ray reports or films were not provided to the patient and were available only on e-Upchaar.

Most of the tests were provided free of cost to the patients. However, CT scan services were provided free of cost only to specific groups such as the Haryana Government employees & pensioners, people with more than 60% disability, unattended accident victims, BPL card holders, and the apparent poor. For the rest, a subsidized rate card has been provided by the government. X-ray services were free for everyone except for medicolegal cases, for which a nominal fee of Rs. 50 was charged.

HIMACHAL PRADESH

The Free Diagnostic Laboratory Service Initiative was operational in a hybrid mode, both in-house and PPP-mode. The State had notified the tests as per the National Health Mission Free Diagnostic Service Initiative guidelines (CHC-97/SDH-111/DH-134).

The in-house laboratory of DH Shimla was operational until 12 PM with a limited number of tests, which were mostly rapid-kit based. Physical reports were provided. The reagents and consumables for in-house laboratories were procured locally at the facility and district level. There was a lack of adherence to quality assurance protocols and record maintenance in the facilities below the level of DH and MC in the visited districts. The facilities did not display the available lab tests.

The State has also outsourced pathology services from PHC level up to the medical college level to a private provider. The service provider has set up laboratories inside the health facilities at AAM-PHCs, CHCs, CHs, and DH/Medical College. The samples were collected at the PHCs and sent to nearby higher facilities for testing and reporting. The service provider has deployed phlebotomists and lab technicians in all the laboratories.

The test prescription was seen on the higher side in the PPP mode. The PPP laboratory at the periphery was lacking in the IQAS/EQAS initiative. Though the Turnaround Time (TAT) for the outsourced tests was defined, there was a lack of overall monitoring of the services in most of the laboratories. The control on the test prescriptions was not observed in most of the facilities.

The X-ray services at some visited CHCs and Civil Hospitals were provided through PPP mode. Though the radiographers were reportedly deployed by the PPP provider, they were not available during the visits. In contrast, in-house ultrasound services were available at the same facilities, with a stationed radiologist at the CHC.

In one of the DH/MC, digital X-ray, ultrasound, mammography, and 64-slice CT scan services were provided through in-house mode. The hospital had one X-ray unit operationalized by the private provider for tele-radiology services.

JAMMU AND KASHMIR

The implementation of FDSI needed to be strengthened. The State reported the availability of diagnostics as per the Essential Diagnostics List (EDL) and Indian Public Health Standards (IPHS) norms, although the notified State EDL amounted to be 34% of the national list. Tele-radiology services have been outsourced to a private provider. These services were reportedly operational with optimum monitoring and reporting times. Services delivered through tele-radiology included digital X-rays, ECGs, ultrasounds (USG), and CT scans.

JHARKHAND

The secondary level hospital laboratories were equipped with Rapid Diagnostic testing kits for infectious diseases like malaria, VDRL, Hep B, Hep C, HIV, and Sickle Cell Anaemia. Thyroid function tests were not available in most of the facilities. The Central Laboratory at the District Hospital (DH) was observably well-performing and supported patient care through timely and accurate diagnostic services. It needed to be adequately supported with necessary resources, such as equipment and consumables, and consistent monitoring to ensure sustainable quality of care.

At one of the visited SDHs, fluorescent microscopy and chest X-rays were being performed; however, CBNAAT was not functional for nearly four months. Storage of laboratory stains such as JSB and ZN in inappropriate containers, including water and cold-drink bottles, was observed, which needed immediate attention and rectification for the safety of healthcare workers and the quality of testing.

Some of the CHCs limited laboratory investigations to 12 in-house investigations. In general, service delivery gaps were observed due to the limited availability of diagnostic services across facilities. Limited access to diagnostic facilities and irregular malaria and TB screenings in endemic areas were also observed.

Sickle cell anaemia screening was conducted in one of the PHCs in an aspirational block. This initiative demonstrated tailored efforts towards addressing local health needs.

Under the FDSI, the in-house essential diagnostic tests were provided free of charge. CT scan services were reportedly unavailable. The implementation of DVDMS needs to be strengthened. Indent of diagnostic reagents and consumables was usually practiced approximately 10 days before the anticipated stock-out, and the supply was done in 2 to 3 days.



KARNATAKA

Most of the diagnostic services available in the rural and urban healthcare facilities were provided through in-house. The availability of essential diagnostic tests was as per norms only in some facilities. In facilities with adequate HR, maintenance of records and equipment were done by the LTs, and where the LT posts were vacant, the staff nurses took this responsibility. The transportation of sputum samples from primary level facilities to the Taluka hospitals was done via couriers.

The state has operationalized FDSI in the higher facilities which included CT scan services at 15 DHs, and MRI services at 6 DHs. The state has also provisioned for convergence of these CT scans and MRIs with the AB-PMJAY-CM's ArK. One of the visited DHs provided 65-70 in-house tests out of the recommended 134 tests as per the FDSI/ IPHS list of diagnostic services. About 2000 tests were being done per day with the Turnaround Time between 4 and 24 hours.

MADHYA PRADESH

The state had implemented the Free Diagnostic Services Initiative through both In-House & PPP mode. The state had adopted selective outsourcing through a wet lease rental reagent model for 06 high-end auto analyzers (hematology, biochemistry, urine, hormone, coagulation, and HPLC) at 50 DHs and 35 civil hospitals, conducting around 134 tests. Sample transportation for CHCs and below facilities was undertaken in PPP mode through runners arranged by the service provider. However, these lab runners were not collecting samples from the AAM-PHCs on a regular basis.

Under PPP mode, there are 324 hub laboratories and 1610 spoke centers in both urban and rural areas. The state had issued the government order to increase the number of tests at various levels of health facilities (DH-134/SDH-134/CHC-80/PHC-80/SC-17); however, facilities were not conducting all types of tests as per the state order. The current average number of tests provided were DH-134; SDH/CHC/PHC-61. Hub labs send their samples to CMC Vellore under the EQAS program, and records of the same were also maintained.



CT scan services were available in the state through PPP mode. At DH Balaghat, a 32-slice CT scan machine was available with the availability of 02 technicians. On an average, 800 footfalls per month were observed at the facility. The services were free for BPL and Ayushman card holders; other patients had to pay the fee as per the contract rate with the service provider.

MAHARASHTRA

The state had operationalized FDSI through a hybrid mode—in-house and PPP. All diagnostics, including high-end investigations like CT scans, were available free of cost to the beneficiaries. Diagnostic facilities for cataract and refractive errors were available at the visited SDH. However, testing for other vision-related ailments such as glaucoma, retinal diseases, trachoma, and diabetic retinopathy was not available.

There was an observed gap in information sharing of imaging diagnostic testing reports (e.g., X-rays), as patients were made to repeat X-rays when referred to higher-level facilities. The private provider for diagnostic services was also responsible for equipment maintenance and repairs. Although the record keeping was satisfactory, there was a noticeable lack of maintenance and prompt repair of diagnostic equipment at the secondary level facilities, which affected service delivery.

MIZORAM

The state had implemented FDSI through an in-house mode. Diagnostic services were also supported by the World Bank's Mizoram Health System Strengthening Project. At the DH, 90 diagnostic tests were available against 134 lab tests; however, user charges were levied. On an average, 10 ultrasounds and 5 CT scans were done at the DH per day. At the CHCs, 28 out of 97 lab tests were provided.

The labs participated in internal and external quality assurance programs for both haematology and biochemistry. Although the lab's infrastructure in Kolasib appeared compromised due to construction, control charts were maintained regularly. Quality tools and methods such as PDCA and fishbone analysis were used for process improvement. Liquid waste management was done efficiently in the laboratories. Radiology units were AERB certified, and TLD badges were available.

ODISHA

The State of Odisha made significant progress in enhancing its healthcare infrastructure. Notably, the State successfully implemented Free Diagnostic Laboratory services through a combination of in-house and PPP modes. The State provided 103 tests at the CHCs. The State Medical Corporation Ltd. (OSMCL) served as the central procurement agency, operating with autonomy and leveraging e-Niramaya, an IT-enabled logistics management information system, to streamline operations up to the Primary Health Centre (PHC) level. Free X-ray services were available in in-house mode, and CT scan and MRI services were operational in PPP mode.

RAJASTHAN

The state had implemented free diagnostic services under Mukhyamantri Nishulk Janch Yojana across all health facilities through an in-house mode. The CHCs provided 35-39 tests. The number of tests performed at each level of health facility fell short as per the FDSI and IPHS 2022 norms.

All OPD and IPD patients visiting government health facilities needed to have the Jan Aadhar Card to avail these services. The number of tests conducted at the labs of secondary care facilities ranged from 15% to 41% of the total list. Multiple laboratories were observed in the CHCs/SDH, and the staff was underutilized. Approximately 85% of the reagents and consumables were procured locally by the facilities.

The CHC/SDH/DH had sufficient equipment like haematology analyzers, fully automatic analyzers, and bio-safety cabinets, with adequate space for performing the tests. Free CT/MRI scan facilities were available at the DH. The MAA voucher yojana used for USG was provided for antenatal women.

The availability of equipment was inadequate to facilitate the extended package of service delivery at the primary facilities. The availability of lab reagents was found to be sufficient and was centrally procured.

X-ray services were provided at the CHCs free of cost, but the rooms were not as per IPHS norms. The lab reports were handed out physically and usually on the same day. The diagnostic tests list was displayed across the primary care health facilities. Lab equipment was not calibrated and was not covered under the Biomedical Equipment Management Programme. The toll-free numbers were not displayed at all healthcare facilities. Lab Management Information Software (LMIS) was not implemented.

TRIPURA

The state had outsourced the diagnostic laboratory services in 22 PPP labs with four hub labs in Agartala, Udaipur, Kulai, and Dharmanagar districts. The state provided 65 diagnostic tests at the DH level and 40 tests at the CHC level. The total number of diagnostic tests was less than the recommended list of diagnostic tests as per the FDSI 2019 guidelines.

Free diagnostic radiology services were not free for all beneficiaries. General patients paid INR 100 per X-ray scan and INR 1000-3600 per CT scan. The in-house laboratory at the state hospital and visited CHC were dysfunctional and needed strengthening.

The visited Kherangbar CHC did not provide X-ray and USG services. There was a shortage of radiologists observed at the state hospital. The state hospital and CHC had state-of-the-art diagnostic machines, but they were underutilized due to a shortage of lab technicians. The biochemistry analyzer was not in use due to a shortage of reagent supply. The reagents at the CHC were directly procured from the OEM.

The provision of EQAS and control run was not followed in the in-house laboratory. AAM-PHCs and CHCs provided laboratory diagnostic services through in-house mode. All diagnostic laboratory tests were free for Ayushman Bharat Card holder patients at AAM-PHCs and CHCs.

A minimal user fee was collected from general patients if reagents and consumables had been purchased by the health facility from RKS funds. The state hospital had AERB certified CT scan and X-ray machines, but the eLORA certificate was not downloaded.

The radiology machines were underutilized due to a shortage of radiologists in the state hospital; also, the services were not provided 24x7. The in-house lab of the state hospital had 2 pathologists, 1 microbiologist, 1 biochemist, 12 LTs, and 4 GDA, and still was testing an average of 90 samples a day. The reagents and consumables were procured through the MS of the hospital.

UTTAR PRADESH

At the State level, 40% of the lab technician positions remained vacant, significantly affecting the availability of diagnostic services. The State needs to improve the IPHS compliance of the diagnostic services. Only 19% of the facilities scored over 80%, while 7% scored between 70-79% and 57% scored less than 50% under the diagnostic component of the IPHS compliance score.

Diagnostic services were reportedly impacted due to delays in the supply of reagents and consumables. Though the equipment were mapped for maintenance under a PPP arrangement, their maintenance was noticeably poor. These factors delayed and compromised diagnostic accuracy, and led to poor quality of care.

The State has implemented an 'e-₹UPI' voucher scheme under the PMSMA program to provide free ultrasound services to beneficiaries. The voucher is redeemed from an empanelled USG center. The initiative aims to close the service delivery gap and reduce out-of-pocket expenditure (OOPE) on USG services.

At the secondary level, underutilization of diagnostic spaces such as RT PCR labs were observed. This was reportedly due to irregular maintenance schedules, and prolonged repairs of the equipment.

UTTARAKHAND

Although the diagnostic tests were available at the level of CHCs, AAM-PHCs, and DHs, user fees were levied from all except JSSK beneficiaries and beneficiaries of government schemes.

Free diagnostic services were available in PPP mode (outsourced) for samples collected after the first half of the day or not available at the facility point, and it was totally free for all patients. It was observed that even for tests available in the facility, samples were sent to the outsourced lab.

Reagents and consumables were available at facilities. The protocols for sample collection, handling of biohazard, and primary disinfection of bio samples were followed well by the technicians. TAT for diagnostic and radiological investigation was satisfactory, even in the outsourced laboratory.

WEST BENGAL

In South 24 Parganas, a Block Public Health Unit has been established and operationalized with dedicated epidemiologists, lab linkages, and specimen collection/transport system. An Integrated Public Health Laboratory was functional with automated entries from analysers to the iHMS, followed by auto-dispatch of reports to patients via SMS. Overall, the availability of tests at the RH/SDH levels were limited and not in line with the IPHS. LMIS was also not implemented.



**BIOMEDICAL EQUIPMENT
MANAGEMENT AND
MAINTENANCE (BEMMP)**

16th

The National Biomedical Equipment Management and Maintenance Program (BMMP) was launched in 2015 by the Ministry of Health and Family Welfare, Government of India, under the National Health Mission (NHM). The program envisages providing support by either In-house mode or outsourcing mode for medical equipment maintenance comprehensively for all facilities to improve equipment uptime and extend its useful life (functionality).

The implementation of BMMP has helped in maintaining equipment uptime of 95% at District Hospitals and diagnostic services in health facilities, making equipment available with 95% uptime, 90% at CHCs, and 80% at PHCs across the states in the country. A total of 22 States/UTs have implemented the BMMP in PPP mode and 11 States/UTs through In-house mode.

In the 19 states visited as part of the 16th CRM, 14 states have implemented BMMP through PPP mode (Arunachal Pradesh, Bihar, Maharashtra, Mizoram, West Bengal, Uttarakhand, Rajasthan, Assam, Chhattisgarh, Jammu & Kashmir, Tripura, Odisha, Madhya Pradesh, Uttar Pradesh) and 3 States through In-house mode (Gujarat, Karnataka, Haryana), while 2 states (Jharkhand and Himachal Pradesh) are in the process of retendering.

KEY OBSERVATIONS

- Lifesaving and critical care equipment were functional at the visited district hospitals, maintaining an uptime of over 90%.
- The complaint management system, utilizing a dedicated toll-free number, was functional and users were adequately aware of it.
- Inventory management by the in-house management committee/BME needed attention at the visited facilities.
- Most users reportedly expressed satisfaction with the BEMMP.
- Preventive Maintenance and Calibration schedules for medical equipment were not adhered to as per the planned schedule in the visited health facilities.
- The complaint resolution time varied across states, ranging from 2 to 12 weeks.
- Training provided to biomedical engineers in handling high-end medical equipment was found to be limited.

KEY RECOMMENDATIONS

- States need to ensure that the equipment availability should meet IPHS-2022 standards and be optimally utilized.
- A centralized breakdown management system for diagnostic equipment should be developed by all States. The implementation of the BEMMP needs to be strengthened to ensure the proper functioning of medical equipment. The dashboard should be updated regularly.
- Preventive maintenance and calibration of all medical equipment should be carried out as per schedule.
- States need to periodically review asset values for the addition or deletion of equipment in the asset base.
- Training and capacity building of BMEs need to be strengthened.
- Hospital management committees should be formed at all DH/SDH/CHC levels for improved inventory control.
- States should ensure that an annual equipment audit is undertaken. Uniform procedures for equipment calibration and maintenance must be established, and policies for condemnation of obsolete equipment must be strictly followed. States should explore mechanisms to regularly

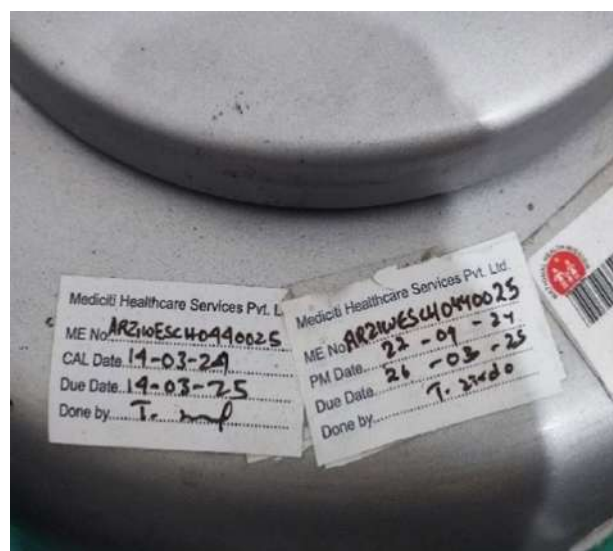
monitor and maintain the functionality of critical lifesaving equipment.

- The service provider shall arrange for periodic user training of all equipment not less than twice a year per institution irrespective of the equipment being within/outside the warranty period. States are advised to achieve 100 % AERB Compliance to ensure radiation safety for the patients and the healthcare professionals.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- BEMMP was rolled out in the state under PPP mode, with the toll-free number displayed prominently. Most of the equipment was covered under CMC or warranty; however, no equipment audit was conducted, and there was no Hospital Equipment Management Committee in place.
- In Longding district, a total of 78 pieces of equipment were tagged, out of which 39 were functional and 19 were declared BER. The district had 34 historical pieces of equipment. A total of 104 maintenance calls were registered, and 87 were repaired. In West Siang district, 343 pieces of equipment were tagged, with 266 being functional. A total of 59 pieces of equipment were marked as BER. Nearly 456 maintenance calls were registered, and 412 were repaired. The turnaround time for services was reported to be approximately one week.
- All lifesaving and critical care equipment at the district hospital were functional. The staff were aware of the BME mobile number for reporting equipment breakdowns, but awareness about AERB regulations among healthcare staff was low.
- Anthropometric equipment were unavailable at all AAMs and PHCs for screening of the children visiting the OPD.
- Laboratory quality control schemes like EQAS and IQAS had not been implemented, and regular audits of equipment were not carried out.



BIHAR

- Maintenance services for biomedical equipment have been contracted out to a private provider, who ensured prompt maintenance

CHHATTISGARH

- BMMP was implemented through District hospitals.
- Inventory equipment was available, and preventive maintenance and calibration records were maintained.
- All equipment was calibrated on a yearly basis.
- There was no Oxygen plant in CHC Duldula (Jashpur), but it was available in Gariyaband district.
- There was no LMO tank in CHC Duldula.
- The AERB certification for X-ray at CHC Duldula expired on 10.02.2021.

- There were no Mammogram, C-arm, or CT-Scan facilities available at any center.

GUJARAT

- Essential diagnostic equipment were available in most visited facilities, and most equipment were functional; however, calibration and maintenance of all equipment remained an issue.
- The BEMMP was noted to be functional, with inventory records maintained. However, Annual Maintenance Contract (AMC) documentation was not maintained adequately, resulting in a prolonged equipment downtime at regional facilities.
- The use of state corporations and health grants for diagnostics and equipment demonstrates resourcefulness. In the urban facilities visited, a shortage of equipment was noted. The municipal corporation team mentioned that they were in the process of bulk purchasing all facilities as per State Directions.
- No Internal Quality Assurance System (IQAS) or External Quality Assurance System (EQAS) has been implemented for lab tests. Most equipment lacks central calibration, and breakdown management systems are inadequate.
- Facilities independently calibrate and maintain equipment through private agencies without uniform procedures. Condemnation records and policies were also not maintained, and strict policy adherence was required.

HARYANA

- BMMP was operational in the DH.
- DH did not have a Biomedical Engineer for the last 3 years.
- The CT scan ran in PPP mode, while DH had its own in-house X-ray machine. Both machines were registered with the Atomic Energy Regulatory Board (AERB).
- The CT scan had a CMC valid in 2024, while for the X-ray machine, DH had gone for AMC (which did not cover the parts), resulting in a turnaround time of more than 7 days in case of a breakdown.
- The turnaround time for the CT scan machine was 72 hours, as shared by technicians.
- Toll-free numbers for breakdown call management were known to technicians for both machines.
- The team was not aware of the Hospital Equipment Management Committee, and decisions related to equipment maintenance and management were taken by the SKS committee.

HIMACHAL PRADESH

- BMMP services were not operational in the state as the contract of the PPP service provider ended after the completion of its term in 2024.
- The facility had a high number of non-functional equipment lying in various departments.
- The facility was repairing equipment locally.
- Inventory records were not seen in most of the facility.
- There was no Biomedical Engineer in the district.
- The PSA plants were operational in two secondary-level facilities (CH and DH/MC).
- The state had arranged PSA plant operators locally.
- All the radiology equipment (X-ray) at the health facility were AERB licensed.

JHARKHAND

- Under the BEMMP, a hybrid model was used for maintaining biomedical equipment. However, no dedicated personnel were assigned to the oxygen plant, and there was a lack of IEC on the proper use of biomedical equipment.
- Essential equipment such as pregnancy test kits, oxytocin, stadiometers, and digital weighing machines were available. Infantometers were also available but required staff training for correct usage.
- While facilities had most essential equipment, gaps in staff training on the correct use of some devices, like infantometers, were observed. Routine checks on equipment functionality were needed.
- An ECG machine was not available in emergencies. ECGs were performed by an on-call ECG technician. Complicated cases, such as MI and Stroke, were referred to MGM Hospital (8 km away).
- Functioning anesthesia machines, surgical lights, and monitors were present. However, it was noted that the equipment's usability required regular maintenance checks to avoid any disruptions during surgeries.

KARNATAKA

- The BEMMP in the state was carried out via PPP mode through an outsourced agency for all urban and rural facilities, except the HSCs.
- Apart from periodic maintenance, the facilities were provided with a toll-free number to contact in case of any urgent need.
- The inventory records were also maintained methodically at the AAM-PHCs/UPHCs.
- The facilities visited were found to have AERB licenses for X-ray units. The TLD badges were found to be used by the technicians but not by the interns.

MADHYA PRADESH

- The State rolled out the BEMMP in PPP mode.
- Awareness about the program and the toll-free number among the staff was noted at all levels of the public health facilities.
- Tagging, preventive maintenance, and calibration were carried out for most of the equipment available at the facility by the service provider under the BMMP program.
- Two ventilators were found non-functional at the district hospital in Balaghat for a long time due to the non-availability of spare parts.



MAHARASHTRA

- BMMP was implemented through PPP mode.
- Most of the facilities had tagged medical equipment.
- Facilities have access to the toll-free number for contacting the service engineers.

- Regular preventive maintenance and calibration were done at most of the facilities visited.

MIZORAM

- The Centralised Medical Gas Pipeline System was not functional in both district hospitals. The PSA plant was also not functional in DH Lunglei.
- The process of obtaining AERB certification for health facilities with X-ray facilities needs to be expedited.
- The Centralised Medical Gas Pipeline System was non-functional at DH Lunglei and Kolasib.
- Oxygen cylinders were utilized in the facility. A buffer stock was maintained with a minimum of 4 cylinders and 2 jumbo cylinders in the A&E.

ODISHA

- Equipment sets were provided at all AAMs for the delivery of CPHC. No equipment breakdown was found. The staff maintained the equipment register and were aware of the toll-free number for repairs.
- Oxygen cylinder usage was optimized by implementing efficient oxygen cylinder management to minimize waste.
- AERB clearance needed to be obtained for the upcoming Cancer Hospitals under the State Government with Radiation Oncology facilities at DHH Bargarh, SLN MCH Koraput, SRM MCH Bhawanipatna, BB MCH Balangir, PRNM MCH Baripada Mayurbhanj, FM MCH Balasore, Jharsuguda Cancer Hospital (PPP Mode), and Government Medical College Talcher.

RAJASTHAN

- The state implemented the e-Upkaran (EMMS) software solution to improve the inventory management and maintenance services of equipment in hospitals.
- The equipment at the facility was functional and mapped with barcodes by the PPP provider under BEMMP.
- The toll-free number was displayed through stickers labeled on repaired equipment. Only a few types of equipment were covered under AMC/CMC in Bharatpur district.
- The average time taken to register a complaint and for the technician to repair the equipment was about 3-4 days.
- A hospital equipment management committee was not in place to oversee the activity.
- As reported, 533 and 707 complaints were raised in Bharatpur and Sikar districts, respectively, and 100% of the complaints were closed during April-October 2024 in both districts.

TRIPURA

- The State implemented the BEMMP program in a PPP mode. The state completed the first tenure of 5 years of services in 2022 and signed the MoU with the service provider for a second tenure in October 2022, with a contract validity of 5 years.
- A total of 8,486 medical equipment were covered under the program. Most of the equipment found in the visited healthcare facilities was tagged, and preventive maintenance (PM) and calibrations were carried out as per schedule. The service provider had provided a live dashboard and toll-free number for the BEMMP program. The facility staff were aware of the program and the toll-free number for logging complaints.

- However, a significant number of beyond economic repair (BER) equipment were available in all the visited facilities, mainly at the state hospital. A new X-ray machine was lying uninstalled in the CHC due to the non-availability of a part.
- The PSA plant in both the visited facilities was non-functional since mid-2023. The CMC and repairs were pending for both plants. The SIHFW planned to have a centralized tender for the repair of these PSA plants across Tripura. Compliance with AERB regulations was observed in the visited state hospital, although the Elora certificate was not displayed.

UTTAR PRADESH

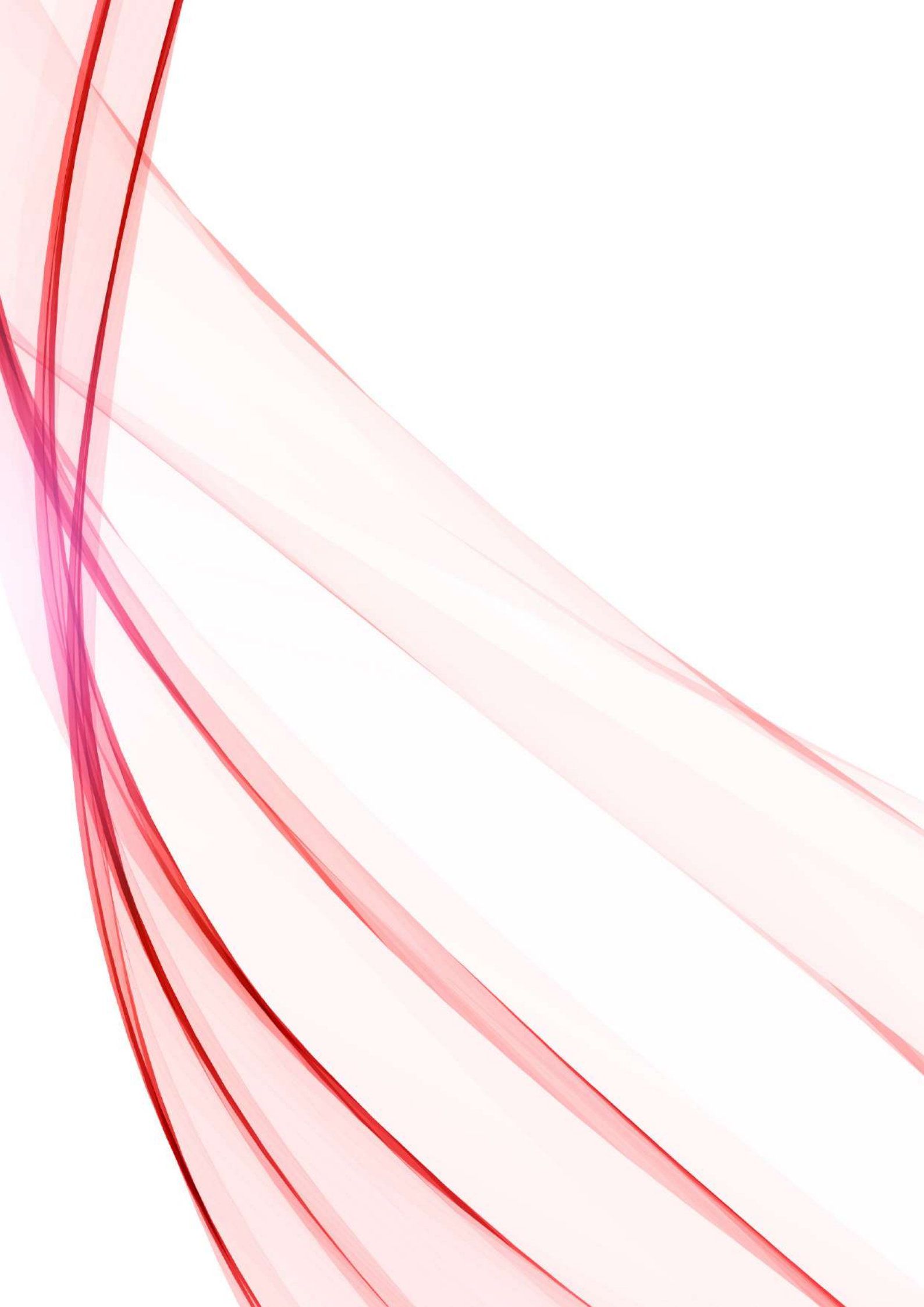
- Equipment mapped and maintenance undertaken in PPP mode.

UTTARAKHAND

- BEMMP was available in the state in PPP mode. An online dashboard was utilized for managing and monitoring the program. The inventory was available. The state had 27,762 total pieces of equipment, out of which 3,221 were critical and 24,532 were non-critical.
- A toll-free number, 18002025094, was available for raising issues.
- The equipment available at CHC and DH levels was mostly functional and in good condition. The installation reports of equipment were available at DH or at the office of CMHO, but a few pieces of equipment were not covered under AMC/CMC. Preventive maintenance was mostly done by the concerned company on a half-yearly basis.
- Calibration of equipment and instruments was not being done and should be encouraged for accuracy.
- The PSA oxygen generation plant was established and functional in DH and SDH Vikas Nagar. Paediatric HDU/ICU beds established at DH Dehradun were not functional due to non-availability of HR. BPHUs work was completed at Kapkot, Kanda, and Vikas Nagar. DPHL – DPR was awaited in Dehradun; there was no DPHL in Bageshwar.

WEST BENGAL

- The BEMMP has been established in PPP mode in the state. The percentage uptime of medical equipment at DH level was over 90%. Delay in repair of breakdown of critical equipment was found in both the districts.





**CATEGORY 3 REFERRAL
TRANSPORT SYSTEM
(AMBULANCES)**



A well-functioning referral transport system is vital for ensuring timely access to emergency and specialized healthcare services. It facilitates patient transportation for emergency care or referral to higher-level facilities. To enhance accessibility, an efficient and affordable transport mechanism is essential, with well-equipped ambulances staffed by trained Emergency Medical Technicians (EMTs) playing a critical role.

To strengthen the referral transport system, Ministry of Health and Family Welfare launched the National Ambulance Services under NHM. It operates through a centralized emergency response system with Dial 102/108 as the toll-free ambulance helpline. Ambulance services are categorized into Basic Life Support (BLS) and Advanced Life Support (ALS) and patient transport vehicles (PTVs) based on the level of care provided. Dial 108 primarily addresses critical emergencies, trauma and accidents, while dial 102 focuses on maternal and child health under Janani Shishu Suraksha Karyakram (JSSK). NHM provides technical and financial support for emergency medical services in States/UTs for establishing referral linkages through a functional National Ambulance Service (NAS). Support for 1 ALS ambulance per 5 Lac population and 1 BLS per 1 Lac population is provided to the States/UTs.

As per NHM-MIS June 2024 Report, over 28,830 ambulances under NHM are operating across 36 states/UTs, providing emergency and patient transport services. It includes 3044 ALS, 15283 BLS, 3918 PTV, 19 Boat, 81 Bike and 6485 other ambulances.

The current section explores the key observations assessing the adequacy, availability, access and service delivery of the referral transport in the CRM States visited.

OBSERVATIONS:

AMBULANCE AVAILABILITY AND FUNCTIONALITY

- The National Ambulance Services (NAS) was observed widely implemented and operational across 19 states.

- Variability in ambulance availability exists across states, with some regions having sufficient ALS/BLS ambulances, while others face shortages.
- Some states (e.g., Jharkhand and Mizoram) report issues with ambulance maintenance, outdated or non-functional equipment, and inadequate fleet size.

RESPONSE TIME AND SERVICE UTILIZATION

- Response times vary significantly across states, ranging from 7-17 minutes in urban areas (e.g., Gujarat, Haryana, and Uttar Pradesh) to 20-40 minutes in rural or hilly regions (e.g., Himachal Pradesh, Jammu & Kashmir, and Mizoram).
- Despite available ambulance services, community awareness and utilization remain low in some areas, leading to patients using private transport instead.

OPERATIONAL CHALLENGES

- GPS-enabled tracking was observed implemented in some states (e.g., Gujarat, Maharashtra), improving response times, but many regions lack effective monitoring mechanisms.
- Cleaning protocols and infection control measures were not consistently followed, particularly in states such as Bihar and Jharkhand.
- Training for Emergency Medical Technicians (EMTs) was conducted in some states, but refresher training and skills enhancement are needed in most States.

SPECIALIZED SERVICES AND INNOVATIONS

- Some states have introduced innovative solutions, such as Gujarat's 'Khilkhilahat' ambulances for maternal and newborn transport and Odisha's boat ambulances for riverine areas.
- Bike ambulances in Rajasthan provide quick first-response emergency care, particularly in congested urban areas.
- 102 Janani Express and other maternal health transport initiatives exist but require better service availability and efficiency.

REFERRAL LINKAGES AND FOLLOW-UP CARE

- In states like Himachal Pradesh, weak referral linkages result in direct referrals to district hospitals, bypassing mid-level healthcare facilities.
- Lack of proper documentation and referral tracking is reported in multiple states, affecting continuity of care and patient follow-up.

INFRASTRUCTURE AND FUNDING GAPS

- Ambulances available in primary healthcare facilities were not optimally utilised due to lack of funds for POL support and high maintenance cost due to bad road conditions. (e.g., Mizoram)
- Ambulances in some regions (e.g., Rajasthan, Himachal Pradesh) were outdated and required systematic condemnation and replacement.

KEY RECOMMENDATIONS

ENHANCING AMBULANCE OPERATIONS AND MONITORING

- States/UT to strengthen real-time GPS tracking and digital monitoring to improve response times and fleet management.
- States/UT to strengthen state and district-level monitoring mechanisms to track ambulance availability and service efficiency.

IMPROVING RESPONSE TIMES AND SERVICE UTILIZATION

- States/UT to deploy more ambulances based on geographic needs to address service gaps in remote/ rural areas.
- States/UT to implement targeted awareness campaigns to increase community utilization of free ambulance services.

STRENGTHENING EMT TRAINING AND INFECTION CONTROL MEASURES

- States/UT to conduct periodic EMT refresher training and certification to ensure competency in handling medical emergencies.
- There is a need to standardize and enforce cleaning protocols and infection prevention measures for all ambulances.

ENHANCING REFERRAL AND FOLLOW-UP MECHANISMS

- States/UT to improve referral transport coordination between different levels of healthcare facilities.
- There is need to maintain referral registers and ensure systematic follow-up for critical cases.

INFRASTRUCTURE AND FUNDING IMPROVEMENTS

- States/UT to initiate timely ambulance procurement, repair, and condemnation of outdated vehicles. Address high maintenance costs in difficult terrains (e.g., Mizoram) and ensure consistent fuel and equipment availability.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- Emergency patient transportation (108 Ambulances) was available through BLS ambulances supported under NHM operated under PPP mode.
- State has 113 ambulances in place including 108 ambulances and other state-owned ambulances. However, there was no system at the state or district level to monitor the availability or response of these services.
- The average response time of the ambulances was 30 minutes to 2 hours.
- JSSK beneficiaries were provided with tokens based on the distance at the health facilities, calculated based on distance from their home to the facility (per km basis) which they could use

to refuelling petrol.

- State needs to develop a mechanism for monitoring the ambulance services.



BIHAR

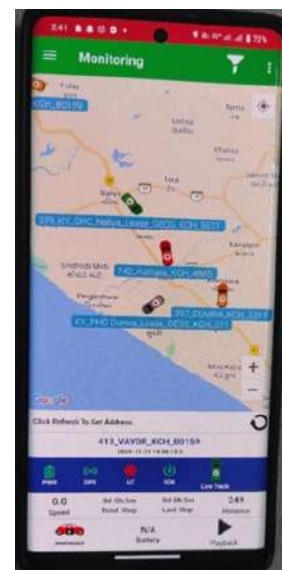
- Ambulance services were available for referral transport from primary and secondary care facilities to the District Hospital in Kaimur. Ambulances services were functional in the Gaya district through private provider (Zen Plus).
- All the ambulances (ALS/BLS) were manned by a driver and an EMT.
- Critical equipment was available and functional in the ambulances and the availability of medicines was also ensured. GPS enabled ambulances were also observed in Gaya District.
- However, no cleaning protocols were displayed for ambulances and no specific guidelines/practices were being followed for infection prevention in the ambulances.
- The training of EMTs was done by the provider however it needs further strengthening as the EMTs could not demonstrate the use of some equipment.
- Though ambulance services were free of cost, community utilization was low and many beneficiaries reported use of local transport such as autos to reach the hospital.
- Due to a recent transition in the service provider, there were no records available on the response time. Log books suggest an average response time of about an hour in Gaya District.
- The monitoring of ambulances for daily trips and response time needs to be done on an immediate basis to ensure record-keeping and performance tracking.
- The availability of 102 ambulance services needs to be strengthened

CHHATTISGARH

- Centralized toll-free numbers (102, 104, 108, 1099) were available.
- Referral transport from primary to secondary care facilities was available
- Response time of Ambulance of 102 and 108 are noted between 30 to 40 minutes.
- Overall, the 108 and 102 ambulance services are used to pick and drop back home.

GUJARAT

- All the ambulances were operational and equipped with critical equipment and trained and certified EMTs to provide pre-hospital care.
- Ambulance vehicles are monitored in real-time through GPS, with alerts sent to the call center if they do not move within 10 seconds of assignment. (Image 26)
- Response time of the ambulances in the state is good at 12 minutes in urban areas and 22 minutes in rural areas.
- It was reported that there was no denial of services, however, there were instances where the nearest ambulance was occupied, and the caller was unwilling to wait for it to become available. Such cases accounted for 0.54% in the State, 0.32% in Vadodara, and 1.78% in Kachchh.
- The State uses a special category of vehicles called 'Khilkhilahat' for transporting mothers and newborns post-delivery, and for RCH functions. Due to high demand, 414 Khilkhilahat vehicles are currently operational, with plans to procure 274 more.
- Good coordination was observed for referral cases where in Medical Officers communicate with higher facilities about the cases.
- There is a dedicated application for EMTs, which has dedicated modules on Stock Management, Patient Case Records, Response time, Duty Record.
- IT-enabled systems, including mobile applications for EMTs and Pilots, manage inventory and provide fleet managers with vehicle status updates.
- Daily vehicle inspections were being conducted by EMTs to report and upload pictures of any equipment issues.
- To address the Challenges to access in the Kachchh region, especially among the two Aspirational Blocks (Rapar & Lakhpat) State was planning to propose new ALS and BLS ambulances based on local requirements rather than population norms.
- Community members were aware of 108 services and reported using the same for emergency cases.



HARYANA

- In the district, there are 33 ambulances (2 ALS, 11 BLS, 17 PTAs, 3 Kilkari vehicles). Only 30 are operational vehicles. In the DH Palwal, 9 ambulances are positioned (2 ALS, 1 BLS, 4 PTA and 2 Kilkari).
- EMTs were available in ALS/BLS ambulances. There are 86 drivers and 38 EMTs in the district Palwal.
- No denial of services was reported under 102/108 due to shortage/unavailability of ambulances.
- Training of EMTs was last conducted in 2020 during Covid and EMTs are also trained at the DH level from time to time by Medical Officers in emergency.
- Average response time for district Palwal was 9 minutes (Jan to Oct 2024).
- Vehicles were replaced in case they complete 5 years or 3 lakh kilometres.

HIMACHAL PRADESH

- 108 Ambulance services were operational in the State through Public Private Partnership mode through a centralized toll-free number (108).

- The service provider has deployed ALS and BLS ambulances in the State as per the scope of work.
- The district Hamirpur had 10 ambulances (1 ALS & 09 BLS) stationed at the various level of healthcare facilities such as Civil Hospital, CHC and DH/MC.
- ALS ambulances are stationed at DH/MC and are only used for referring patients to the higher centre.
- The average response time as reported by the State was 30-40 minutes, however, delay has been observed in some of the cases.
- The Emergency Medical technicians were available and trained in managing the emergencies.
- Himachal Pradesh being hilly terrain, it is important to ensure the availability of Ambulance services in a timely manner.
- Non-functional ambulances (18) parked inside the compound of Civil Hospital Suni indicate the need for following the scrapping policy for ambulances to be disposed off properly and updated on 'VAHAN' database.

JAMMU & KASHMIR

- UT has 203 ambulances out of which 139 are ALS and 64 BLS.
- 108 Ambulances were equipped with Automated External Defibrillators (AED) and other necessary equipment and operational through a toll-free centralized 108 number.
- The average response time of ambulances was 30-45 min.
- As per the records no calls were denied under 108 services.

JHARKHAND

- In both the Districts visited, out of the two ambulances allocated, only one was functional, while the other had been reported as being in the garage for the past three to four months, indicating prolonged delays in repair and upkeep.
- Significant gaps in ambulance maintenance and management were observed in both the districts severely impacting service efficiency.
- The condition of the ambulances was found to be extremely poor. The stretcher and door of the operational ambulance were broken, posing a risk to patient safety and usability.
- Ambulances lacked critical equipment, including monitors, medications, and functional oxygen cylinders at the time of inspection.
- The registers were poorly maintained as the entries were found only for 20 days of January and 15 days of July.
- Suboptimal number of ambulances contributed to longer response times, with the average response time being approximately 20 minutes which is higher than the national average.
- Management and operational oversight of the service were transitioned from 'Ziqitza Healthcare Ltd'. to GBK Emergency Management and Research Institute in August 2023 to improve service delivery. However, recent inspections revealed that cleanliness and staff conduct issues within the ambulance service remained a concern.
- Immediate actions are needed to implement robust quality control measures, conduct regular inspections, and ensure adherence to safety and hygiene protocols.
- Considering Sahibganj's geographic challenges and population distribution, an increase in the number of ambulances, particularly Advanced Life Support units, is essential to enhance coverage

and response efficiency.

- Accurate and timely record-keeping is essential for tracking ambulance utilization, ensuring accountability, and planning resource allocation.

KARNATAKA

- State had undertaken local empanelment of vehicles but community expressed low use and delayed response.
- EMT and equipment available but state to ensure regular maintenance of vehicles.

MADHYA PRADESH

- Balaghat district had a total of 04 Advanced Life Support (ALS) ambulances and 16 Basic Life Support (BLS) ambulances available to cater to emergency healthcare needs.
- Mixed responses were received from the community regarding the quality and effectiveness of the ambulance services.
- Patients who had availed of the services of the “108” ambulance system expressed general satisfaction with its availability and timely assistance.
- During interactions with beneficiaries in the Rewa district, it was noted that while the services were available, a few beneficiaries reported being unable to use the ambulance services due to delays in response time.
- Response time of ambulance services needs to be reduced to address the issues observed in the ambulance services, particularly in Rewa district where delays were reported by beneficiaries.

MAHARASHTRA

- Maharashtra Emergency Medical Services (MEMS) project under National Health Mission provides pre-hospital health services to patients requiring emergency services through life support ambulances to nearby hospitals for further treatment.
- Total 937 ambulances are in service of which 233 are ALS and 704 are BLS.
- Ambulance services are operated through a centralised call centre Control Room/Emergency Response Centre (ERC) established at Chest Hospital, Aundh Pune.
- 24X7 trained Call takers & call dispatchers were available for emergency response.
- Real time location of ambulances using GPS-GPRS technology was being monitored from the call centre.
- During April to October 2024 total 9,26,313 patients utilized ambulance services in the State.
- The average response time was 19 minutes in the urban areas and 24 minutes in rural areas.
- Only 233 out of 937 ambulances are ALS-equipped, which may not be sufficient for handling critical emergencies. Investment in additional ALS-equipped ambulances, particularly in rural and tribal regions, is required to improve emergency care for critical patients.
- Limited awareness about ambulance services especially in remote and tribal areas was observed as a Challenge indicating the need for increasing awareness in rural areas to educate communities about availability of free ambulance services.

MIZORAM

- State lacked adequate emergency and referral transport system
- 5 patient transport vehicles were available in the DH Lunglei, of which 1 was BLS.
- Oxygen cylinder was available in the BLS but medicines and EMTs were not available.
- The logbook was maintained, but the fire extinguisher placed in the ambulance expired.
- The response time of the ambulance was 5-15mins.
- In the Kolasib district, patients arrange their own vehicles to transport patients.

ODISHA

- Emergency medical ambulance and referral transport services in the CRM-visited districts (Koraput and Sambalpur) were functioning well.
- The districts had a total of 29 Advanced Life Support (ALS) ambulances, with 16 in Koraput and 13 in Sambalpur.
- Both districts had a notable number of 108 ambulances, with 35 in Koraput and 29 in Sambalpur.
- Additionally, there were 35 Basic Life Support (BLS) ambulances, with 19 in Koraput and 16 in Sambalpur.
- 108 ambulances services could be accessed through the toll-free number '108' catering to various emergencies, including accidents, pregnancies, cardiac arrests, and other medical crises.
- Average response time was 24 minutes in Koraput and 23 minutes in Sambalpur.
- However, the service could only be availed upon request from the on-duty Medical Officer and does not provide drop-back facilities for patients.
- 24/7 102 referral transport ambulance service, also known as 'Janani' in Koraput district, provides vital transportation for delivery cases, sick newborns, and infants up to one year old.
- Koraput has 18 ambulances, with average response times of 27 minutes while Sambalpur has 13, and response time of 28 minutes.
- Under-utilization of the 102 service was observed in both the districts probably due to difficulty in accessing the services in remote areas.
- Boat ambulance services have also been implemented in regions with significant water bodies or difficult riverine terrains, since February 2019.

RAJASTHAN

- The State has been providing free emergency ambulance services to people through 108 emergency ambulances, 104 Janani Express, Bike Ambulances and Mamta Express through outsource mode.
- 147 ALS and 797 BLS are providing the services and it is being managed by 'EMRI – Green health Services'.
- All the ambulances were operational with EMTs and 147 ambulances were fully equipped with critical equipment dressing materials, surgical materials, and medicines kept in the ambulance as per GOI norms.

- In Sikar District 32 ALS/BLS were operational, where as in Bharatpur District 38 ALS/BLS were operational.
- On an average 3 trips were taken by 108 ambulances in a day and maximum distance travelled noted was about 30 kms.
- The average response time of ambulance services (urban/rural) in the State was 7.44 minutes (from April to October 2024)
- '104 Janani Express Ambulance' – Provide 24*7 ambulance referral/ transport services to pregnant women, sick children up to 1year, malnourished children, children screened under RBSK and drop back to home for sterilization cases through 108/104 toll free numbers in rural area of entire State. Average response time of 104 Janani Express ambulance services (urban/rural) from April- October is 5 minutes.
- 'Mamta Express Ambulance' is a hybrid model of ambulance service working for eight hours at mobile OPD camp with provision of free drugs & diagnostic services and remaining sixteen hours as 104 Janani express.
- State also has initiated Bike ambulances for emergency healthcare services with an aim of providing first-responder emergency services. There are 45 bike ambulances operational in the State.

TRIPURA

- The state has 09 ALS and 61 BLS ambulances available for providing emergency transport services.
- 50 BLS ambulances were fully equipped with critical equipment and EMTs as per GoI norms (AIS 125 Type C Ambulance, MoRTH).
- On an average 5% to 7% calls were denied services under 102 due to shortage/ unavailability of Ambulances.
- Inter-district variability was observed in the average response time of the ambulance.

UTTAR PRADESH

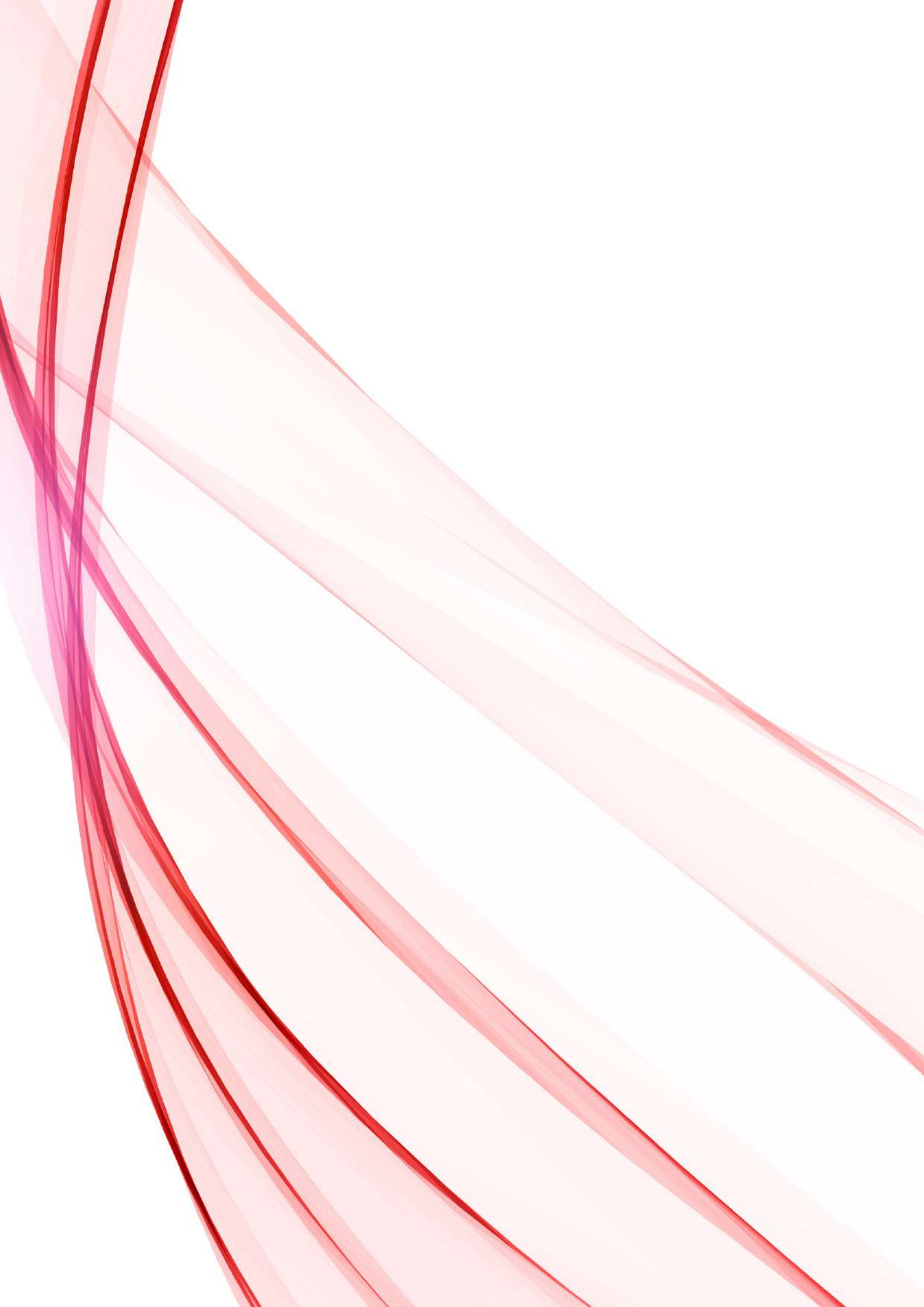
- 2,270; 102 Ambulances and 2200; 108 Ambulances are operational in the State with 9.18 crore beneficiaries availed the services till date.
- State reported that 100% saturation of Basic Life Support (BLS) is achieved but coverage Advanced Life Support (ALS) was 57% as per population norms.
- The reported average response time per vehicle was 07:40 Minutes. However, while verifying the response time at the field it was found that the response time was 20 minutes in rural areas.
- On an average, the response time at the state level has been reported to be 30 minutes in hilly areas and 20 minutes in plain areas whereas the facilities visited have reported varying response times, with an average response time of around 15 minutes.
- The state conducts training for ALS and BLS once every year. The last training for ALS was conducted in March 2024, and for BLS, it was conducted in September 2024.
- State needs to ensure that all ALS and BLS staff attend the EMT refresher trainings being undertaken periodically by the EMTS cell.

UTTARAKHAND

- Emergency Care is poorly organized. Right from referral chain, availability of transport (54 ALS and 218 BLS), response time (urban 12.50 minutes; rural 23.32 minutes), utilization (mainly for pregnancy related services 23120, followed by RTA 6931 in this year)
- Assign a medical officer to inspect referral transport (ALS/BLS) monthly

WEST BENGAL

- Adequate number of BLS ambulances were deployed through a centralized call center -Dial 102 in attempts to reach the designated tertiary care institutions.





**CATEGORY 4: PRADHAN
MANTRI JAN AROGYA
YOJANA (PMJAY)**

BACKGROUND

- Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) was launched on 23rd September 2018 in Ranchi, Jharkhand. It is the largest health insurance scheme in the world which aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization. The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas respectively.
- The AB PM-JAY scheme has witnessed continuous expansion of the beneficiary base since the past 7 years. Initially, 10.74 crore poor and vulnerable families comprising the bottom 40% of India's population were covered under the scheme. Later, the Government of India, in January 2022 revised the beneficiary base from 10.74 crore to 12 crore families considering India's decadal population growth of 11.7 % over 2011 population. Additionally, the scheme was expanded to cover 37 lakh ASHAs/AWWs/AWHs working across the country and their families for free healthcare benefits. Furthermore, it is now also providing free healthcare coverage of Rs 5 lakh to all citizens of the age-group of 70 years and above across the country.
- As of February 2025, the scheme has recorded 8.6 crore hospital admissions and created 36.7 crore Ayushman cards. Under the scheme, a total of 31,794 hospitals have been empanelled including 17,403 public and 14,391 private hospitals.

KEY OBSERVATIONS

- Awareness among the population regarding the PM-JAY scheme was observed, however awareness about the hospitals empanelled under PM-JAY scheme was lacking.
- Some States were also implementing State specific health insurance schemes like CM-AAY in Arunachal Pradesh, Gopabandhu Jana Arogya Yojana in Odisha, Jyoti Rao Phule Jan Arogya Yojana in Maharashtra, Ayushman Bharat Pradhan Mantri Jan Arogya Yojana - CM's Arogya Karnataka (AB PMJAY-CM's ArK) in Karnataka.
- Many states have effectively integrated their health insurance schemes with PM-JAY, such as Maharashtra, Odisha, Rajasthan, and Karnataka, ensuring broader coverage and streamlined benefits for beneficiaries.
- States have successfully implemented diverse enrolment strategies, with Karnataka, Rajasthan, and Mizoram achieving high uptake through strong community engagement, conducting special drives and camps for increasing enrollment under the Scheme especially in difficult to reach areas while other states were working towards enhancing awareness in the communities.
- Progress in Karnataka, Mizoram, and Odisha demonstrate effective scheme implementation, with Karnataka leveraging ASHAs for enrolment, Mizoram achieving high hospital admissions, and Odisha ensuring interstate treatment portability.
- Administrative bottlenecks and governance challenges impact implementation, with Gujarat encountering challenges in oversight of empanelled private hospitals, and Uttar Pradesh facing poor communication and financial inefficiencies as Significant amount of funds under scheme remain unutilized.
- Public health infrastructure needs strengthening, particularly at CHCs, to reduce unnecessary referrals, as seen in Jammu & Kashmir, Rajasthan, and Odisha
- Private hospitals are preferred over public facilities in multiple states, such as Rajasthan, Odisha, and Mizoram, due to better service availability, while Uttar Pradesh sees underutilization of PM-JAY in government hospitals and PHC level facilities due to limited services in the health benefit package.
- Some states were facing challenges in strengthening data management mechanisms and claims processing. However, efforts were underway to improve real-time tracking, reduce claim pendency,

and enhance transparency in reimbursement systems.

- It was observed that adaptable financial models, timely payments, and improved scheme governance were playing an important role in enhancing accessibility and ensuring financial sustainability of PMJAY.
- Innovative scheme adaptations like Tripura's CMJAY-2023 provide universal coverage, including state government employees who opt-in by surrendering existing medical allowances
- In Arunachal Pradesh, CMAAY (state specific insurance scheme) was utilized more as compared to PMJAY due to easy enrolment process via a paper-based form compared to the online enrolment process for PM-JAY.
- In Uttar Pradesh, the AB-PMJAY claim settlement was very slow and a high number of claims were pending.

KEY RECOMMENDATIONS

- States/UT to strengthen community awareness programs about empanelled hospitals and coverage details, particularly in Madhya Pradesh and other states where limited knowledge impacts utilization. Engage ASHAs, ANMs, and Health Workers (as successfully done in Karnataka) for targeted enrolment drives, particularly for hard-to-reach and vulnerable populations.
- States/UT to provide hospital staff with training on digital claim submission, fund tracking, and PM-JAY platform management, reducing administrative bottlenecks. Additionally, conduct periodic training for Arogya Mitras and allied health personnel (Jammu & Kashmir) to enhance service delivery efficiency.
- States/UT to strengthen community awareness programs about empanelled hospitals and coverage details, particularly in Madhya Pradesh and other states where limited knowledge impacts utilization. ASHAs, ANMs, and Health Workers to be engaged (as successfully done in Karnataka) for targeted enrolment drives, particularly for hard-to-reach and vulnerable populations.
- Hospital staff to be provided with training on digital claim submission, fund tracking, and PM-JAY platform management, reducing administrative bottlenecks. Additionally, conduct periodic training for Arogya Mitras and allied health personnel (Jammu & Kashmir) to enhance service delivery efficiency.
- States/UT to conduct regular performance audits and claim verifications to ensure effective fund utilization (as seen in Tripura's judicious use of funds for local purchases and minor repairs) and ensure improved regulation of empanelled private hospitals and financial transactions through effective monitoring mechanisms.
- Administrative issues to be resolved on priority causing pending payments (Jammu & Kashmir and Uttar Pradesh) through centralized real-time tracking and escalation mechanisms.
- Internet connectivity issues in hard-to-reach areas to be addressed on priority or offline data entry tools with auto-sync capabilities to be deployed when connectivity is available in states like Assam.
- Ensure each empaneled hospital has dedicated kiosks with trained personnel (as seen in Karnataka), providing real-time assistance and guidance to beneficiaries.
- Poor awareness about fund utilization guidelines among administrators can be improved by capacity building and additionally training of concerned administrative staff for effective utilization of AB PMJAY fund.
- The AB-PMJAY IEC shall be done at dialysis centre to prevent OOPE on account of Inj. erythropoietin.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- The state has CMAAY (Chief Minister Arunachal Arogya Scheme) running alongside PM-JAY (Pradhan Mantri Jan Arogya Yojana) in the state. Under CMAAY, families receive coverage up to Rs 5 Lacs per year for hospitalization and surgical procedures. This includes a cap of Rs. 1 lakh per year for secondary ailments and Rs. 4 lakhs per year for high-cost tertiary ailments.
- The Ayushman card coverage in Longding district was 77%, and in West Siang district, it was 69%. Overall, the state has 62% targeted families covered under the scheme. The state plans to achieve 100% Ayushman card coverage by 31 December 2024.
- CMAAY is utilized more as compared to PMJAY. The main reason was easy enrolment process via a paper-based form compared to the online enrolment process for PM-JAY.
- A total of 37 hospitals, both within and outside the state, were empanelled under CMAAY. The scheme covers a package of 2,601 medical conditions under both CMAAY and PM-JAY.
- In Longding, 207 benefits received treatment under CMAAY and 17 under PM-JAY outside the state. In West Siang, 525 benefits were treated under CMAAY and 12 under PM-JAY outside the state.

ASSAM

- There were 5 PMJAY empanelled public healthcare facilities in Morigaon District of Assam but the beneficiaries primarily avail the PMJAY benefits from the STHG Civil Hospital, Morigaon. There is no private healthcare facility empanelled under PMJAY in Morigaon District.
- The process of e-KYC verification under AB-PMJAY for validating NFSA beneficiaries has been initiated in the Morigaon District.
- Government frontline workers such as ASHAs, MPWs, Bima Sakhis, Bank Sakhis, Digipay Sakhis etc. have been deployed for undertaking the process through house to house visits and organized camps.
- The e-KYC of the beneficiaries is done through a mobile application developed by National Health Authority (NHA).
- Till date, against a target of 7,02,543 beneficiaries the e-KYC verification of 5,56,201 has already been completed in Morigaon District.
- Records on the number of beneficiaries availing services under PM-JAY were not maintained, impacting programme monitoring and evaluation.
- Persistent issues with server and internet connectivity hinder real-time processing and service delivery.

CHHATTISGARH

- State implemented the PM-JAY and empanelled the hospitals as per the norms within the state
- The state has rolled out the PM-JAY scheme, along with the existing PM-JAY scheme, the state also came up with state-specific insurance coverage of Rs. 50,000 for Above Poverty Line population and Rs.25,00,000 under Mukhyamantri Vishesh Swasthya Sahayata initiatives.

GUJARAT

- In Kachchh district, positive feedback was provided regarding the benefits under PM-JAY, including the example of seamless access to care at a private hospital in case of a cardiac bypass surgery.

HARYANA

- Registration of ASHA under PM-JAY schemes needs to be initiated in the State of Haryana.

HIMACHAL PRADESH

- The visited health facilities were empanelled under the PMJAY and State initiative HIMCARE. The tertiary care facilities had linkages with PMJAY.

JAMMU & KASHMIR

- Under PMJAY, Ayushman Bharat PM-JAY Scheme was launched in December 2018 in Jammu and Kashmir. However, Ayushman Bharat PMJAY SEHAT Scheme was launched on 26th of December 2020 in order to provide the benefits of AB-PMJAY to all residents of UT of J&K irrespective of any age.
- The facilities are having PM-JAY aligned with JK eSEHAT, which is open for all citizens of Jammu and Kashmir under which Rs 5 lakh support is available to per family per year.
- Strengthening of CHCs is needed to reduce frequent referrals to GMC under the scheme.
- The scheme is categorized as Priority household and non-priority households for availing the benefits.
- Under PMJAY, Arogya Mitra were available in the facility and, cases are being admitted, and claims were being submitted. Under Training and orientation of Human resource, Documentation regarding training, orientation was not available with the facility and Paramedic Staff was not properly trained in service delivery for their care area of interest.
- During 2024-25 all the payments of 6268 patients is pending, under AB-PMJAY SEHAT Scheme due to some administrative issues at the UT level.
- During 2023-24 all the payments of 8607 patients is pending, under AB-PMJAY SEHAT

JHARKHAND

- PMJAY provision was present in DH East Singhbhum.
- Dedicated personnel and area for providing PMJAY services was available. Dedicated personnel was enrolling individuals and providing registration and claim services under PMJAY.

KARNATAKA

- PMJAY was being implemented as Ayushman Bharat Pradhan Mantri Jan Arogya Yojana - CM's Arogya Karnataka (AB PMJAY-CM's Ark). The scheme offers 1650 treatment packages, through 2964 public and 590 private empaneled health facilities. The state was launching a 'Free second opinion scheme' on the requirement of procedures.

- There were dedicated PMJAY kiosks with adequate branding at District Hospital/ Sub-district hospital. Arogya Mitras and claim executives were present at the PMJAY kiosks for offering guidance and support to the patients.
- Most patients and their caregivers present at the hospital were aware of the PMJAY and AB-PMJAY-Ark ID cards were being registered.
- In terms of claim fund utilization by district hospital, 70% was used for infrastructure development and 30% for incentives to health professionals.
- The ASHA & Health Workers promote the PMJAY/ Arogyashree enrollment in their communities. The different CHO's/MOs reported 60-70 percent of their target population to be having PMJAY enrollment cards.
- Special PMJAY card enrollment drive was conducted for difficult to reach population (mostly the farmers and labourers) who were generally not available during Gram-One's (Authorized agent in villages for PMJAY enrollment) opening hours.
- The patients need to wait for a long time to take services under AB-Ark as it takes more time in the approval process by the head of AB-Ark.
 - Though awareness was high among hospital attendees, awareness about PMJAY and enrollment of beneficiaries at the community level needs to be improved.
 - As suggested during the community interaction, the State may consider empaneling more private hospitals under AB-Ark scheme for better utilization.

MADHYA PRADESH

- Awareness among the population regarding the PM-JAY scheme was observed, however they were not aware about the hospitals that are empanelled under PM-JAY scheme.
- Civil Hospital, Wara Seoni had an Ayushman card centre, where they were enrolling the eligible IPD patients under PM-JAY. The facility was also issuing the PM-JAY cards for the people with the age above 70 years.
- A total of 320 cards were provided to IPD patients and 80 cards were issued for the people with age above 70 years.

MAHARASHTRA

- State has implemented Mahatma Jyotirao Phule Jan Arogya Yojana integrated with PMJAY which covers all population of Maharashtra.
- The scheme provides end to end cashless quality medical services for identified secondary and tertiary diseases requiring hospitalization through empanelled hospitals.
- State to ensure awareness about the PMJAY scheme among the population

MIZORAM

- AB-PMJAY is being implemented in the State to provide tertiary care services to eligible beneficiaries (SECC/RSBY/NFSA), benefiting 2,16,584 families.
- A total of 2 State level Hospitals, 11 District Hospitals, 2 Sub District Hospitals, 8 CHCs, 56 PHCs and 8 Private Hospitals are empanelled under the scheme.
- In addition to the treatment cost as per Health benefit package rates, state is also providing cost of transportation and cost of treatment beyond package rates through State specific scheme

(Mizoram State Healthcare Scheme).

- A Medical referral board has been constituted for gatekeeping of interstate tertiary referrals.
- A total of 1,18,720 Hospital admissions with an amount of Rs. 127.55 crore have been claimed under the scheme from 2018 to 2024-25 (up to October 2024).
- The Average Hospital admission per lakh beneficiary family in Mizoram is 61,882, compared to the National average of 49,764, indicating high utilization of the scheme in the State.
- PMJAY enrolment is approximately 70% and it can be increased by better advocacy and IEC.

ODISHA

- Odisha has its own health assurance scheme, Gopabandhu Jana Arogya Yojana (GJAY), which was previously known as Biju Swasthya Kalyan Yojana. Launched in 2018, GJAY provides universal health coverage, focusing on economically backward populations. The scheme offers comprehensive healthcare services, including free OPD consultations, ICU, and surgery in government hospitals. Additionally, GJAY provides ₹5 lakh annual coverage per family, with an extra ₹5 lakh for women members, benefiting 1.03 lakh families across Odisha and 16 more States where it is honoured. GJAY has a provision for beneficiaries to avail the benefit into selected healthcare facilities in other States as well.
- GJAY also offers cashless health coverage for nine critical ailments, covering 494 packages, to rural residents not covered under NFSA/SFSS schemes.
- Currently, 1.03 crore families, approximately 80% of the State's population, are covered under GJAY.
- Every month, around 1.5 lakh patients receive cashless services worth over ₹350 crores at empanelled private hospitals, with a remarkable 98% patient satisfaction rate.
- Although Odisha was planning to transition to the Pradhan Mantri Jan Arogya Yojana (PMJAY) scheme in the future, GJAY remains the State's primary health assurance scheme.

RAJASTHAN

- PM JAY (Chiranjeevi Scheme) was operational across facilities. Gold cards were being issued by e-Mitras (common service centres) in the district. Around 79.87% of targeted families are covered under Ayushman Bharat-Mukhya Mantri Ayushman Arogya Yojana (MAA-Yojana).
- The families are covered for up to Rs. 25 lakh (Rs. 5 Lakh on insurance mode for 1761 packages and Rs. 20 lakh on Trust Mode for 45 packages). Any family can enroll by paying the premium of Rs. 850/- per family per year and currently 3.98 lakh such families are covered under the scheme.
- A total of 877 Government and 905 Private Hospitals are Empanelled under MAA-Yojana. The Conversion rate of the scheme in Government Facilities against the total IPD of the facility is very low, it ranges between 39.15% at DH, 31.80 at SDH & 23.94 at CHC, whereas the Conversion rate in the Private empanelled facilities is 74.66%. Further, out of 1806 packages under the MAA-Yojana only 5 & 8 packages are covered at few CHCs & SDH respectively, in Sikar District.
- State requires to strengthen the Health facilities to cover maximum number of packages in the Government facilities and increase the conversion in Government facilities under MAA.

TRIPURA

- Being sensitive to the healthcare need of the people of the state, couple with the ever-increasing

healthcare expenditure and, the Government of Tripura had on 15th February 2024 launched the Chief Minister Jana Arogya Yojana (CMJAY) – 2023 and ushered in Universal Health Coverage (coupled with AB-PMJAY and other schemes being implemented on the AB-PMJAY platform).

- The cashless, paperless scheme is being fully funded by the State Government and being implemented upon AB-PMJAY platform.
- It was observed that the flagship scheme of AB-PMJAY covers around 5.50 Lakh households in the state. Beyond this, other health insurance schemes like PM JANMAN, CAPF Scheme, BoCW Scheme aims to bring around 50,000 families under health insurance coverage. Therefore, the State Government had felt the necessity to bring the leftover population of around 3.70 Lakh households, irrespective of socio-economic status, under some sort of public-funded health insurance coverage, which had led to the inception of CM-JAY 2023.
- Under CM-JAY, each beneficiary family is eligible to receive cashless, paperless treatment worth up to Rs.5.00 Lakh per year for hospitalization episodes, i.e. on In-patient basis, across all the AB-PMJAY empanelled hospitals all over the country. Unlike private insurances, there is no age limit at entry for any beneficiary under the scheme. Also, all pre-existing diseases are covered under this scheme from Day 1.
- State Government employees who will surrender existing Medical Allowance and Medical Reimbursement will be included in CMJAY-2023 scheme. This scheme is a commendable step to provide health protection to everyone in Tripura to implement UHC .. By now, 4.66 Lakh individuals from 2.12 Lakh eligible households have availed CMJAY Cards. Since February, 17,559 patients have availed treatment worth Rs.20.00 Cr in various empanelled hospitals within and outside the State.

UTTAR PRADESH

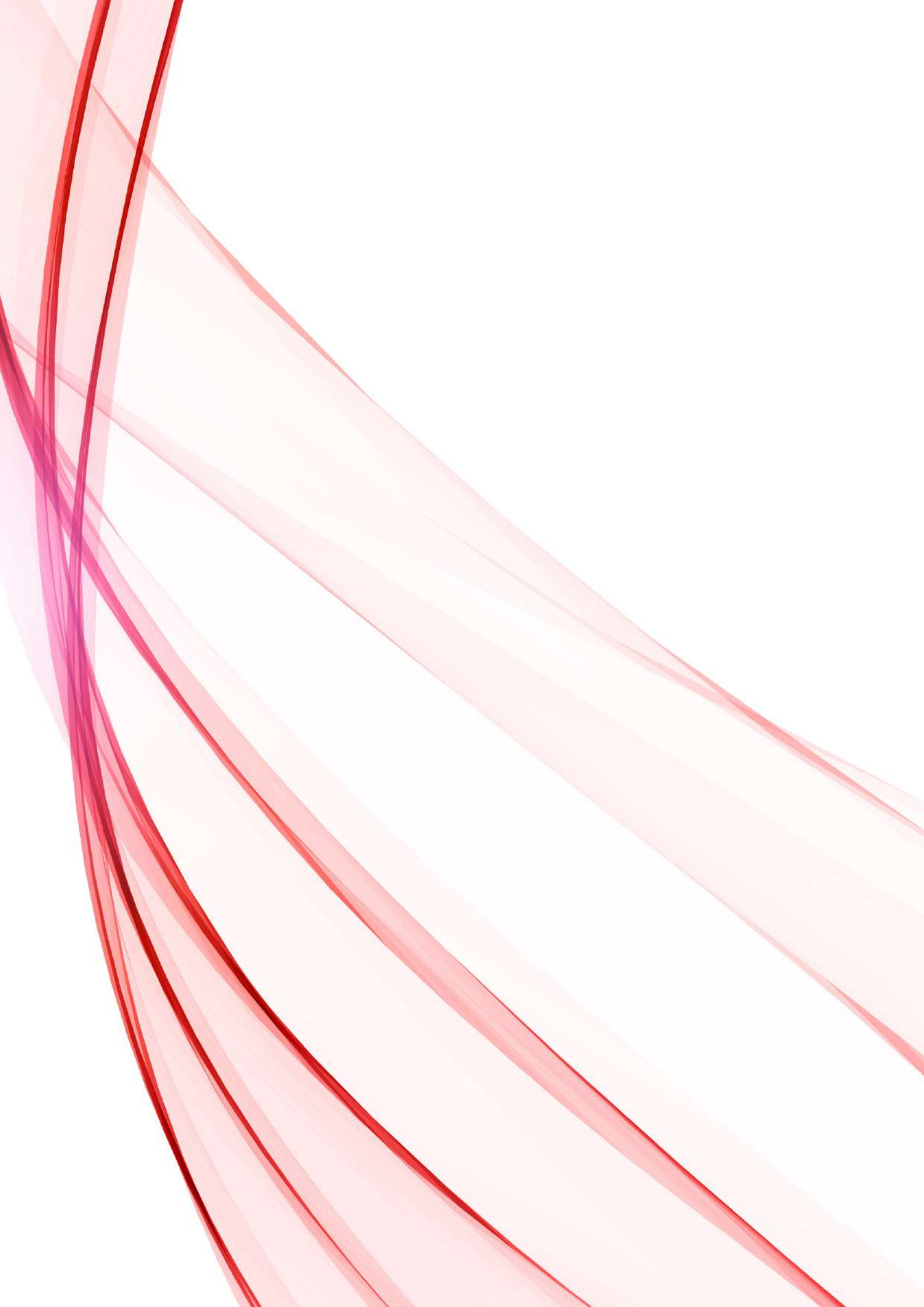
- High pendency of the claim of AB-PMJAY which totals 517236 (10% of total claims initiated) at the state needs to be cleared on a priority basis.
- The AB-PMJAY claim settlement was very slow and a high number of claims were pending. The majority of claims were applied for orthopedic procedures and oncosurgery/chemotherapy whereas minor reasons like patient not presenting his/her photograph or incomplete documentation were given reasons for pending claims.
- The Medical superintendent was unaware of tele helpline or grievance officer availability at district level for any AB-PMJAY concerns.
- The Medical superintendent was not aware of fund utilization guidelines for revenue generated under AB-PMJAY scheme.
- Significant funds under programs such as AB-PMJAY and Jan Arogya Suraksha (JAS) remain unutilized, highlighting inefficiencies in financial planning and management.
- As health services are provided free of cost in public hospitals, patients do not prefer to use their PMJAY wallet in availing services from these hospitals.
- It is reported that there are very limited services in the Health Benefit Package (HBP), for PHC level hospitals.
- The AB-PMJAY IEC shall be done at dialysis centre to prevent OOPE on account of Inj.erythropoetin.
- The Medical superintendent, and District health team shall coordinate with grievance officer at common meet e.g., DHS meeting for solution of claim pending and expense guidelines or any other relevant issues.

UTTARAKHAND

- State has PMJAY empanelled hospitals – 101 in Uttarakhand (4 in Bageshwar, 13 in Dehradun).

WEST BENGAL

- West Bengal was implementing the state health assurance scheme, Swasthya Saathi, equivalent to PM-JAY. However, its uptake in secondary healthcare facilities was found to be significantly low, with inpatient department (IPD) utilization below 5%.





**CATEGORY 5
IT APPLICATIONS**

BACKGROUND

India's healthcare landscape is undergoing a digital transformation, driven by government initiatives, policy reforms, and technological advancements. Digital health solutions are playing a crucial role in enhancing the accessibility, affordability, and efficiency of healthcare services. Various IT-based web portals and mobile applications have been developed by MoHFW for the seamless collection and transfer of Data from the various levels of healthcare facilities to sub-national & National levels. These IT initiatives are also aimed at improving the planning and efficiency of healthcare services by enabling data-driven decisions and policy changes. In addition to National IT applications, various States have also developed their state-specific portals and applications based on their local context and needs. While multiple national and state-specific IT portals are currently operational, their effectiveness depends on availability of proper IT infrastructure and network connectivity. The CRM teams assessed the implementation of IT solutions' and their functionality at various levels of Healthcare facilities.

OBSERVATIONS

- Most States were using Govt portals/applications like HMIS, NP-NCD, NIKSHAY, DVDMS, NIKUSHTH, U-WIN, PMNDP etc. Few States have also developed state specific IT systems like BHAVYA in Bihar, e-UPCHAR in Haryana, Mantra& e-kavach in Uttar Pradesh, PCTS in Rajasthan.
- Inadequate training of the HRH in IT systems in some States like Uttar Pradesh, Chhattisgarh, Jharkhand posed a challenge in data entry and management leading to potential errors and data inaccuracy.
- While most of the IT applications were being used across the States, real time data entry and utilization required further improvements.
- Internet connectivity and server issues were reported as challenges in harnessing/unleashing the potential of IT applications their real time utilization.
- Leveraging central portals for enhancing digital adoption and further comply standards and frameworks to ease integrations was limited.

KEY RECOMMENDATIONSS

- Capacity building of staff orientation and refresher training to staff on all portals and data entries is required to improve the data quality.
- States should not develop similar portals that are already being run by central govt to avoid duplication of efforts and resources.
- Improving internet connectivity in both rural and urban areas for robust IT application system.
- Validation of data accuracy should be monitored and checked frequently.
- Full operationalization of e-Hospital for registration, consultation, lab tests and medicine indenting from IPD wards to be ensured.
- Integration of Portals: States/UT to ensure a unified platform that consolidates multiple reporting portals, reducing redundancy and improving data management.
- Strengthen data security protocols to protect patient records from cyber threats and ensure compliance with healthcare data regulations.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- At DH Longding, applications like HMIS, NCD, Nickshay, E-sanjeevani NIKUSHT 2.0, e-RaktKosh, Ni-kshay, Ni-kshay Aushadhi, and TB Arogya Sathi App were being used, but their functionality could not be checked because of connectivity issues.
- In West Siang district, many of the staff were aware of the NIKUSHT app; however, it was not being used as there were no leprosy cases.
- The e-RaktKosh app was being used at the Blood Bank at the DH, while the NIKSHAY portal was in use at DH, but not at the Community Health Centre (CHC).
- The TB Arogya Sathi app was also being used by the staff.
- The Hospital Management Information System (HMIS) has been working at DH for the past two years.
- Internet connectivity was very poor across both the districts, and dedicated broadband lines are needed in healthcare facilities.
- The state was using a “hub and spoke” model for telemedicine services through the e-Sanjeevani platform. The hubs were located at district hospitals/ general hospitals/ medical colleges (TRIHMS), BPGS Passeghat, and GTGH Ziro were fully functional.

BIHAR

- Hospital Information Management System (HIMS) is being implemented across all the healthcare facilities in the State through ‘BHAVYA’ portal
- The expansion of the BHAVYA Digital Health Record system and integration of various health portals is instrumental in streamlining data collection and interoperability, contributing to more efficient healthcare delivery.
- The State of Bihar’s comprehensive and forward-looking plan underscores its commitment to transforming healthcare services across the state.

CHHATTISGARH

- All application were adopted in DH, however, in some CHC facilities (Mainpur) all applications were not adopted (NCD portal, DVDMS etc.).
- UWIN, HMIS, RCH, IHIP portals were functioning properly. However, dedicated HR for data entry is required to update the data on real time basis.
- Some state specific applications were being used by the facilities, however currently only central portal was using due to duplication.
- IHIP was not updated regularly due to lack of HR.
- Most of the data reporting was matching (RCH portal, HMIS portal, U win) however some mismatch was reported in the reported data and physical records (OPD register) due to some technical issues.

- Data privacy was well maintained, and data reporting process was well established.
- There was lack of refresher training for Data entry operator as well other Staff (ANM) using IT applications.
- Lack of data entry on Nikusth portal was observed.
- State needs to orient the concerned health facility teams regarding all the portals to start updating information in respective portals.
- “PVTG” option is included in RCH portal, NCD portal and IHIP portal. District and block level users need training/ awareness to capture the data.

HARYANA

- In Haryana ‘e-Upchaar’ (HMIS) is being implemented to register patients and facilitate maintenance and retrieval of Electronic Medical Records (EMR), when the patient returns to the public health facilities for another episode of care.
- Laboratory machines and digital X-ray machines have been integrated with the application, thus Laboratory and Radiology reports get automatically available against the patient’s unique ID.
- Laboratory reports are also accessible online and patients can easily access these reports through their smart-phones anytime and anywhere.

JAMMU & KASHMIR

- JK e-SAHAJ, JK eSEHAT, Mera Aspatal, PMNDP portal, ANMOL, U-WIN, RCH, HMIS, PFMS-EPFO, IHIP, DVDMS, 104-Grievance Redressal and e Samadhan, Saksham Portal, ABHA portal, PCPNDT portal, portal, Nikshay, e-VIN etc platforms were available across all the health facilities.
- All the portals were widely used across all the facilities and the staff had good knowledge and were using the portals.

JHARKHAND

- U-WIN, NIKSHAY, NIKUSHT applications were demonstrated in CHC Potka; efficient data manager was available in facility
- NIKSHAY portal use was demonstrated at most of the visited facilities.
- Real-time data entry into the National NCD portal remain consistent issue across the facilities.
- Some portals like DVDMS, NIKUSTH, SaQsham etc. were not fully functional and utilized by the facilities.
- DVDMS (Drugs and Vaccine Distribution Management System) software for inventory and supply chain management was being used, however uptake was low.
- Training healthcare workers in digital tools and promoting community awareness about telehealth services can also enhance uptake.



KARNATAKA

- Implementation of E-Hospital in the State to make paper less health facilities was in progress. The speed of internet as well as server was reported to be a bottleneck in making it fully functional.
- In Ballari district an android-based mobile application "Skip the Queue" had been developed. It was available at the district and sub-district level, and was very helpful to the patients to get OPD registration slip by themselves.
- District hospital Ballari has developed their website to update the respective information in public domain.
- An audio-visual monitor has been set up in DH and SDH in Ballari district to display the availability of drugs and services.



MAHARASHTRA

- Currently there are 18 portals (this information is taken from the web site, there is no information about IT in the state briefing booklet) are in function. Most of the portals are used for the daily and monthly reporting.

MIZORAM

- Various IT interventions and Programme portals such as HMIS, NIKSHAY portal, PMNDP Portal, DVDMS etc. were being used at the District Hospital.
- Indicators checked for HMIS Data quality matched with the source data/registers.
- Key performance indicators and outcome indicators were displayed in various departments/units such as Operation theatre, SNCU, Labour room, Emergency etc in visited health care facilities.

RAJASTHAN

- Digital adoption was equitably visible at various level of health facilities with mixed bag of National and State specific application.
- IHMS, PCTS, RCH portal, NCD portal, IHIP (IDSP), Nikusth, NIKSHAY, e-Sanjeevani, e-VIN, HMIS, e-Sushrut, e-Raktkosh, e-Aushadhi, Asha software, Marudhar, Rajhealth, e-Upakaran, OJAS and other IT systems were available at all levels of the facility.
- PCTS, one of the best practices observed, was being used for tracking Pregnant women and Child for the MCH Services.
- DH had a functional HMIS for both OPD and IPD patients. However, a mechanism for tracking the same patient during subsequent visits to hospital could not be identified.
- IHMS application for OPD registration was available in few facilities, which may be extended to all the health facilities across state.
- Patients were able to give feedback through the Mera Asptaal portal.
- Real time entry could not be observed into e-Raktkosh, Pradhan Mantri National Dialysis Program Portal, Mera Aaspatal, due to server issues.

TRIPURA

- The state utilizes a diverse range of health portals, including HMIS, RCH, AB-HWC, NCD, PMSMA, eSanjeevani, ehospital, eHRMIS, NHP, Nikshay, Nikushta, SCMS, PFMS, and eOffice.
- Furthermore, several mobile applications are employed, such as ANMOL, AAM app, CPHC ASHA app, e Sanjeevani app, FPLMIS, UWIN, IDSP, and Nikshay.
- However, challenges have been observed with data synchronization, particularly within the ANMOL and NCD portals.
- At the CHC level, data entry in the NVHCP portal revealed discrepancies, with only 6 out of 33 patients registered at the facility being visible at the district and state levels
- To address these issues, the state HMIS team conducts regular monthly training and monitoring sessions at healthcare facilities to ensure accurate data entry and reporting across all relevant portals. These sessions aim to cross-verify data reported on various platforms and identify areas for improvement. It is crucial to address the data synchronization issues in the ANMOL and NCD portals to ensure accurate and timely data availability for program planning, monitoring, and evaluation at all levels.

UTTAR PRADESH

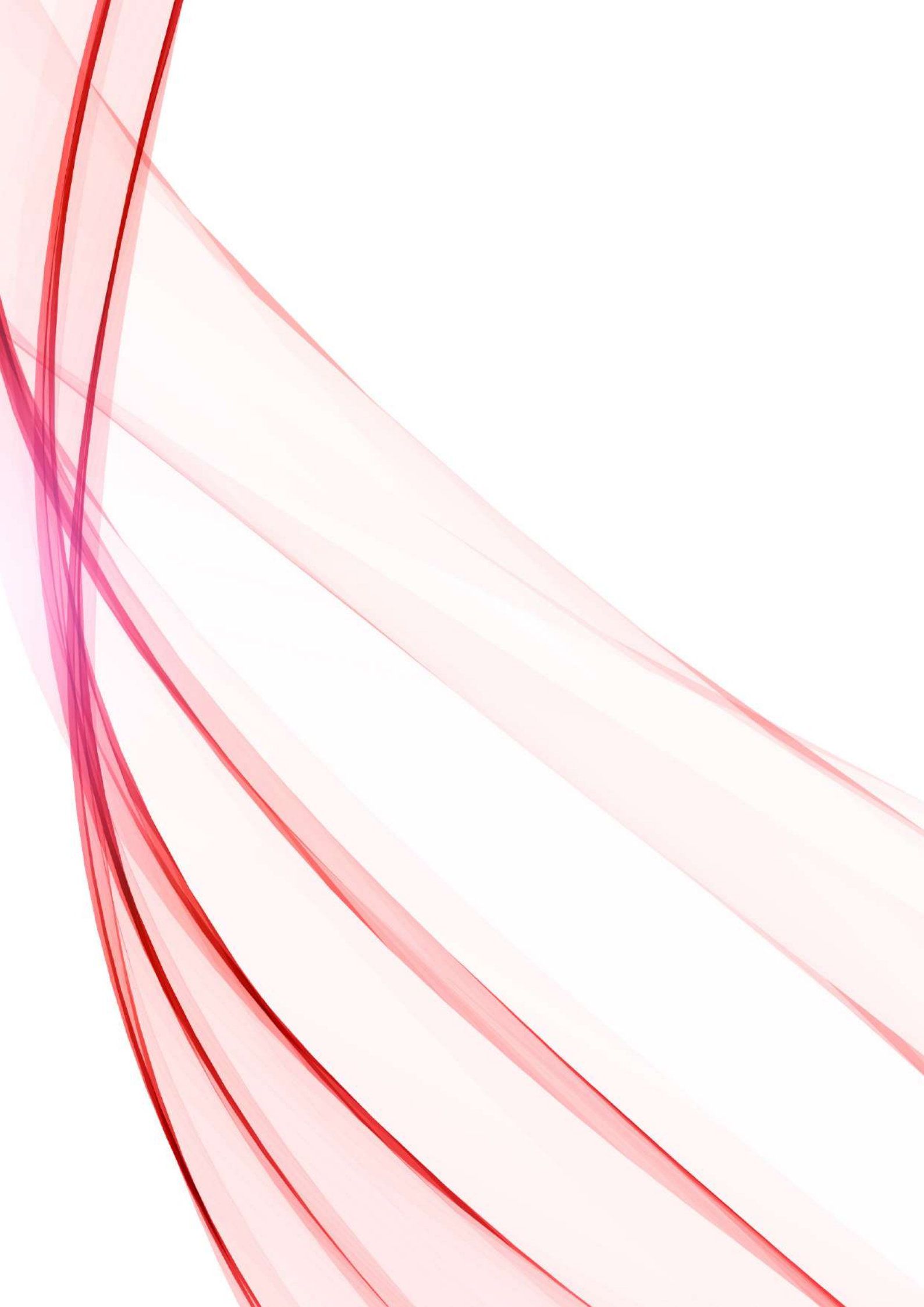
- The e-Sanjeevani telemedicine platform has achieved notable success, recorded 3.41 crore consultations and highlighted its potential to enhance access to healthcare, especially in underserved areas.
- Teleconsultations are of poor quality, and there is no systematic channel for teleconsultation as calls directly connect to district hospitals.
- DH Hubs prescribe medicines based on chats rather than video calls. The quality of prescriptions from teleconsultations did not meet the required standards.
- Significant mismatches were observed between E-Kawach records and ASHA diaries, which affected data reliability.
- Merge platforms like e-Kawach, ANMOL, and U-WIN to create a single, streamlined system for data collection and tracking. This integration will eliminate redundancies, improve efficiency, and

provide comprehensive insights into maternal and child health indicators.

- Provide hands-on training for Health Management Information System (HMIS) to improve data accuracy, reduce data entry errors, and enhance report reliability.
- Printed HMIS formats were unavailable at several facilities, leading to guideline violations and challenges in maintaining accurate records
- Comprehensive training for HMIS data handlers was not provided, resulting in inconsistent adherence to indicator guidelines
- Identical values across multiple indicators were reported monthly, raising concerns about data accuracy and potential fabrication
- Errors identified during audits or reviews were not consistently addressed, allowing inaccuracies to persist
- HMIS data was not effectively utilized for decision-making or planning at the facility level, limiting its impact on healthcare outcomes.
- Network issues were found due to which operationality of IT portals remains a challenge
- E-Kawach does not allow users to backtrack data to check the quality and compliance of the entered data
- Staff reported not using ANMOL and NP-NCD apps.
- Network issues create challenges in the operationality of IT portals
- The state may integrate state-specific portals as an immediate action. This will help avoid duplication and ensure efficient maintenance of records.

WEST BENGAL

- In Malda district, it was found that the mapping of facilities such (PHC and above) was not done in SKMIS portal.
- Significant mismatch was there in the data available in the HMIS portal and Matri Maa portal. In South 24 Parganas, KPI monitoring portal, CCMIS software was being used for HDU, SCAN and SHARE.





TOR 3 CROSS CUTTING THEMES

HUMAN RESOURCES FOR HEALTH

NATIONAL OVERVIEW

A key strategy under NHM is the strengthening of Human Resources for Health (HRH), recognizing that a rationally distributed, adequately skilled and motivated health workforce is essential for delivering quality healthcare services. NHM supports States and Union Territories (UTs) by supplementing regular staff with contractual HRH and providing program management support. Additionally, NHM offers significant flexibility in HRH planning and implementation, allowing states to tailor solutions to their specific needs.

The 16th CRM evaluated the HRH landscape across states in which CRM was conducted this year, identifying progress, persistent gaps, and systemic challenges. Key focus areas included recruitment processes, retention strategies, equitable workforce distribution, the effectiveness of state-level HRH policies, integration of digital HRH management systems, and access to structured training programs. While some states have streamlined recruitment and introduced specialist cadres, others continue to face delays in hiring, salary disbursement, and long-term workforce retention.

KEY OBSERVATIONS

AVAILABILITY OF HRH

- States are yet to achieve compliance with the IPHS 2022 norms for HRH, with creation of posts under the regular cadre impacting the availability of staff.
- Persistent gaps in HRH availability continue across states, particularly in specialist cadres such as anaesthetists, obstetricians, paediatricians, and radiologists. States such as Bihar, Chhattisgarh, Jharkhand, and Madhya Pradesh have reported critical shortages, affecting service delivery at secondary and tertiary care levels.
- High vacancies among medical officers, staff nurses, pharmacists, and lab technicians were reported in Rajasthan, Uttar Pradesh, Odisha, and Tripura, with shortages affecting service delivery at both primary and secondary levels. While Odisha and Gujarat have successfully recruited Medical Officers (MOs), Community Health Officers (CHOs), and multi-Purpose Workers (MPWs), vacancies remain high in specialist cadres.
- Karnataka, Gujarat, and Chhattisgarh are among states that have implemented rural service bonds for medical graduates, requiring compulsory service in underserved areas. However, despite these efforts, retaining specialists in remote regions remains a challenge.
- Incentive structures such as differential salaries, top-up pay through District Mineral Foundation Trust (DMFT) funds, and hard area allowances have been introduced in Odisha, Mizoram, and Chhattisgarh. However, these measures face limitations in attracting medical officers and specialists.
- HRH shortages persist in rural and remote areas. States have employed various mechanisms such as:
 - Odisha, and Uttarakhand have attempted to address this by offering additional weightage to NHM staff who serve in these areas during regular cadre recruitment.
 - States like Chhattisgarh have also started the practice of awarding additional marks/ weightage to those who have served in rural and remote areas when they apply for their post graduate degrees.
- A few states like Karnataka and Bihar have taken concurrent measures such as initiation of District Residency Programs and DNB courses, additional weightage for admission to PG courses and during recruitment to regular cadre, to strengthen HRH availability in public facilities.
- States such as Assam, Rajasthan, Madhya Pradesh, Tripura, and Mizoram reported conducting

recruitments at the state-level. Generally centralized recruitment is taken up to ensure quality as there is lack of capacity at district levels.

- States like Arunachal Pradesh, Chhattisgarh, Jammu and Kashmir, Jharkhand, and Uttar Pradesh have undertaken decentralization of some recruitments to the district-level.
- Irrational deployment of HRH was reported in Arunachal Pradesh, Chhattisgarh, Haryana, Himachal Pradesh, Rajasthan, Jharkhand, and Madhya Pradesh. In both Haryana and Uttarakhand, dental surgeons have been posted without a functional dental chair. This is also leading to underutilization of skilled HR at a functional facility, thus needs attention.
- Vacancies were also noted under programme management in Karnataka, Madhya Pradesh and Rajasthan, impeding the effective implementation and monitoring of programmes.

MANAGEMENT OF HRH

- Approximately half of the visited states - Mizoram, Gujarat, Bihar, Jharkhand, Odisha, Uttar Pradesh, Madhya Pradesh, Rajasthan, and Karnataka - have a dedicated HR cell. In other states either one dedicated HR personnel or a nodal for HR has been designated to manage HRH functions.
- HRH policies for NHM have been formulated in Rajasthan, Bihar, Chhattisgarh, Haryana, Uttarakhand, Uttar Pradesh, Odisha and Madhya Pradesh. However, implementation of the policy and the staff's awareness and implementation of these remains weak. In states and UTs like Karnataka and Jammu and Kashmir, policies for transfers, and posting have been framed and implemented.
- Performance appraisal systems are present in Arunachal Pradesh, Chhattisgarh, Odisha, and Karnataka. While Rajasthan and Mizoram have an appraisal system in-place its implementation was reported to not be comprehensive and uniform. While Odisha and Mizoram have introduced structured monitoring systems, states like Madhya Pradesh and Tripura lack such system.
- Timely disbursement of salaries ensures motivation among the staff and ensures optimal functioning of the health system. At the time of visit, salary delays were reported only in Mizoram and Jammu and Kashmir. In the UT of J&K, staff highlighted delays of up to two months.
- Grievance redressal mechanisms were functional in some states and UTs, such as Jammu & Kashmir, Rajasthan, Karnataka and Mizoram. A common online portal for the state is used in Rajasthan and Jammu and Kashmir, whereas Mizoram has a dedicated grievance redressal portal for the health department. Karnataka has grievance redressal committees at the state and district level.
- A functional HRMIS system can support various HR management functions and serve as a tool for more effective planning. Currently, HRMIS is either partially or fully functional in the states and UT of Tripura, Madhya Pradesh, Arunachal Pradesh, Odisha, Mizoram, and Jammu and Kashmir. However, in many states the HRMIS is not integrated for both the regular staff and NHM contractual. Additionally, for some states only a few modules for training, leaves, pay slip generation etc. are functional while in others it is currently serving as a database of HR.
- The states have employed various methods of monitoring the attendance of staff. Biometric attendance systems are in place in Rajasthan, Uttar Pradesh, Karnataka, and Jammu & Kashmir. However, there is variation within the states with primary care facilities in many states still employing manual attendance monitoring i.e. in registers. Other states like Jharkhand and Tripura are monitoring attendance manually at all levels of facilities.

CAPACITY BUILDING

- Training gaps were widely reported across states with most states reporting no trainings being conducted in the past year. Chhattisgarh reported having backlogs in training due to the COVID-19 pandemic, while Districts in Jammu and Kashmir reported not receiving any funds for conducting trainings.

- Induction training remains inconsistent. In Maharashtra, Tripura, Uttar Pradesh Karnataka and Jammu and Kashmir many staff have not received any induction trainings. In contrast, Rajasthan provides induction training only for CHOs and in Madhya Pradesh only Medical Officers and Dental surgeons receive a month-long training.
- Specialized training needs remain unmet across multiple states. Maharashtra, Uttar Pradesh, and Tripura reported inadequate training in areas such as family planning, elderly care, emergency response, and telemedicine.
- Skill-based and simulation-based training remains limited. Karnataka and Maharashtra highlighted the need for expanded hands-on training programs.
- Some states have collaborated with institutions for capacity-building initiatives. Bihar and Gujarat have partnered with IIMs and public health institutions for leadership and management training.
- States such as Uttarakhand and Uttar Pradesh reported a lack of continuous learning opportunities and professional development pathways for HRH.

PUBLIC HEALTH MANAGEMENT CADRE

- Public Health Management Cadres (PHMC) are under development in several states, including Arunachal Pradesh, Chhattisgarh, Gujarat, Madhya Pradesh, and Tripura, where state task forces have been established. However, full operationalization remains pending in all states.

KEY RECOMMENDATIONS

- Recruitments, especially to fill critical vacancies for specialists, medical officers, staff nurses, lab technicians, and allied health workers at primary and secondary care levels, should be expedited. There is a need for shorted and more frequent recruitment cycles.
- States should ensure that human resources are deployed rationally and in line with the IPHS 2022 norms and caseload requirements. As a preliminary step, gap assessments can be conducted to ensure an equitable distribution of human resources, with a focus on underserved, tribal, and hard-to-reach areas and aspirational districts and blocks.
- Mechanisms need to be developed to ensure timely payment of salaries and disbursement of incentives to staff in order to maintain their motivation. If required, states can also revisit and review their salary structures to make them competitive, especially in case of positions where the joining rates are low.
- Induction training should be conducted for newly recruited staff, and refresher training should be provided for existing staff, with a focus on the expanded package of services, biomedical waste management, and infection control.
- States should establish an adequate number of positions in accordance with the IPHS 2022 guidelines, while adhering to the HRH integration principle.
- States/UTs need to develop their own HR policies, which are informed by the State Health Policy (if any), envelope strategies to tackle the needs and challenges specific to their context, and streamline key processes such as recruitment, posting and transfer, performance appraisal, exit policies, staff welfare activities, and grievance redressal. This will also provide clarity and consistency in managing HRH, enhancing workforce satisfaction and efficiency.
- NHM advises local recruitment so that there is no need for transfers. Routine transfers for contractual staff is not recommended. Any transfer rules and posting policies for regular staff should also pay heed to the need for appropriate skill-mix of HRH.
- Decentralized recruitments, wherever feasible, should be explored by the States/UTs, provided the district teams have the capacity to carry out quality recruitment. Recruitment for ANMs, staff

nurses, lab technicians, and pharmacists, for example, can be done at the district-level, to expedite hiring and improve accountability.

- States should establish specialist cadres to improve availability of specialists in remote and rural areas.
- States and UT should institute a dedicated HRH cell which undertakes not only routine HR functions but also strategic planning.
- States should operationalize HRMIS and ensure its utilization for HRH planning and decision making.
- States can conduct Training Needs Assessments (TNA) and develop structured training calendars, ensuring all HRH receive competency-based training at regular intervals.
- States should focus more on post creation under regular cadre.
- States should develop comprehensive staff welfare initiatives such as provision of health insurance, annual health checks ups, and non-monetary incentives to maintain staff motivation.
- The states need to strengthen long-term workforce planning, taking into consideration factors such as HRH generation capacity, disease burden, demographic shifts, health seeking behaviour, caseloads etc.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- The state has adequate posts in most of the cadres except Nursing. However, there were few vacancies reported under NHM.
- Despite the existence of a GNM Nursing school and B.Sc. Nursing schools, a shortage of nurses was observed at all levels. The state has not created adequate posts of staff nurses to meet the IPHS requirements only 53% of the required posts are sanctioned under regular cadre.
- At most of the PHCs, services were provided by ANMs. According to IPHS norms, ANMs are supposed to be posted only at primary care facilities, however, the state had posted them even at district hospitals.
 - In recent times, some of the ANMs were posted back to the SHCs including 3 SBA-trained ANMs who were previously posted in the labor room at DH, West Siang.
- Irrational deployment of HRH is a major challenge in the state. While the HRH posted in West Siang district exceeded IPHS norms for most cadres, a shortage of HRH was observed in Longding.
 - West Siang District Hospital (DH) had 12 specialists. An Ophthalmologist from neighbouring district provided services at the DH for 2 weeks every month as the post was vacant.
 - While a UPHC visited in Itanagar had 04 allopathic doctors against 1 Essential post as per IPHS, the PHCs and CHCs in Longding district were primarily being managed by Ayush MOs and MO Dental (as MO in-charge). Similarly, services at CHC Kamba (West Siang) were limited due to unavailability of required number of allopathic MOs and Specialist.
- The acceptability of staff was seen to be good in PHCs and CHCs as they belonged to the same locality.
- The unavailability of equipment is found to be one of the key reasons limiting the provision of expanded range of services by CHOs.
- Recruitments are conducted both at the state level and district level. HRH are also appointed by the District Hospitals through the Hospital Development Committee. Additionally, students (including doctors, nurses and allied health staff etc.) also join the health facilities for 3–6-month

long internships and contribute to the workforce.

- HR functions were overseen by a Nodal Officer of NHM, with support from an HRH consultant. The HRH Consultant was a trained professional specializing in HRH management. However, there was no dedicated HR unit in place. The state did not have an HRH policy for NHM staff but had developed a transfer and posting policy for the MOs and specialists.
- The state has an HR-MIS in place with various modules for managing HR functions, including leave management, transfer management, salary management etc. However, the system is not integrated to encompass both regular and contractual HRH, which undermines the purpose of implementing such system.
- In the state, non-practicing allowance (NPA) was optional (10% of Basic pay). The doctors had the option to choose private practice and forego the NPA.
- Salary rationalization of all NHM staff (service delivery and programme management) was carried out by the state a few years back wherein base pay for each cadre was revised and fixed.
- The state has limited the annual increment to 5% on the base pay for each cadre, instead of 5% of the existing salary. The delay in releasing increments and incentives was a major reason for demotivation among staff. Annual increment for FY 2024-25 had not been disbursed to the staff at the time of the visit (November 2024).
- Though an appraisal system is in place, it mostly includes non-measurable indicators/subjective criteria. The staff fills in the self-appraisal form and submits it to their reporting officer in March every year. The appraisal is not linked to any incentive and a flat 5% annual increment is given to all. Contracts for staff are renewed automatically, and no document is signed by the staff every year.
- Although the performance appraisal system had indicators related to the need for skill upgradation, this data is not presently used for planning training for the HRH. There was a lack of training opportunities for programme management staff for continuous professional development.
- During interactions, staff also mentioned that contractual employees are not provided with TA/ DA when they travel for outreach activities.
- Utilization of the public health services in the state is a major concern. The PHCs and SHCs visited were catering to a low catchment population, leading to very low caseloads. During an interaction, an allopathic doctor at a PHC, mentioned that the low footfall at the PHC is demotivating and it hinders his ability to practice properly. Similarly, CHC Kamba, despite having a large infrastructure and adequate staff did not have any in-patients at the time of the visit affecting the productivity of staff.

Public Health Management Cadre

- The State Task Force for the implementation of Public Health Management Cadre (PHMC) was established in June 2023.

ASSAM

- The staff in the facilities visited were not found adequate as per IPHS 2022 norms. The state reported high vacancies among lab technicians in the regular cadre and among specialists under NHM.
- In the visited districts, the posts of specialists are vacant at the CHCs and Model hospitals.
- While recruitments have been undertaken in Assam, the state reported that many of the selected candidates did not join.
- The health facilities in the state of Assam are facing significant shortage of human resources.

This gap hampers the ability of these facilities to meet the healthcare needs of the community effectively. This deficit not only affected the quality of care that patients received but also lead to overwhelming workloads for the existing staff.

- Additionally, the state reported that there is a high number of transfer applications.
- The staff highlighted the need for periodic programmatic and clinical trainings and refresher trainings at the district level to ensure that health workers at all levels are equipped with the skills and knowledge needed to effectively provide essential services to the community.

BIHAR

- There are critical shortages in the Human Resource for Health (HRH) across multiple cadres and specialties. Delays were reported in the centralized recruitments impeding service delivery.
- High vacancies are reported under NHM among key cadres of specialists, pharmacists, lab technicians, staff nurses and ANMs impacting the quality-of-care delivery at healthcare facilities.
- No specialists are posted at the CHC level, leaving critical gaps in service delivery, especially in specialties like OBGYN, Paediatrics, and Radiology.
- Ayush doctors in Gaya are managing emergencies at night in CHCs due to the high vacancies in MO MBBS posts.
- The state has implemented policy mandating three years of compulsory service in public health facilities for post-graduate specialist doctors. This policy ensures availability of specialized healthcare services in underserved areas. The District Residency Programme is being implemented to ensure the availability of medical residents in underserved areas.
- Additional marks for PG admissions are awarded to doctors serving in rural areas, encouraging aspirants to opt for rural postings.
- The state has rolled out a Facial Recognition Attendance System (FRAS) for attendance monitoring. This system has not only enhanced the transparency and efficiency in attendance management but also enabled real-time monitoring through a live dashboard, significantly reducing administrative overhead and ensuring accountability across the workforce.
- To address workforce retention and boost morale, Bihar implemented salary rationalization for NHM employees. Salaries were restructured to align with minimum wage regulations, educational qualifications, and industry benchmarks, acknowledging employees' contributions and creating a more equitable pay structure.
- The state has introduced Group Health Insurance and Personal Accidental Insurance policies for all NHM employees, ensuring extensive coverage starting December 1, 2023. The policy offers accidental insurance, health insurance, maternity benefits of up to for two children, and air accident coverage. Additional benefits include children's higher education.
- To strengthen the leadership and management capacity of healthcare personnel, Bihar has nominated 100 staff members based on their performance for executive training courses at IIM Ahmedabad and IIM Bodhgaya. These trainings focus on enhancing decision-making and managerial skills among healthcare professionals.
- Additionally, a proposal is under process to introduce advanced AI and machine learning courses in collaboration with ISB Hyderabad.
- During the visit it was reported that no training sessions were conducted this year, further widening knowledge and competency gaps among healthcare workers engaged in service delivery.
- CHOs at Ayushman Arogya Mandirs (AAMs) emphasized that though they had been trained on the expanded package of service, there is a need for refresher courses and periodic training.

CHHATTISGARH

- The state reported high vacancies among Specialists, Medical Officers, staff nurses and Multi-Purpose Workers.
- The state conducts both centralized and decentralized recruitment where certain posts are recruited at the district level.
 - The state reported that large scale recruitment drives are in the process to fill approximately 4000 vacancies across various cadres.
- The state is still following the IPHS 2012 norms and has not moved towards IPHS 2022 norms.
- The state provides top-up salary for staffs through District Mineral Foundation Trust Fund and Performance Based Incentive (PBIs) through Chhattisgarh Rural Medical Corporation.
- The state has started a two-year compulsory rural service for medical graduates.
- Additionally, the state provides additional marks during the PG admission process for those staff who have completed rural posting.
- The state offers a differential salary package for Specialists and Medical officers based on qualification and the difficulty of posting. The state reported that despite these financial incentives, they still faced challenges in attracting medical officers and specialists.
- There is a policy of performance appraisal of NHM staff linked with annual increment. The state has designed a software for Performance Linked Payments (PLPs) measurement and distribution to the CHOs. This software has reduced the time for PLP disbursement.
- The state reported that a majority of the programmatic trainings had been put on hold during COVID-19 resulting in a major backlog of training.
- The CHOs in all visited facilities are trained in non-communicable diseases. In one Ayushman Arogya Mandir-SHC, the CHOs was also trained in undertaking the VIA-Cancer screening however, due to the unavailability of acetic acid was unable to conduct the screening activities regularly.
- The state in coordination with NIMHANS Bangalore have trained CHOs and ASHA on mental health packages and it was observed that mental health services were being provided at the AAM-SHC centres.

Public Health Management Cadre

- The state has established a specialist cadre and the State level task force has been constituted for Public Health Management cadre. The formation of Public Health Management cadre is still under process.

GUJARAT

- In the case of Staff Nurses, Lab Technicians, pharmacists, MOs, and Specialists, less than the required positions as per IPHS 2022 have been sanctioned. The state has also reported high vacancies for key cadres like Specialists, LTs and Pharmacists.
- While the vacancies in NHM are not high, some crucial posts like Early interventionist cum Special educator need to be filled up urgently. There are also persistent issues such as the unavailability of Audiologists despite multiple rounds of advertisement, due to the low joining salary.
- To maintain a steady flow of health professionals in public health facilities, NHM Gujarat has a bond policy for medical students in place. The service period for those who've completed MBBS is 9 months-1 year, while it is 1.5 years for those who have completed PG. Posting in PHCs in rural and remote areas are prioritized. The policy is applicable to students from across the country applying for medical courses in state-run colleges. However, it was observed that the PHCs have

only doctors 'on -bond' in place.

- The state has created a specialist cadre whereby PGMOs under regular services are recruited directly at a higher level than the General Duty Medical Officers (UG-MBBS GDMOs). There is also a provision for differential salaries between GD-MOs and Specialists. This is a good strategy for the strengthening of secondary care services.
- The state has robust structures and systems in place however, timely and regular recruitment (preferably on an annual basis) is essential for keeping the system working.
- The state does not have an HRH policy.
- In comparison to other states, Gujarat has almost negligible dual practice. However, infrequent recruitment cycles through GPSC, and very late or no promotions may gradually deter doctors from considering the government sector as a viable career option.
- Most of the urban population of Vadodara is looked after by the Municipal corporation. It had a good system of HRH recruitment and management. Though a part is funded by NHM (erstwhile NUHM), the corporations have good budget for HR in Health.
- In Kachchh district, most of the trainings for which funds have been approved in the RoP 2024-25 had not been conducted at the time of the visit.
- The training on expanded package of services for the primary healthcare team has been completed in Vadodara but not in Kachchh. VIA training for ANMs was completed but, was pending for CHOs at the sub-centre level. ANMs in Vadodara reported that they lacked confidence in providing services and often refer cases to the PHC level.
- The state has launched an initiative in collaboration with the Indian Institute of Public Health -Gandhinagar (IIPH-G) over the past two years, sending approximately 50 senior officials to participate in the Healthcare Leadership Enhancement Program (HLEP).
- Gaps in the training of technicians on malarial microscopy were noted, as Laboratory Technicians (LTs) at the SDH level were observed to take only thin smears.
- The State, with the support from Indian Council of Medical Research (ICMR, has initiated the process of 4-day long online trainings for CHOs on the utilization of tools such as the Patient Health Questionnaire (PHQ), General Anxiety Disorders (GAD) scale, etc. for the assessment of mental health conditions at the level of SHC-AAM. The tools are implemented in the native language and have been pre-validated for accuracy and effectiveness. The state has envisaged to train all 8000 CHOs in the next two months.

Public Health Management Cadre

- The state has been working towards implementing the PHMC framework to enhance its public health management system. At present, the framework has the Public Health cadre, Specialist cadre, and Teaching cadre.
 - Gujarat has also prioritized providing public health training to in-service candidates. This strategy aims to strengthen public health capacity and improve management efficiency.

HARYANA

- Haryana reported vacancy among Medical Officers, Lab technicians, staff nurses, and pharmacists. Specialists, particularly radiographers, were not available.
- HRH have not been rationally deployed – for e.g. dental surgeons were posted at places where the dental chair was non-functional, or its procurement was under process.
- Integration of HRH was also not observed. ICTC counsellors handle huge patient load daily, and the vacant STI/RTI Counsellor post added to their burden. Meanwhile, divisions like mental health, adolescent health, and RBSK had lighter workloads. Biometric system was being used by the state

for monitoring the attendance of staff.

- Lack of training is found to be a major barrier to the delivery of services.

HIMACHAL PRADESH

- The state reported vacancies for various cadres across all levels of facilities, which affected the availability of staff as per the IPHS 2022 norms.
- In one of the facilities visited, an ophthalmic assistant was not in-place, so, others from nearby facilities had been deployed on rotational basis.
- Rational deployment of HRH was lacking.
- Staff reported being overloaded with non-clinical work at one of the SNCUs visited.
- There has been no revision in the remuneration of contractual employees which was reported as a challenge.
- Himachal Pradesh reported limited training for healthcare workers on Family planning methods.
- At one of the AAM-SHCs visited, the ANM mentioned that she was unable to conduct HbSAg due to lack of training HbSAg despite the availability of test kits.

JAMMU AND KASHMIR

- The availability of HRH was not as per IPHS 2022 norms or in an integrated manner as the HRH were posted as per programmes.
- The Number of sanctioned positions in the regular cadre was less than requirement as per IPHS for the cadres of MPWs, Staff Nurses, and Lab Technicians.
- The UT has reported high vacancy in the regular cadre for Specialists, Staff Nurses, Lab Technicians, and MPWs. Under NHM, high vacancies were reported under NHM among Specialists, Medical Officers – MBBS, and Staff Nurses.
- For the regular cadre, UT undertakes requirement through the service selection board for non-gazetted posts and the Public Service Commission for the gazetted posts. Under NHM, the recruitment is based on vacancies shared by the districts and is conducted both at the state level and at the district level. The recruitment for specialists, medical officers and Programme Management Unit staff is centralized through State Health Society. For Allied care workers, it is decentralized and done at district level.
- The Terms of Reference, the eligibility and selection criteria are predefined. However, the UT reported that since these were made long ago, the ToRs are in the process being revised.
- Currently, the UT does not provide any weightage to the NHM staff for recruitments in the regular cadre.
- While CHO/MLHPs are present across most of the facilities, in Uri block, due to shortfall of CHOs in 3 SHC-AAMs, CHOs were posted on rotation basis, or senior pharmacists were being deputed on temporary basis to ensure uninterrupted service delivery at the primary level.
- UT does not have a dedicated Human Resources for Health (HRH) cell. Director planning is the head of the HRH unit in the UT. Under the director, there are two divisional nodal – one each for Jammu and Kashmir divisions under which HRH team is functioning.
 - In absence of a dedicated HRH cell, additional responsibilities are given to programme officers within the State Programme Management Unit. Key functions for the HRH unit include mapping of positions/HRH, recruitment, posting/deployment and overall HRH management. Additionally, work allocation is done based on experience in health and is frequently changed.

- At the district level, CMO and DPM are responsible for and support the HRH related functions.
- UT does not have any specific HRH policy. However, benefits like social security benefit, leave policy, performance appraisal systems, POSH committee for HRH, minimum wage policy are defined in the system.
- There is no transfer policy in the UT but mutual transfers are considered.
- The UT has provisions for difficult area allowances for Specialists, Medical Officers and allied health workers.
- Grievance redressal mechanism is being supported through the UT's portal "JK SAMADHAAN" which is an 'open for all' portal for grievances and feedback.
- The UT had a partially functional HRMIS. It was not being utilized as envisaged due to incomplete information for regular HRH, as they had another existing HRMIS portal. The data on HRMIS had also not been updated for last two years.
- Salary disbursement was being done through SNA and is decentralized, where the release of salary was done at the block level for NHM workforce. Annual increment and EPF benefits were being given to the NHM staff in the UT.
- The UT has implemented a biometric attendance system. However, it was observed only in selected health care facilities.
- The UT reported a backlog of at least 1-2 month in salary disbursement for HRH across the visited facilities.
- The state or district level HRH reported not receiving an orientation or induction training at the time of their joining.
- The staff reported that there are no provisions for continuous learning and career progression for the health workforce in the UT. At all levels, only programmatic trainings were conducted.

Public Health Management Cadre

- The state has established a specialist cadre and the State level task force has been constituted for Public Health Management cadre. The formation of Public Health Management cadre is still under process.

JHARKHAND

- A shortage of HRH, especially Nurses, MOs and specialists, was reported across the visited districts.
 - Only 1 anaesthetist was available in East Singhbhum, limiting the provision of services. In Sahebganj, it was reported that the high vacancies among MOs and specialists led to ANMs and ASHAs being overburdened and often tasked with responsibilities beyond their training.
 - Similarly, the vaccine store at CHC Musabni in East Singhbhum was being maintained by support staff as opposed to a pharmacist.
- At the time of the visit, CHOs were on strike, impacting delivery of services at the AAM-SHCs.
- Irrational deployment of HRH was observed.
- The state is in the process of implementing an Attendance Monitoring System for all staff.
- Staff in East Singhbhum received incentives and salary on time. However, CHOs and ANMs had not received team-based incentives.
- Training records were available, and staff confirmed that trainings had been conducted. However, they highlighted the need to further strengthen the training system.

KARNATAKA

- The state has a higher number of functional facilities than required as per population norms which has resulted in higher HRH requirements for the state.
- Approximately only half of the posts have been sanctioned against the requirement in the six key cadres, i.e., MPW- Male and Female, Staff Nurses, Lab technicians, Pharmacists, Medical Officers, and Specialists, as per State data.
- Significant vacancies exist across the 6 key cadres, especially among Medical Officers and Pharmacists. Most of the facilities were also observed to be working with 50% of the required HRH as per IPHS.
- Recruitments in the state are decentralized, but many positions including specialists and staff nurses remain vacant, despite advertising through various platforms. However, the gap in the availability is not directly related to the generation of HRH as the state has a large number of nursing and UG and PG medical seats.
- The state has taken some steps to improve HRH availability :
 - Medical graduates and postgraduates serve a mandatory one-year rural service in public healthcare facilities.
 - Weightage is granted to candidates with prior service under NHM by awarding additional marks for their experience during regular cadre recruitment.
 - In Dakshin Kannada, health facilities have partnered with the private medical colleges to supplement HRH. The nursing students from private colleges are posted in the facilities where they provide support to the existing staff and in return gain practical exposure. However, the facilities run on skeletal staff during exams or holidays. Moreover, staff reported having to undertake additional mentoring and supervision roles.
 - In Ballari, the District Residency Program and DNB program at the District Hospital are ongoing for various specialities, which is helping to increase the number of specialists available for service delivery.
 - Due to a significant gap, MO-MBBS had not been posted at many of the AAM-PHCs. At one such visited AAM-PHC, MOs from the block level were providing services on a rotation basis. In their absence, the staff nurses managed the patients along with CHOs (who were also posted on a rotation basis) using a treatment protocol that had been developed by one of the visiting doctors. MOs were also available for follow-up through teleconsultation.
- There is an HR cell in the state, led by the Chief Administrative Officer from the regular cadre. However, there is a high vacancy among key posts of programme management staff. As a result, the State Health Systems Resource Centre (SHSRC) staff have been assigned additional responsibilities to cover these gaps for the time being.
- The state has recently undertaken salary rationalization to bring pay parity.
- The staff did not mention any salary delays and had received an annual increment every year. The state had started giving the provision for annual increment for Specialists only from FY-2023-24, but specialists in Ballari reported that they had not received it for the current year, while the ones in Dakshin Kannada had received it.
- The state has a transfer policy in place, wherein a one-time mutual transfer is permitted.
- The state has initiated staff welfare measures for health insurance along with term insurance for all the contractual employees. The implementation of this is under process through Suvarna Aarogya Suraksha Trust. The state also has employee recognition schemes (including Programme Management staff).
- The state has a performance appraisal system in place for contract renewals conducted by a six-member committee headed by the Mission Director. The performance appraisals are conducted

annually through a paper-based form but only for contractual staff.

- The state also has a grievance redressal committee formed at both levels - state and district – as well as a separate committee for the outsourced staff. Quarterly meetings are held for discussing and resolving the issues.
- Regular programmatic training programs are conducted for the service delivery staff at the district level. The trainings for the programme management staff were irregular and scant. No Induction training program was being conducted for any staff.

Public Health Management Cadre

- Karnataka does not have an existing public health management cadre, however, the state does have an established Specialist cadre.
- The state has not taken any steps to establish a State level Task Force for PHMC and will be conducting an internal meeting to decide how to proceed with it.

MADHYA PRADESH

- Among the six key cadres, the state has adequate sanctioned positions for specialists and pharmacists whereas the number of sanctioned positions for MPW (Male and Female), Staff Nurse, Lab Technician, and Medical Officer falls short of the requirement as per IPHS 2022.
- High vacancies were reported under the regular cadre among specialists, pharmacists, and lab technicians. High vacancies also exist under NHM, particularly in the case of Specialists, MOs, Pharmacists, Staff Nurses and Lab technicians.
- The state has recently established a specialist cadre, allowing for the direct entry of postgraduate doctors. This initiative is aimed at attracting specialists and ensuring that they are appropriately posted at secondary care facilities.
- Madhya Pradesh has implemented a reservation policy, allocating 50% of the seats in the regular cadre for staff who have served under NHM for five years or more.
- The recruitment process in Madhya Pradesh is centralised at the state level. There are significant delays in the deployment of staff at district and block levels, particularly for critical service delivery roles such as specialists, pharmacists, and dentists.
- Key positions such as the District Programme Manager (DPM) and District Accounts Manager (DAM) were vacant in Rewa.
- HRH has not been rationally deployed, which is also affecting utilization of available equipment and service delivery. For instance, it was observed that certain visited facilities with X-ray machines lacked a radiographer, while those with a radiographer lacked functional X-ray machines. Similarly, facility visited had dental chairs but lacked dental surgeons.
- The state has formulated an HRH policy, although it does not outline principles/ standards for planning such as IPHS norms, or the details of HRH processes to be followed, the structure of various units/ cells, etc. There is low awareness about the policy among staff, as it has not been circulated beyond the DPMU.
- An integrated Human Resource Management Information System (HRMIS) for all staff has not yet been implemented in the state.
- The state has introduced the Sarthak Portal, an attendance reporting system that utilizes GPS and facial recognition technology and is implemented up to the sub-center level.
- Inadequate supportive supervision and monitoring of health programmes by the DPMU and Block PMU was identified as a challenge.

- As reported by the State, a month-long induction training is provided for MOs and Dental officers. However, the need for role and responsibility-based orientation was highlighted by some staff.
- Training institutes such as SIHMC Gwalior and RHFUTC centres at Gwalior, Jabalpur, and Indore conduct programs for ASHA trainers, CHOs, ANMs, Nursing Officers, and MOs on topics ranging from SBA, IUCD, GBV, medico-legal care, to air pollution.
- Continuous learning is also supported through the refresher trainings and through iGOT platform, and simulation-based training at AIIMS Bhopal.

Public Health Management Cadre

- The state has established Public Health Management and Hospital Manager Cadre under the MP Gazette in 2022. The state has conducted administrative and MPH training for CMHOs, hospital managers, and MOs.

MAHARASHTRA

- The state has reported a shortage of Specialists, Medical Officers, nursing staff, lab technicians, and allied health staff against the IPHS 2022 requirements.
- During the visit, vacancies were observed for pharmacists and specialists at the SDH and FRU facility levels. Pathologists and radiologists are not available, and USG services are being provisioned at the SDH through radiologists from private facilities. In Sindhudurg district, nearly half of the posts sanctioned for the DEIC are vacant, including key positions such as paediatrician, optometrist, audiologist, and speech therapist. Vacancy was also noted against the sanctioned strength of support staff.
- There are also vacancies across programme management posts, such as Accountant, Budget-cum-Financing Officer, etc.
- The state midwifery training institute is located in the DH Akola. Training for participants will commence next year with a batch of 30 students. Currently, five midwifery educators are undergoing training. The program focuses on promoting natural births with minimal interventions, respecting mothers' choices regarding birth companions and positions, and ensuring dignity through respectful maternity care (RMC).
- It was reported that there is greater acceptability of counselling services if the counsellors are of the same gender.
- Primary care teams reported facing a double burden of maintaining registers and having to make data entries on all the relevant portals.
- Measures have been taken by the state to build the capacity of staff, with training for all CHOs, RBSK Lady MOs, and ANMs for the provision of counselling service to women above 30 years of age, having been completed under NP-NPCD.
- However, certain gaps in training were also identified, as follows –
 - Newly recruited staff are not provided induction trainings.
 - Only a small proportion of staff has received SBA training.
 - Programmatic refresher trainings of SHC-AAM teams have not been conducted.
 - AAM-PHC teams have not received training for Elderly care.
 - Staff is not well-versed with the clinical aspects of BLS, and the use of life-saving equipment.
 - Staff tasked with making entries onto the HMIS portal have not been provided with adequate training for the same.

- Some healthcare workers using telemedicine platforms like e-Sanjeevani reported experiencing difficulties, due to a lack of adequate digital skills training.
- Need for training of programme management personnel in finance was also raised.
- Training on clinical skills needs to be provided and details of the same need to be uploaded on the Sashakt Portal.

MIZORAM

- Vacancies were reported to be higher in the regular cadre, with the exception of specialists, where more positions are vacant under NHM.
- Recruitment processes are centralised at the State level and facing delays.
- Though the state offers hard area allowance for the staff to ensure the availability of health services in remote and difficult areas, there are few applicants for these positions and vacancies persist, especially in the case of specialists.
- There is a state HR cell, staffed by 6 personnel performing basic HR management functions.
- There is a functional HRMIS in Mizoram, and data of all NHM staff is available on the same. Integration with the regular cadre was also in the process at the time of the visit. Modules for transfer, posting and staff management were available on the HRMIS, however the staff reported not being able to generate their pay slip through the system.
- The state does not have a comprehensive HR policy.
- HRH planning is done according to the Indian Public Health Standards (IPHS), 2022.
- A delay was reported in the salary disbursement of NHM staff due to delay in obtaining funds from MoHFW and subsequently late release of funds from State Treasury to State Health Account.
- An attendance monitoring system is in place but has been implemented only at the state level.
- The state has launched the VAHUI app for grievance redressal, which has provisions for addressing both, patient and staff grievances.
- There is a performance appraisal system for monitoring HR productivity. However, the system is not comprehensive as there is no self-appraisal and performance appraisals aren't linked to any increment/incentives.
- A training calendar is uploaded on the state's NHM website (nhmmizoram.org/events) along with the officer order outlining the training details

ODISHA

- The State reported high vacancies of staff nurses. However, state has successfully recruited Medical Officers (MOs), Community Health Officers (CHOs), and Multi-Purpose Workers (MPWs) against the sanctioned posts.
- The visited districts also reported a significant gap in the human resource available especially amongst the Specialist doctors, Medical Officers, and nursing staff etc.
- To achieve 100% operationalization of AAMs, the State is accelerating the recruitment of Community Health Officers (CHOs) by deputing Nursing Officers from the regular cadre to AAM-Sub-Centres (SHCs).
- Despite facing a shortage of specialists, the district mental health teams in Koraput and Sambalpur, comprising psychologists, psychiatric social workers, community nurses, and certified medical officers, are actively implementing the programme.

- To address the scarcity of specialists, the state has deputed doctors to pursue certification courses at NIMHANS, who then return to serve at their place of posting.
- Lack of specialists at CHC and radiologist at DH hampering regular services in Koraput.
- The state has a practice of giving additional weightage to NHM staff for recruitment under the regular cadre.
- The state has a robust appraisal, remuneration, and the performance-based incentives linked “Blended Payment” system.
- The state has implemented mandatory Post PG bond of 2 years to increase availability of specialists.
- The state provides additional allowances for staff working in difficult areas. Additional weightage (up to 30% marks) for selection to PG Course for Medical Officers is given to those serving in difficult areas.
- The state has a posting policy that allows choice of district to staff after serving five years in difficult areas.
- The state has introduced staff welfare schemes including accidental and life insurance for NHM staff.
- Odisha has implemented an Integrated Human Resource Information System (iHRIS) for all HRH (both regular and contractual). iHRIS platform has provisions to generate salary slips, generate posting and transfer orders and maintain facility-wise line lists of all staff.

RAJASTHAN

- Among the six key cadres, the State has a surplus of Staff nurses, Pharmacists, and Medical officers-MBBS posts sanctioned against the IPHS 2022 requirement.
- Rajasthan has reported high vacancy in the regular cadre for staff nurses, lab technicians, pharmacists, and clinical specialists. High vacancies are also reported under NHM for all six key cadres.
- Key Program Management Unit (PMU) positions across all levels are also vacant.
 - Recruitment is conducted centrally for all staff and face significant delays, with the most recent cycle which was initiated in 2022 yet to conclude. Decentralization to the district level is planned for smaller-scale recruitments, while SPMU-level recruitments will be managed by the HR cell in the future.
- Recruitment for allied health staff under regular cadre provides up to 30% weightage for experience which facilitates the recruitment of NHM staff.
- The Trio recruitment process for Gynaecologists, Anaesthetists, and Paediatricians has ensured specialist availability at District Hospitals (DHs), but gaps in infrastructure, such as non-functional operating theatres, limit the utilization of these specialists. Irrational deployment was also observed with surgeons being posted at SDH without anaesthetists.
- The state has implemented the service rules for contractual staff in 2022. With the implementation of these rules, there have been changes in HRH management including:
 - Recruitment of all staff notified under the new service rules, through the State Service Board. The initial/ first contracts are for five years, with provisions for renewal.
 - Rationalization and restructuring of both service delivery and programme management staff including salaries determined by the State’s finance department.
 - Revised Terms of Reference (ToRs) for staff roles and qualifications have been submitted for approval.

- Enrolment of all staff in the New Pension Scheme (NPS) and coverage under the Mukhya Mantri Ayushman Aarogya Yojana. However, there are no provisions for other allowances or EPF contributions.
- The state has a dedicated HR cell which undertakes HR functions including recruitments, increments, salaries, and HR related grievances.
- State has completed the mapping of the NHM staff into the state's existing HRMIS (RajHealth) and the development of NHM-specific modules are underway.
- Attendance is monitored using biometric systems for facility-level staff up to the sub-centre level.
- Salaries are decentralized, with disbursements mandated by the 5th of each month. There were no delays reported in the disbursement of salary.
- Though there is no transfer policy, a relocation policy for specific groups, such as differently abled staff and single or divorced women is available and prioritized.
- The state government has an integrated portal for Grievance redressal where the staff can also report their grievances.
- Annual Performance Appraisal Reports (APAR) have been introduced but are not uniformly implemented across cadres.
- Training programs are limited to select cadres. Induction training is offered only to Community Health Officers (CHOs) who have not completed the bridge course, while other cadres lack structured induction or refresher training.
- The State Institute of Health and Family Welfare (SIHFW) is the nodal agency for training but faces resource and operational challenges, impacting training frequency and coverage.

TRIPURA

- The state reported high vacancies among Specialists, Medical Officers, CHOs, Staff Nurses and ANMs. A shortage of specialists hindered the delivery of specialized services through teleconsultation at AAM- SHCs and AAM-PHCs .
- Despite there being proper infrastructure at the DEIC in Agartala, it was non-functional due to the unavailability of the required HRH.
- The state-of-the-art diagnostic machines at both the State hospital and the visited CHC were underutilized due to a shortage of lab technicians. Similarly, radiology machines were not fully utilized because of a lack of radiologists at the State hospital.
- Recruitments are centralized and significantly delayed.
- Only 50% of the NHM posts had defined ToRs.
- The state lacked a dedicated Human Resources (HR) department/cell with qualified personnel to manage HR functions effectively, and there is currently no comprehensive State HRH policy.
- Salary disbursal is decentralized and staff reported that they received salaries on time.
- Though the state provides EPF to the staff, they cited the need for a comprehensive welfare scheme.
- Attendance is monitored using a combination of the biometric system as well as manual attendance records.
- A formal performance appraisal system is not in place, hindering employee development and motivation. The state also does not have a specific grievance redressal system for employees.
- A Human Resource Management Information System (HRMIS) has been designed specifically for NHM employees. Currently, it only stores employee information and is used for generating

payslips. Other relevant modules, such as automated leave management system, or the generation of seniority lists, training requirements etc are yet to be introduced/ integrated.

- A total of 400 CHOs have received hands-on training on the National Mental Health Programme (NMHP) as part of a state-level training held in collaboration with National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru. This noteworthy initiative was designed to strengthen capacity for providing mental health care at the primary care level.
- There were very few steps taken for continuous learning or professional development of the staff.
 - The staff did not undergo any induction training.
 - They also cited need for training related to specific programmes and quality assurance initiatives.
- With the absence of a dedicated training institution at the state or regional level, trainings are primarily conducted at the GBM medical college, or the state-run IGM hospital.

Public Health Management Care

- A taskforce has been formed to review, revise and implement The current public health management cadre in the state comprises three primary categories:
 - GDMO Cadre: Established through a notification dated October 26, 2022, this cadre encompasses 1131 posts.
 - Teaching Cadre
- Specialist Cadre: This cadre, established through a Government of Tripura notification dated March 10, 2023.
- Furthermore, a high-level committee has been formed to review, revise, and implement these cadre structures.

UTTAR PRADESH

- Vacancies were reported in the lab technician and pharmacist cadres, and observed to be affecting diagnostic services and the availability and management of drugs respectively. There are also shortages of specialists, including obstetricians, gynaecologists (OBGYNs), and paediatricians, limiting the capacity of health facilities to deliver essential and specialized services.
- High-demand areas, such as MCH wings, obstetric HDUs/ICUs, SNCUs, and Pediatric Intensive Care Units (PICUs), were reported to be particularly affected by the unavailability of these specialists, and lack of appropriately trained HRH. Frequent rotations in the postings were identified as disruptive to the continuity of care in specialized units.
- It was observed that RBSK teams were rarely present in the field.
- Key Programme Management HRH like District Accounts Manager, Block Accounts Manager had been vacant for more than three years.
- State and district-level monitoring mechanisms lacked uniformity, reducing the effectiveness of governance structures.
- Due to Uttar Pradesh's large size and administrative complexity and for effective program implementation, a well-structured and strengthened State Program Management Unit is required. State may even consider a post of an additional Mission Director.
- Supportive supervision at the facility and district levels is inconsistent.
- Lack of integration in service delivery were observed at the level of primary care facilities - ANMs primarily focus on RMNCH services, while CHOs primarily undertake blood pressure and sugar measurements.

- Knowledge and training gaps were evident across service delivery as well as programme management staff. Training of staff in expanded packages is incomplete. Induction and refresher training opportunities are also limited. Training of staff in BMW management was also observed to be incomplete.

UTTARAKHAND

- Though the sanctioned strength of staff in the districts is comparable to the norms given in IPHS 2022, bottlenecks in recruitment are impacting the availability of HRH. High vacancies against the approved number of specialists are a major challenge in the state. Shortages of anaesthetists, psychiatrists, and OBGs were especially pronounced in Bageshwar.
- It was reported that due to specialists such as OBGs not being available at CHCs, high risk pregnancies were being referred to District Hospitals for deliveries, with newly graduated MOs often relying on seniors to provide guidance over the phone.
- The District Residency Program had been implemented in Uttarakhand. It seems that the State wanted the DRP to address the shortage of doctors at District Hospitals. However, it was reported that residents do not assume accountability.
- Absence of necessary equipment and instruments was also identified as a barrier to service delivery. For eg. despite the presence of a dental surgeon, the dental unit lacked essential amenities.
- A need was felt for enhanced safety measures for the HRH as well as patients, given the vulnerability of facilities in certain locations to intrusions of wild animals.
- Although teleconsultation is being used to enhance availability of skills and specialized services, challenges persist in the form of insufficient HRH at hubs as well as spokes.
- An HRH policy has been formulated by Uttarakhand.
- A biometric system is being used by Uttarakhand for monitoring the staff's attendance.
- It was noteworthy to observe that some motivated staff such as the NTCP counsellor have taken proactive actions such as customizing IEC materials and develop a questionnaire.
- Records detailing the number, level (i.e., state/district/institutional) and types of trainings were largely absent at most of the visited facilities.
- As per interactions with the staff, there is a lack of induction training for newly joined MOs as well as refresher training for existing MOs and specialists. Office and administrative staff have also received minimal to no training since their appointment and reported facing difficulties in handling software and portal updates due to inadequate training.
- Most staff were unaware of the Tele MANAS programme and e-Sanjeevani services. Awareness among staff about the observation of different health awareness days was also low.

WEST BENGAL

- Shortage of specialists at secondary care facilities was reported across the two districts visited in the state. Gaps were also noted in the availability of other health staff at primary healthcare facilities such as Medical Officers, Staff Nurses, Lab technicians, and Pharmacists.
- In South 24 Parganas, HRH was not available as per IPHS standards.
- Notably, in Malda district, the presence of ENT, audiometric assistant & audiologists (along with audiology room) at the SDH ensured comprehensive delivery of ENT services to a large catchment area.
- Block Public Health Units are functional across the state, and dedicated epidemiologists have

been recruited at the same.

- Motivation was observed to be high among HRH.
- Trainings of staff are currently not being updated on the SASHAKT portal. In Malda district, training calendar and ToRs for trainings had not been prepared.
- Training of SHC-AAM staff on the expanded package of services has not been completed.
- Under NQAS, need was identified for the training of Block Medical Officers Health, Sr Public Health Nurse, and CHOs, on the assessment process, and documentation.



INDIAN PUBLIC HEALTH STANDARDS (IPHS)

16th

BACKGROUND

Indian Public Health Standards (IPHS) were introduced as a comprehensive framework to deliver quality healthcare services across the length and breadth of the country. It was first launched in 2007 and has been last revised in 2022. The IPHS guidelines set uniform benchmarks for various aspects of public health facilities, including infrastructure, medical personnel, essential medicines, diagnostic capabilities, equipment, and quality assurance mechanisms. These standards are applicable to all levels of healthcare delivery, ranging from the smallest health facilities, now known as Ayushman Arogya Mandir, to the largest district hospitals.

The overarching goals of IPHS are multifaceted: to equip the facilities with adequate resources, to improve access to healthcare services, establish a seamless system for patient referrals, reduce the financial burden of out-of-pocket expenses for the underprivileged, and ensure that healthcare services are delivered in a patient-friendly and dignified manner. The latest 2022 revision of the IPHS guidelines places a strong emphasis on defining the specific services that must be provided at each level of healthcare facility, ensuring that every Indian has access to essential healthcare services, regardless of their location.

To support states in their efforts to implement these standards effectively, the government has harnessed the power of technology by developing a digital assessment tool based on the Open Data Kit (ODK) platform and an online dashboard. This innovative solution enables state authorities to rapidly identify gaps and areas requiring improvement within their public health facilities. Additionally, it facilitates the provision of tailored support and guidance to help these facilities meet the prescribed IPHS norms.

KEY OBSERVATIONS

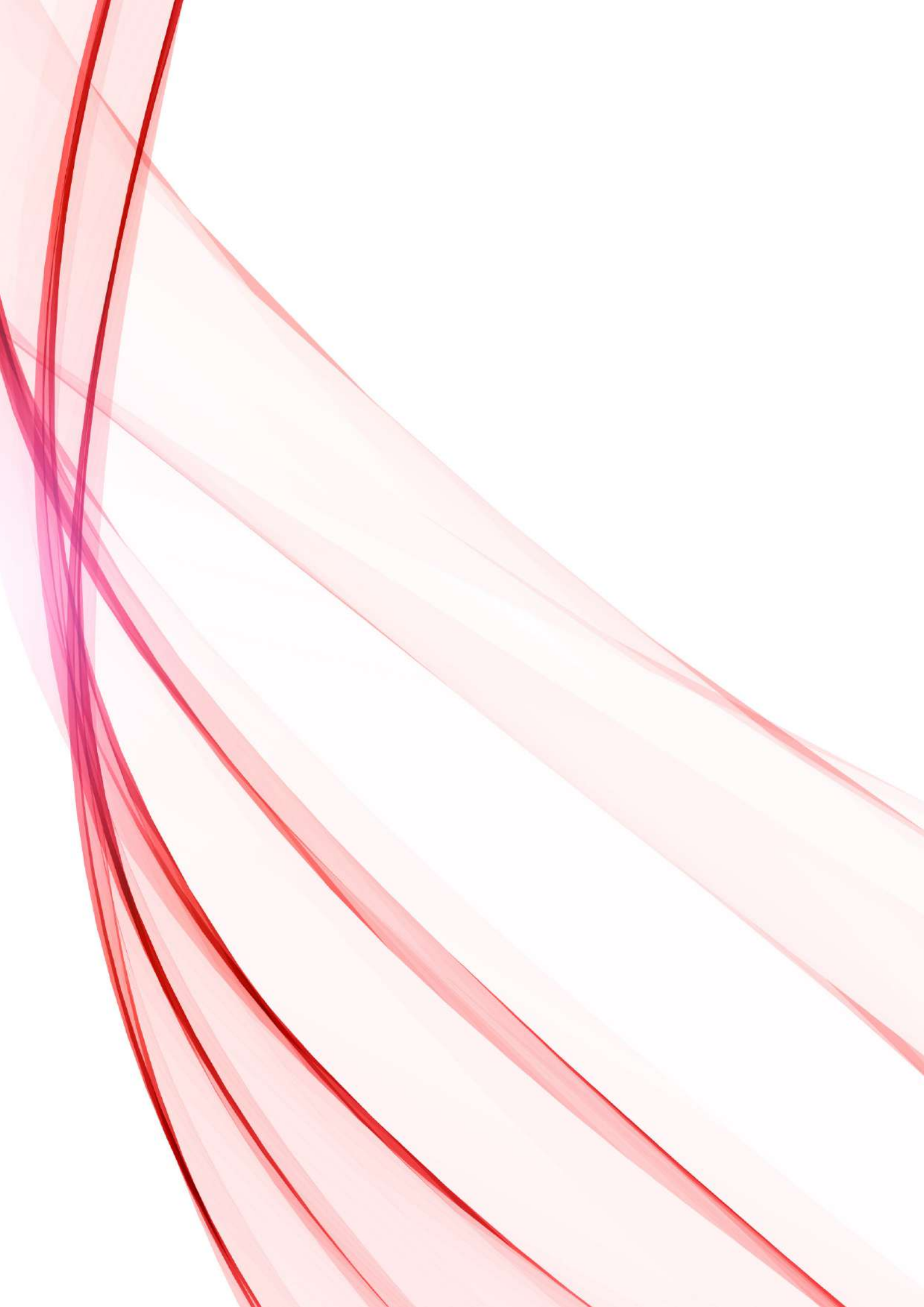
- Most of the visited facilities were observed to have undertaken IPHS assessment using the ODK toolkit. However, in Balaghat district of Madhya Pradesh, facilities were yet to initiate the process of baseline assessment. In Arunachal Pradesh, one of the visited DHs had not been assessed for IPHS compliance.
- Compliance to IPHS norms (facility score >80%) was found to be absent for most of the visited facilities across states. In Karnataka, almost half of the assessed facilities were found to be IPHS compliant, while in Tripura, over a third of the assessed facilities were deemed to be compliant, which is close to the national achievement of 50% IPHS compliant facilities by FY 2025-26.
- In Gujarat, Jharkhand and Arunachal Pradesh, most of the visited facilities scored less than 50% on the IPHS toolkit, placing them in the aspirant category, thus indicating a wide gap in quality service delivery.
- In Bihar, Jharkhand, Chhattisgarh, Uttarakhand and Uttar Pradesh, the number of IPHS compliant facilities was low.
- Overall, the domain-wise norms for HR, infrastructure, drugs & diagnostics and service delivery were mostly non-compliant in most of the visited facilities. Facilities in Bihar, Jharkhand and Assam were observed to have poor maintenance and sanitation, lack of essential equipment, and inadequate space. Moreover, some hospitals were operating from makeshift buildings.
- Lack of HR was a pertinent issue reported in Assam, Karnataka & Haryana where HR vacancy was seen to be prevalent across facilities.
- The PMU staff at the state and district level in Karnataka and Chhattisgarh had adequate understanding and knowledge of the IPHS ODK toolkit and guidelines. However, it was observed that the service delivery staff in Madhya Pradesh and Rajasthan were largely unaware about IPHS assessments.
- District and State level orientation on IPHS assessment was given to the facility in-charges in one

district of Madhya Pradesh.

- The gap assessment analysis for IPHS compliance was not being conducted in majority of the states visited.
- Environment-friendly initiatives like Herbal Gardens were found in some facilities in Jharkhand and Madhya Pradesh.

KEY RECOMMENDATIONSS

- States need to expedite the process of baseline assessment for IPHS compliance for all facilities, to achieve the GoI national target of 50% compliant facilities by FY 2025-25. This will also ensure adequate availability of good infrastructure, drugs and diagnostics, quality service delivery and rational HR at the facilities.
- State/district health authorities may devise a roadmap by undertaking in-depth analysis activities of the domain wise performance of health facilities in order to develop targeted interventions for achieving compliance.
- Facilities scoring between 70-79% may be prioritized for targeted interventions aimed at improving their performance to exceed the 80% threshold, thereby achieving IPHS compliance.
- State to also undertake regular training and orientation of IT personnel and other health staff to increase their awareness regarding the ODK toolkit.
- Facilities that are currently under-construction or planned for constructions may be reviewed to make them IPHS-2022 compliant.
- The states may also consider introducing environment-friendly practices like rainwater harvesting and energy-efficient designs for the health facilities





QUALITY AND PATIENT SAFETY

16th

NATIONAL OVERVIEW

The National Quality Assurance Standards (NQAS) have embarked on a quality journey in India by establishing a comprehensive framework under the Ministry of Health and Family Welfare to systematically improve the quality of healthcare services provided at public health facilities nationwide. This initiative ensures patient-centric care, safety, and standardized quality through certification processes at various levels of healthcare facilities, including primary and secondary healthcare facilities. NQAS set defined quality standards and regular assessments are conducted to identify areas for enhancement and to promote ongoing quality improvement practices. Overall, National Quality Assurance Programme (NQAP) has significantly contributed to elevating the quality of healthcare services in India by providing a structured framework for quality improvement, fostering accountability, and continuously incentivizing healthcare facilities to strive for better patient outcomes.

KEY OBSERVATIONS

- Most of the states have prepared a road map as per the NHM target towards achieving quality certification; however, the lack of systematic District Action Plans hinders the consistent scaling of NQAS.
- According to the progress shown by the states under NQAS certification, seven states out of 19 visited, are on the right trajectory to achieving their targets, including West Bengal, Tripura, Odisha, Madhya Pradesh, Karnataka, Gujarat, and Assam.
- The remaining 12 states need to accelerate the progress of certification to achieve the national goal of 100% certified facilities by Dec 2026.
- Most states are lagging in achieving quality certification for sub-divisional hospitals, community health centres, and urban primary health centres.
- The state and district quality assurance committees were established and operational in most of the visited states, except for Rajasthan and Jharkhand, where the positions of district quality consultants were vacant.
- There is a shortage of certified assessors and limited handholding support for facilities in aspirational districts.
- Most of the states visited were manually recording patient satisfaction surveys since Mera-Aspataal was non-functional. Additionally, the findings of the manual satisfaction score were not used for decision-making.
- Most states have mapped their facilities on the SaQsham portal, except for Maharashtra.
- Only a few states, namely, Odisha, Uttar Pradesh, and West Bengal, were optimally opting for virtual assessment of AAM-SHCs.
- It was observed that ground-level staff require training on various topics, such as Quality Tool implementation, SOP preparation, and recording Key Performance Indicators, among others.
- Compliance with statutory and regulatory requirements emerged as a foremost challenge in most states.

KEY OBSERVATIONS

- The states should expedite the process of NQAS certification as per the roadmap towards achieving the targets by strengthening the state certification mechanism.
- As AAM-SHCs make up the majority of facilities to be certified, the States must leverage the opportunity for virtual certification to achieve quick wins. Therefore, states should focus on promoting Virtual Certification through capacity-building initiatives.

- Institutionalisation of quality assurance framework at the district level by recruiting against vacant positions.
- To accelerate NQAS implementation, it is essential to develop comprehensive District Action Plans to guide and standardise certification efforts across all districts. Regular training and capacity-building for facility staff are crucial to strengthen workforce readiness and adherence to quality standards. Additionally, periodic reviews by the State team are essential to monitor progress, address gaps, and ensure the effective and sustainable implementation of NQAS in public health facilities across the state.
- Strengthening recertification processes will ensure timely renewals, maintaining continuous quality improvement. Strengthening processes and tracking recertification timelines can safeguard progress and uphold consistent healthcare quality across certified public health facilities.
- Virtual certification offers a streamlined, cost-effective process, reducing logistical challenges and enabling quicker certification of facilities. Promoting awareness, training staff, and enhancing digital readiness can help leverage this approach, ensuring more facilities benefit from timely recognition, improved service delivery, and adherence to quality standards without the need for extensive on-site assessments.
- Enhanced coordination between state and national certifying body will minimise delays in transitioning state-certified facilities and kayakalp-incentivised facilities to National Certification of NQAS.
- Strategy and plan to be developed for part NQAS certification of health facilities in Aspirational blocks.
- Need-based training should be conducted at the district and facility levels
- Maintain accurate and up-to-date records with utilisation of data for evidence-based decision-making and performance improvement.
- Mapping and registration of health facilities on SaQsham portal automated for NQAS assessments
- Inter-departmental convergence for regulatory and statutory compliances.
- Lastly, robust monitoring and evaluation frameworks must be implemented to track progress, identify gaps, and ensure accountability.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- Implementing NQAS in Arunachal Pradesh remains challenging. Only 13 healthcare facilities in the state have achieved NQAS certification (2 state and 11 national), reflecting the slow pace of progress in meeting quality standards. PHC Bilat recertification is also pending.
- Five AAM-SCs in West Siang were nationally certified under NQAS. However, despite having two external and three internal NQAS assessors, no NQAS-related activity was undertaken in Longding in this FY.
- Under the LaQshya initiative, 4 Labour Rooms and 3 Maternity Operation Theatres were certified until November 24, including the labour room and OT of DH Aalo (West Siang District).
- The implementation of the quality framework at the district level was inadequate. In many districts, the DQACs, essential for promoting quality initiatives, were either inactive or non-existent.
- The state has 100 state-level and 13 national-level NQAS assessors, but their involvement in handholding and mentoring targeted facilities was inadequate.
- Sixteen DHs and four UPHCs have been integrated with the Mera Aspataal platform; however, uploading patient data to the Mera Aspataal portal remains a challenge.

- It was observed that ground-level staff require training on various topics, including NQAS awareness, LaQshya, MusQan, Mera Aspataal, infection control practices, BMW management, quality tool implementation, prescription audits, etc. These skill gaps adversely affect facilities' ability to meet NQAS standards.

ASSAM

- Assam has made notable progress in quality certification under NQAS. Currently, around 18% (665 state-certified and 134 nationally certified) of healthcare facilities are quality certified compared to the total number of facilities in Health Dynamics of India. Of the total certified facilities, 8 AAM-SC were certified virtually.
- The state has empanelled 454 internal assessors and 72 external assessors under NQAS, but no professionals have been trained through the Tata Institute of Social Sciences (TISS) program as yet.
- In addition, 29 Labour Rooms and 15 Maternity Operation Theatres have attained LaQshya certification. The state also has 1 District Hospital certified under the MusQan initiative.
- District Quality Assurance Committees (DQACs), essential for facilitating quality improvement initiatives, were inactive across several districts.
- It was observed that most healthcare workers in primary and secondary facilities know the NQAP's goals and processes. However, personnel at AAM Sub-Centres lack this awareness and understanding.
- Several staff members across healthcare facilities have not received formal training on the NQAP, nor are they adequately familiar with established quality protocols or infection control practices. This lack of training limits their ability to implement and adhere to the standards required for effectively maintaining healthcare quality and safety.
- The visit highlighted deficiencies in the monitoring and evaluation processes for quality assurance. This lack of oversight hinders the identification and correction of critical gaps in service delivery standards.

BIHAR

- As of November 15, 14 facilities had received state-level certification, 23 had attained national certification, and 147 were currently undergoing assessment.
- The state has empanelled 429 internal assessors and 44 external assessors under NQAS.
- The state has one MusQan-certified DH, 25 Labour Rooms and 13 Maternity Operations that are quality-certified under the LaQshya initiative.
- More than 6,190 facilities have registered on the SaQsham portal. Despite these achievements, a significant proportion of healthcare facilities remain unevaluated or unprepared for certification.
- Challenges include the lack of staff orientation and implementation of key quality assurance programmes like NQAS, SUMAN, LaQshya, and MusQan, which are critical for improving maternal, newborn, and child health outcomes.
- The state aims to certify 2,275 facilities by March 2025, with targets distributed across months:
 - October 2024: One facility per district (38 facilities).
 - November 2024: One facility per sub-division (101 facilities).
 - December 2024 to March 2025: One facility per block (534 facilities per month).

- DQACs have been reestablished to regularly review and monitor progress.
- Regular training and capacity-building sessions are being implemented to augment the preparedness of healthcare facilities.
- Mentors have been assigned to districts to assist facilities in identifying and addressing gaps.
- An NQAS compendium and FAQ resource book have been developed to support facility teams in preparing for certification.

CHHATTISGARH

- The state has made noticeable progress under the NQAS certification. Although only 6% of healthcare facilities (59 state, 294 national) are quality certified, the state has met the target for district hospitals (77%) and urban primary healthcare facilities (52%), surpassing the target of 50% for healthcare facilities to be certified by December 2025, as set by the GOI.
- In Aspirational districts, the state has achieved the NQAS certification of 61 facilities.
- The state has 11 quality-certified facilities under MusQan; 28 Labour Rooms and 25 Maternity Operation Theatres certified under the LaQshya initiative.
- State-level and district-level quality committees have been formed; however, meetings of the same have not been held in the last year.
- At the regional level, 5 quality consultant posts are designated, however, 3 out of these are vacant.
- The state has 167 internal and 19 external assessors, while 3 Ayushman assessors are also available.
- Incentives for NQAS-certified facilities are being disbursed. Upon inquiry, the state informed that a total of ₹4.5 crore is expected to be disbursed for the year 2024-25, and the file is currently under process for this.
- A total of 20 out of 222 (9%) health facilities have been certified in the Gariyaband district.
- A dedicated district quality cell has not been established in Gariyaband. Additional responsibilities for NQAS have been assigned to PHN nurses.

GUJARAT

- As a progressive state, approximately 19% of healthcare facilities (1,109 state and 791 national) were NQAS certified. Among the total certified facilities, 25 AAM-SC were certified virtually. Of the total, 152 facilities were from Aspirational blocks.
- The state rationally uses its 174 internal and 77 external assessors. In addition to NQAS certification, the state has four quality certifications under MusQan and 63 Labour rooms and 53 maternity operation theatres quality certified under the LaQshya initiative.
- Additionally, the state has one comprehensive lactation management centre and one haemodialysis unit that is quality certified under NQAS.
- Jamnabai General Hospital in Vadodara was LaQshya certified until 2022 and is currently undergoing the renewal process.
- In the facilities visited, Key Performance Indicators (KPIs) were not calculated, and no records were available.
- Manual forms were used to measure patient satisfaction, but relevant analyses of the gathered information or action plans based on it were not evident.
- A grievance redressal mechanism is in place, with complaints received through a complaint box. The 104 Health Helpline was also working.

- Documentation pertaining to quality, quality processes, and improvement cycles demands attention.
- Mentoring and hand-holding support of the district quality team is needed to conduct continuous internal assessments to address remaining gaps before NQAS certification.

HARYANA

- The state has certified around 13% of healthcare facilities (82 state and 258 national) under NQAS. Virtual certification was undertaken for 18 AAM-SHCs. Out of the total certified facilities, 10 are from the cohort of aspirational blocks.
- The state has achieved the NQAS target in the District Hospital category, with 64% of DHs quality certified compared to the national target of 50% certification by December 2025.
- The state has a pool of 196 internal assessors and 85 external assessors.
- Sixteen Labour Rooms and 9 Maternity Operation Theatres met the LaQshya norms, while three facilities met the MusQan norms.
- Only five facilities in Palwal are certified NQAS, and 46 have been targeted, out of which 13 are in the pipeline for assessment.
- Quality teams were functional in the visited facilities; however, mentoring support from state and district quality teams was lacking.

HIMACHAL PRADESH

- The overall percentage of NQAS Certified facilities in the state is just 5.25% against the functional facilities (HDI 2022-23 + AAM-SC as per AAM portal as of 31-03-2024). Out of these, only 4 are certified in Aspirational blocks.
- The progress of AAM-SC is 8%, and that of District Hospitals is 33%. However, the progress of SDH is only 4%, and there is no progress in PHC and UPHC.
- The state has 8 Labour rooms and 7 Maternity Operation Theatres certified under the LaQshya initiative and has yet to initiate the process of MusQan certification.
- State Quality Assurance Committee and District Quality Assurance Committees are in place.
- There is an adequate pool of Internal (140) and External assessors (16) within the state.
- There was a lack of dedicated Quality Staff in most of the facilities.
- None of the facilities in the visited districts (PHC Nalti, CHC Galore, Civil Hospital Tauni Devi, DH Hamirpur, AAM-SC Nari, AAM-SC Bhira) were NQAS-certified, except AAM-SC Bhira, which is State NQAS certified and has applied for National Certification.
- Quality teams were in place, and meetings are being conducted monthly in all the facilities except PHC Nari and DH Hamirpur.
- Display of the citizen charter, information about the services, entitlements, and clinical conditions was found in all the facilities except DH Hamirpur.
- Drinking water and toilets are available but lack maintenance at CHC Galore and AAM-SC Bhira. Running water in toilets is available in all the facilities visited, except AAM-SC Bhira. Proper waiting areas with seating are mostly absent at DH Hamirpur and CHC Galore. A separate toilet for transgender individuals was found at PHC Nalti.
- All facilities except AAM-SC Bhira have well-established grievance redressal systems. However, the system at DH Shimla was inadequate. The person answering the call was unaware that it was

a grievance redressal number.

- Facilities are disability-friendly, with ramps available except at AAM-SC Bhira, Riog, Nala, and AAM-SC Nari. Disability-friendly toilets were only found in district hospitals.
- KPIs are recorded inconsistently at DH Hamirpur and CHC Galore. PHC Nalti and AAM-SC Nari record KPIs regularly, but action is not taken on the poor indicators. AAM-SC Bhira, Civil Hospital, regularly records KPIs and uses the data for decision-making.
- All facilities except DH and CHC Galore regularly calculate PSS. Although Mera Aspataal is operational in DH, it is not used to monitor PSS. Most facilities did not take appropriate action based on the PSS.
- Fire extinguishers and related mechanisms are installed in all facilities except AAM-SC Nari and Civil Hospital. None of the facilities possess a Fire NOC, but AAM-SC Bhira and DH have applied for one.
- Three facilities have yet to be re-certified, and letters have been issued to them periodically. The state has not yet rolled out the Virtual NQAS certification of AAM-SC.

JAMMU AND KASHMIR

- The UT has formed the Quality Assurance Unit but does not have enough manpower to achieve ambitious targets under NQAS. As of now, only 59 healthcare facilities (27 state and 32 national) are quality certified.
- The state has yet to upscale the virtual certification mechanism, as only one AAM-SC is virtually certified.
- None of the facilities in the aspirational block are quality certified.
- The state is not utilizing its quality professionals effectively, although 198 internal assessors and 36 external assessors are empanelled under NQAS.
- Under the LaQshya initiative, 12 Labour Rooms and 11 Maternity OTs are quality certified.
- Since DH Baramulla was upgraded to a Medical College, it is not being considered for NQAS certification.
- CHC Katra is also the first NQAS-certified and LaQshya-certified facility of J&K in FY 2019-20.
- SHC Salamabad was NQAS certified. The facility provided patient-centric care with proper IEC, grievance redressal, and monthly JAS meetings. It featured amenities that were friendly to specially-abled individuals. The staff were trained in fire safety, disaster management, biomedical waste management, infection control, and patient safety.
- KPIs and Patient Satisfaction Scores were analyzed at regular intervals.

JHARKHAND

- The state has certified around 7% of healthcare facilities (143 state and 77 national) under NQAS. Virtual certification was undertaken for only one AAM-SHC. Out of the total certified facilities, 38 are from aspirational blocks.
- The state's progress regarding sub-divisional hospitals and urban primary health centres is concerning, as none of the facilities in this category are quality certified.
- The state has a pool of 179 internal assessors and 21 external assessors.
- Twelve Labour Rooms and 9 Maternity Operation Theatres met the LaQshya norms. The state has yet to sign up for MusQan.

- The District Quality Assurance Committee (DQAC) is functional in District Sahibganj. Two meetings of the District Quality Assurance Committee were convened by the district, and the implementation of the QA program is reviewed.
- Posts of Regional & District Quality Consultant are vacant, and no Hospital Manager was posted at Sadar Hospital, Sahibganj.
- All the healthcare facilities in the district are not registered on the SaQsham portal, which is a mandatory requirement for certification. To assist health facilities in implementing NQAS, frequent monitoring and supportive supervision visits by the members of DQAU are required.

KARNATAKA

- The state has made significant progress under quality certification, with approximately 16% of facilities (1,158 state and 334 national) certified under NQAS. The state has also achieved quality certification of 73 facilities from aspirational blocks against a target of 321. Karnataka has developed a strong team of quality assessors: 167 State (Internal) Assessors, 57 National (External) Assessors, and 4 TISS-trained Quality Professionals.
- A significant number of health facilities (535) are linked to the Mera-Aspataal platform, improving feedback mechanisms and accountability.
- Focus on Maternal and Neonatal Health: Successful identification and certification of Labor Rooms (LRs) and Maternity Operation Theatres (MOTs) under the LaQshya initiative. At present, 119 Labour Rooms and 114 Maternity OTs are LaQshya Certified. Eighteen facilities are MusQan certified, ensuring child-friendly health services.
- However, the lack of systematic District Action Plans hinders the consistent scaling of NQAS across Karnataka.
- Pending recertifications of 43 facilities risk stagnation in quality improvements. Timely recertification is vital to ensure continued adherence to NQAS standards, sustain service excellence, and maintain community trust.
- Besides this, the limited uptake of NQAS Virtual Certification for SHS-AAM, with only six facilities certified so far, highlights a missed opportunity for accelerating quality improvement.
- Delays in transitioning state-certified facilities to National Certification beyond six months highlight process inefficiencies. Transitioning to National Certification is crucial for achieving broader recognition, ensuring higher quality benchmarks, and aligning with national standards.

MADHYA PRADESH

- The state has made substantial progress in NQAS certification throughout the region. A total of 15% of health facilities (1,281 state and 525 national) are quality certified under NQAS. Notably, 83% of district hospitals have achieved NQAS certification, and those in the visited districts have undergone successful surveillance recertification, receiving incentives for these accomplishments.
- Only 22 AAM-SCs are quality certified, and 101 facilities are quality certified from aspirational blocks.
- 183 Labour Rooms and 56 Maternity Operation Theatres met the LaQshya norms. The state has 21 facilities certified under the MusQan initiative.
- In the Rewa district, both Civil Hospitals, CH Semariya and CH Sirmour, have completed Peer and State assessments, while national assessments are underway. However, only one out of nine CHCs and three out of 45 AAM PHCs in the district have achieved NQAS certification, and two additional AAM-PHCs have completed Peer assessments.

- The roadmap for achieving NQAS certification at the district level was not available, although the state has 56 external assessors and 449 internal assessors empanelled under NQAS.
- DQAC has been formed in the Rewa district, and a quality circle team is in place at the Rewa DH and PHC Rahat. However, a quality team and Infection control committee were not in place at the CHC and PHC levels.
- Mera Aspataal integration was only implemented at the DH. None of the PHCs or CHCs were integrated with Mera Aspataal for patient satisfaction feedback.
- In most visited facilities, nursing staff demonstrated adequate knowledge of common procedures and basic skills in the Labour Room.
- Sterilisation practices also varied, with PHC Rahat using bleaching powder instead of fumigators, while CHC Govindgarh relied on Cidex solution for sharp instruments. Basic amenities, such as geysers, were absent in some facilities.
- Records for Quality Indicators, Departmental SOPs, infection control protocols, cleaning checklists, BMW logbook, Adverse events, Fire NOC, BMW authorisation letter from pollution control, NQAS standards, and Kayakalp were maintained at the District hospital level.

MAHARASHTRA

- As of December 31, 2024, the state has achieved the NQAS certification of only 90 health facilities, of which only six are certified from aspirational blocks.
- The state has conducted a rapid assessment of 17 district-level facilities, of which 14 district hospitals are prepared for state-level assessments. The state needs to prioritise the certification of these facilities.
- Given the quantum of the AAM SC, the Ministry of Health and Family Welfare (MoHFW) launched the virtual assessment of the AAM SC; however, the state has yet to initiate the process of virtual certification.
- The state needs to conduct a surveillance assessment of all certified facilities.
- Out of more than 4,500 facilities in the state, only 407 have been registered on the SaQsham Portal.
- The state needs to utilise the quality-trained personnel for mentoring and supporting the facilities in obtaining NQAS certification. Currently, the state has a pool of 417 internal assessors and 96 external assessors.
- The state has 82 labour rooms and 80 maternity OTs certified under LaQshya and three MusQan Certified facilities, which can be prioritised for NQAS certification.
- At most of Sindhudurg's visited facilities, privacy is not maintained while examining patients in the OPD.

MIZORAM

- State and District Quality Assurance committees are in place, and the state is working towards achieving its NQAS targets.
- Thirty facilities (19 state and 11 national) are NQAS certified, against the target of 54 committed under state PIP. Two facilities are certified from aspirational blocks against a target of 33.
- Four labour rooms and three maternity OTs are LaQshya, and three facilities are MusQan certified. As of Dec 2024, one facility is due for the surveillance assessment, and the state is in the process of completing the surveillance.

- The state uses the IPA (Internal Performance Agreement) to ensure healthcare facilities' preparedness for gap identification, action planning, and NQAS state and national assessments. Only 92 facilities till AAM-PHCS are enrolled under the project.
- The state has designated a Quality Nodal officer, state Quality consultant, and Program assistant. The District Quality Manager (DQM) and District Hospital Quality Managers (DHQM) are available at district level one. DHQM is responsible for quality activities at the DH level, while DQM works for CHC and PHC in the CMO's office. Notably, these district-level Quality managers are hired through the IPA, and their posting is till 2026. As such, the state does not have any dedicated HR for Quality at the district level, which will affect the progress and sustainability of NQAS and its domains in the long term.
- The state has 143 trained internal assessors, 24 External Assessors, and two Ayushman Assessors (trained to conduct virtual assessments on AAM-SC).
- The state is progressing toward NQAS certification of DH, PHCs, and UPHCs while facing challenges in implementing NQAS under CHCs and AAM-SC.
- The key challenge is the non-FRU CHC, which requires customising the NQAS assessment checklist per the non-FRU requirements.
- Another challenge is the travelling and logistic cost for the state/district NQAS assessment, especially in AAM-SCs.
- Currently, the state uses IPA incentives for the NQAS state and national evaluations of facilities other than AAM-SCs. However, no funds are available to conduct the district and state assessments of AAM-SCs.
- Under SaQushal, the state has internally assessed 11 DH (out of 12 DH) in FY 2024-25.

ODISHA

- The state has certified around 20% of healthcare facilities (949 state and 482 national) under NQAS. Virtual certification was undertaken for 61 AAM-SHCs. Out of the total certified facilities, 86 are from the cohort of aspirational blocks.
- The state has made noticeable progress in the AAM-SC category. Currently, 24% of SHCs are quality certified, compared to the national target of 50% certification by December 2025.
- The state has a pool of 218 internal assessors and 40 external assessors.
- 30 Labour Rooms and 26 Maternity Operation Theatres met the LaQshya norms, while two facilities met the MusQan norms.

RAJASTHAN

- Out of all health facilities, 7% (401 state and 310 national) have achieved NQAS certification. Five AAM-SC facilities underwent virtual assessments as per the guidelines.
- In aspirational blocks, 112 facilities (7.6%) received NQAS certification out of a total of 1,473 health facilities.
- District-wise Performance:
 - Sikar District: Out of 651 health facilities: NQAS Certified-12; State Certified-23
 - Bharatpur District: Out of 313 health facilities: NQAS Certified-4; State Certified-3
 - 80 Labour Rooms and 46 Maternity OTs met LaQshya norms, while four facilities met the MusQan norms.

- Human Resources for Quality Assurance:
 - 463 Internal Assessors
 - 67 External Assessors
 - 34 District Quality Consultant posts are vacant despite approval under PIP
- One regional review meeting was held in Jodhpur. From April to October 2024, state teams visited 16 districts to provide handholding support.
- District officials reported a delay in releasing award money to NQAS-certified facilities.
- 80% of beneficiaries expressed satisfaction with the quality of services (under Mera Aspataal/ manual patient feedback).
- Non-compliance with fire safety norms was observed in several facilities, including CHC Bhusawar and PHC Randheergarh.
- There is an absence of designated parking areas for staff vehicles.
- Patient satisfaction studies, policies, SOPs, and quality-related records are absent at some facilities (e.g., CHCs and Sub-Health Centres).
- District-level plans and review meetings for quality intervention goals are absent (Bharatpur District).
- Key Performance Indicators (KPIs) are available but not utilized for decision-making.

TRIPURA

- The state has certified around 20% of healthcare facilities (154 state and 52 national) under NQAS. Virtual certification was undertaken for 5 AAM-SHCs. Out of the total certified facilities, 2 are from the cohort of aspirational blocks.
- The state has made noticeable progress in the PHC and UPHC category. Currently, 35% of PHCs and 60% of UPHCs are quality certified, compared to the national target of 50% certification by December 2025.
- One PHC in the Dhalai district, located in an aspirational block, has achieved NQAS certification.
- The state has a pool of 103 internal assessors and 23 external assessors.
- Five Labour Rooms and four Maternity Operation Theatres met the LaQshya norms, while the state needs to initiate the certification process under the MusQan initiative.
- The absence of a dedicated District Consultant and a sufficient number of Assistant Hospital Administrators (9 posts sanctioned, all vacant) presents a significant challenge to effective quality oversight and management.
- Initiatives such as freezing the Performance-Based Incentives (PBI) of CHOs and enhancing AYUSHMAN incentives by 50% motivate facilities.
- The state has set a target of 20 facility certifications for each month.
- Twenty-nine facilities are linked to the 'Mera Aspataal' platform, while others rely on manual feedback collection.
- The grievance redressal mechanism is not very well-functional or effectively promoted.
- Medication safety and the documentation of adverse drug reactions are not adequately addressed.
- Fire safety training for staff is not being provided consistently.

UTTAR PRADESH

- The state has certified around 10% of healthcare facilities (1727 state and 498 national) under NQAS. Virtual certification was undertaken for 134 AAM-SHCs. Out of the total certified facilities, 81 are from the cohort of aspirational blocks.
- The state has made noticeable progress in the DH category. Currently, 80% of DHs are quality certified, compared to the national target of 50% certification by December 2025.
- The state has a pool of 376 internal assessors and 135 external assessors.
- Eighty-three Labour Rooms and fifty-four Maternity Operation Theatres met the LaQshya norms, while nine facilities met the MusQan norms.
- As observed, none of the visited AAM-SHCs was quality certified.
- The state must streamline and strengthen the certification process to reach the goal of 100% certified facilities by the end of December 2026.

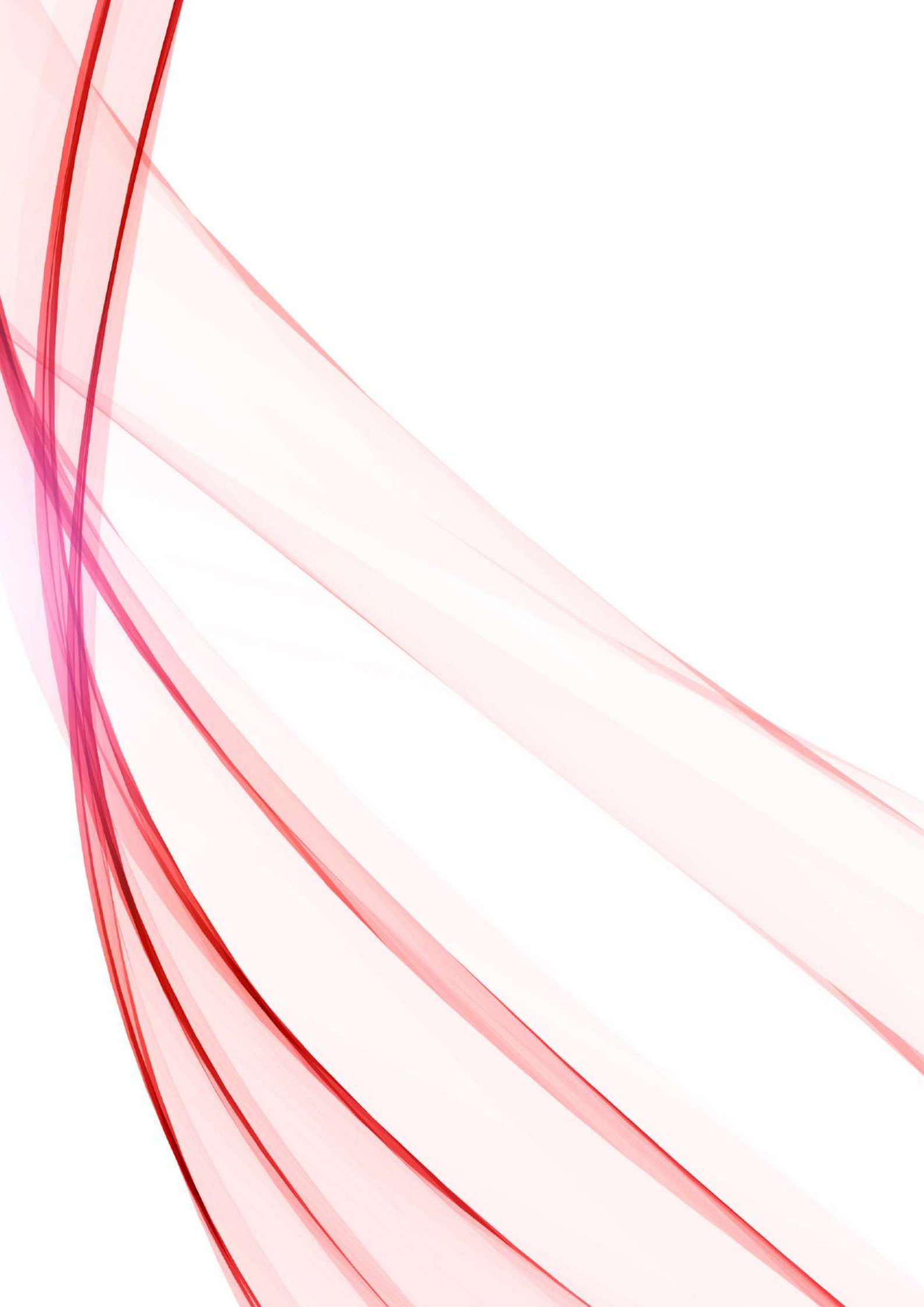
UTTARAKHAND

- In the state, 27 facilities (11 state and 16 national) were NQAS certified, of which 3 AAM-SCs were certified virtually. The state has almost nil progress in quality certification in the aspirational blocks, as only 3 facilities are certified against a target of 176.
- Sixteen Labour Rooms and ten Maternity OTs were LaQshya-certified, while none of the facilities in the state were MusQan-certified.
- In Dehradun, a total of three facilities were NQAS certified, and five facilities were LaQshya certified. None of the facilities in Bageshwar were NQAS or LaQshya certified. The district NQAS assessment was in progress for two AAM facilities in Bageshwar.
- There is a good pool of trained Quality team (13 external assessors, 211 internal assessors, 4 Ayushman assessors) who can be involved in training, supportive supervision, and mentoring of the facilities.
- No facility in both districts, whether certified or not, observed a quality culture, as staff were not aware of Quality Objectives, quality tools, or the relevant portions of Standard Operating Procedures (SOPs).
- The feedback system via Mera Aspataal was functional only at DH, Coronation, Dehradun, and the score was 60%.

WEST BENGAL

- The state has made remarkable progress in quality certification. Currently, around 26% of facilities (2537 state and 775 national) are NQAS certified, and 245 AAM-SHCs were certified virtually.
- Out of the total certified facilities, 62 are from the aspirational blocks.
- The state has made noticeable progress in the DH category. Currently, 79% of DHs and 49% of SDHs are quality certified, compared to the national target of 50% certification by December 2025.
- Also, 28% of AAM-SHCs meet the quality norms, which is another achievement worth praising.
- The state has a pool of 273 internal assessors and 46 external assessors.
- Thirty-nine Labour Rooms and thirty-seven Maternity Operation Theatres met the LaQshya norms, while twenty facilities met the MusQan norms.
- The team observed that both health districts were implementing the NQAS programme.

- In South 24 Parganas, internal assessment reports were found to be inappropriate. The BMOH signed the report with zero scoring. Orientation on the Assessment and document process was required for BMOH, Sr PHN, and CHO.
- The team observed that the licenses of the Blood Bank of Medical College and SDH Chanchal in Malda district expired in 2020 and 2022, respectively, and tertiary care facilities had a high patient load.





**KAYAKALP INCENTIVE SCHEME,
BIOMEDICAL WASTE MANAGEMENT
(BMWM) AND INFECTION
PREVENTION AND CONTROL (IPC)**

KAYAKALP INCENTIVE SCHEME

INTRODUCTION

Over the last few years, the number of Kayakalp incentivized facilities increased. The number of healthcare facilities participating in Kayakalp has increased from 750 facilities in FY 2015-16 to more than 75,000 facilities in FY 2023-24. The number of facilities incentivized for Kayakalp increased from 97 in FY 2015-16 to 32780 in FY 2023-24. The Kayakalp assessment toolkit has also been updated taking into consideration the recent/current changes.

The overall progress of 19 CRM States/UT is mentioned in table 1:

Name of States/UTs	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21	FY 2021-22	FY 2022-23	FY 2023-24
Arunachal Pradesh	2	210	9	11	13	17	16	32	47
Assam	2	46	46	157	213	274	517	1000	1678
Bihar	4	33	25	29	48	94	134	170	353
Chhattisgarh	2	50	94	108	274	380	480	852	1347
Gujarat	3	597	636	1006	1223	1410	521	1503	2230
Haryana	3	41	47	103	139	207	285	394	462
Himachal Pradesh	3	36	45	64	114	156	225	289	450
Jammu & Kashmir	2	11	11	28	48	39	73	176	250
Jharkhand	1	6	15	30	77	166	273	292	346
Karnataka	4	65	290	479	611	900	42	1643	0
Madhya Pradesh	9	43	63	90	267	220	396	780	1996
Maharashtra	5	81	305	366	369	396	927	1692	2179
Mizoram	2	47	63	67	67	64	97	133	192
Odisha	3	20	91	182	337	586	892	2414	3570
Rajasthan	4	46	151	205	489	1496	723	1475	2176
Tripura	0	8	22	30	50	87	138	193	268
Uttarakhand	3	11	16	46	65	64	95	137	174
Uttar Pradesh	11	37	116	184	351	690	1078	1423	2383
West Bengal	2	6	89	204	462	917	841	1216	1883
Total	65	1394	2134	3389	5217	8163	7753	15814	21984

KEY OBSERVATIONS

- The implementation of the Kayakalp scheme in health facilities significantly contributed to improved cleanliness, hygiene, and infection control practices.
- The number of participating health facilities in the Kayakalp scheme showed an increasing trend in all the 19 States/UTs, except Karnataka.
- Most of the States could not adhere to the Kayakalp activities timeline, except for Haryana, Gujarat,

Tripura, and West Bengal.

- Kayakalp incentivized health facilities were encouraged to apply for NQAS certification, as the staff were well aware of assessment methods and scoring rules of checklists.
- The Eco-friendly facilities under the Kayakalp scheme contributed to making health facilities climate resilient, and raised awareness among the staff on eco-friendly initiatives.
- Biomedical waste management rules 2016 were implemented by all the States/UTs, but obtaining BMW authorization from the state pollution control board was widely reported as a challenge.
- Staff lacked knowledge about proper segregation and handling of biomedical waste. This was evident as mixing of general and biomedical waste was observed in most of the facilities.
- The transportation and disposal of biomedical waste from smaller health facilities like AAM-SHCs was found to be challenging.
- The transportation and disposal of biomedical waste was a challenge in some states/UT due to the limited number of Common Bio-medical Waste Treatment Facilities (CBMWTF).

KEY RECOMMENDATIONS

- The States/UTs need to adhere to the Kayakalp assessment schedule to conduct internal, peer, and external assessments and declare results.
- A designated biomedical waste storage area for the temporary storage of BMW may be allotted for those AAM-SHCs where the AAM-PHCs function as the collection point, or if collection is done on specific days.
- Regular refresher training for the healthcare staff may be planned and provided for IPC and BMW.
- The States need to adhere to BMW disposal timelines of 48 hours as per BMW (2016) rules.
- States need to develop policies to guide the collection, segregation, and disposal of BMW generated at AAM-SHC and outreach levels.
- Regular health check-ups, essential PPE, and immunization of staff handling BMW need to be strengthened.
- Periodic audits and inspections by facility teams must be undertaken to ensure adherence to mandated BMW practices.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- Participation of health facilities in Kayakalp remained sub-optimal, as only 46 health facilities were awarded under the Kayakalp incentive scheme in FY 2023-24. In Longding District, none of the facilities had completed the Kayakalp internal assessment during FY 2024-25.
- Effective BMW management was a significant challenge in both primary and secondary healthcare facilities, highlighting the need for a more robust waste management framework.
- The state lacked CBMWTF, which contributed to unregulated disposal practices that posed environmental and public health risks.

ASSAM

- About 1,673 facilities across the state received the Kayakalp incentive during FY 2023-24. Additionally, 2 facilities were incentivized under the Eco-Friendly facility for their environmental sustainability efforts.
- Colour-coded BMW bins and containment areas were available with signage in most of the visited facilities. However, liquid waste management was not available in a few of the visited facilities.

BIHAR

- BMW practices were found to be satisfactory.
- Biomedical waste from the healthcare facilities was managed by an empaneled agency, which ensured compliance with waste collection and disposal protocols.

CHHATTISGARH

- The State had a target of 1000 facilities for Kayakalp and achieved around 1,345 facilities for the Kayakalp incentive. The State has an online system for Kayakalp assessment and result declaration.
- The State had three CBWTF located in Raipur, Ambuja, and Bilaspur. However, they were not sufficient to meet the requirements of the State.
- Deep burial pits were available at the AAM-SHCs due to the non-availability of CBWTF.
- Needle/hub cutters were available but needed to be replaced as per new norms.
- Mixing of bio-medical waste with general waste was observed.
- In the District Hospital in Gariyaband (CG), hazardous waste was stored near the water tank. It noticeably contaminated the premises and made the environment unhygienic and unsafe.

GUJARAT

- The adherence to BMW management across the visited districts was poor. All facilities lacked designated storage areas for the temporary storage of biomedical waste.
- In Kachchh, the knowledge of infection control among staff at the AAM-SHC level was inadequate, and the members of the AAM-SHC team lacked clarity on BMW rules and regulations. In Vadodara, the knowledge of staff was relatively better, but they could not adhere to waste segregation protocols due to the unavailability of necessary provisions.
- Capacity building of staff for infection control and BMW management was required. Periodic refresher trainings were needed for CHOs and facility staff on IPC practices and waste segregation rules.

HARYANA

- The State did not conduct the annual Kayakalp peer assessment of the health facilities. There was a need to strategize the scaling up of Kayakalp activities.
- Bio-medical Waste Management Rules, 2016 (BMW Rules 2016) were implemented in all facilities. The State has empaneled a private agency for waste disposal. Segregated waste was stored in a storage unit and was collected every day from DH, and once a week from the AAM-PHCs.

HIMACHAL PRADESH

- All the facilities participated in the Kayakalp scheme. Though a few of the visited facilities received the Kayakalp commendation award for FY 2023-24, they were still awaiting cash incentives.
- Most of the facilities had BMW authorization for storage and disposal, as well as the use of deep burial pits and Sewage Treatment Plants (STP).
- All the facilities adhered to the BMW Rules 2016 and were connected to the CBWTF. Bar code systems and effluent treatment plants for liquid waste management were observed in a few visited health facilities.
- Authorized deep burial pits were used for anatomical and sharp waste disposal in AAM-SHCs Bhira, and Nari, while plastic disposable waste was transported to the linked AAM-PHC once a month.

JAMMU & KASHMIR

- A total of 248 health facilities (6 DH, 28 CHC, 79 PHC, 13 UPHC, and 122 AAM-SHCs) achieved Kayakalp status in FY 2023-24.
- Implementation of BMW 2016 rules was not satisfactory in both visited districts. Staff were unaware of the proper waste management practices. BMW waste disposal was outsourced and had a CBWTF which was 100 km from the facility. Facilities were using chlorinated plastic bags. Bar code or GPS system had not yet started.

JHARKHAND

- Color-coded bins for waste segregation were available across the facilities. However, there were no visible work instructions to ensure proper segregation, and biohazard signs were not displayed.
- Staff in all facilities demonstrated adequate knowledge of BMW segregation and disposal norms. The BMW was regularly collected and disposed off at the CBWTF operated by a private vendor.
- The supply of personal protective equipment (PPE) and cleaning equipment was inconsistent and inadequate. In Sahebganj, no training was provided to the staff on their proper use and disposal.
- Instrument disinfection and sterilization practices were poor, with no standardized protocols being followed. The unavailability of autoclaves and disinfectants further compounded this issue, leaving the instruments inadequately sterilized and unsafe for reuse.

KARNATAKA

- Regular collection and disposal of BMW as per the Infection Management and Environmental Plan guidelines was observed.
- Collection of biomedical waste every alternate day was done from AAM-PHCs/UPHCs and the records were well maintained.
- BMW disposal and clear signage were observed at the all the facilities.

MADHYA PRADESH

- 1,994 facilities achieved the Kayakalp incentive.
- Though the BMW disposal bins were available, general waste and biomedical waste were mixed

in a few visited facilities.

- At the District hospital level, SOPs of infection control, cleaning checklist, BMW logbook, authorization letter from pollution control and standards for Kayakalp were maintained.

MAHARASHTRA

- The State needs to perform the activities under Kayakalp Initiatives as per the calendar of the activities shared by the MoHFW.
- State lacked routine coordination with the Waste Collection Agency. Prior approval for the Deep Burial pits from SPCB for BMW generated was not procured.

MIZORAM

- In FY 2023-24, a total of 188 DHs, SDHs, CHCs, UCHCs, AAM-PHCs / UPHCs were incentivized, and 4 facilities (DH and CHCs) received 'eco-friendly hospital' status.
- Biomedical waste was managed as per rules in most of the visited healthcare facilities.
- The state did not have a CBWTF, and so the waste was disposed of in deep burial and sharp pits.
- AAM-SHCs / UPHCs did not have a system for disposing of BMWs; they were shifted to the DH in hospital vehicles as there was no dedicated vehicle available for the purpose.

ODISHA

- 106 AAM-UPHCs and 5 Urban CHCs received the Kayakalp Award in 2023-24 for their exceptional performance.
- Color-coded bins were available for Bio-Medical Waste (BMW) disposal, but segregation was not done as per guidelines in AAM-SHCs.

RAJASTHAN

- A total of 2,170 health facilities (21%) received the Kayakalp incentive in 2023-24.
- In Sikar District, 201 health facilities received the Kayakalp incentive, while in Bharatpur District, 49 health facilities received the Kayakalp incentive.
- BMW practices, including liquid waste management and infection control practices, were poor. The BMW generated at the health facility was lifted on a weekly basis. BMW was segregated at the point of generation and sent to the empaneled agency for disposal.
- Facilities below the CHC levels transported biomedical waste to the nearest healthcare facilities by maintaining proper records.
- There were few protective measures for the staff handling biomedical waste. The lack of personal protective equipment (PPE), immunization against critical infections such as Hepatitis B and tetanus, and the unavailability of routine annual health check-ups for the staff members were observed. There was no mechanism for the mandatory pre-treatment of laboratory waste and highly infectious biomedical waste, categorized under the yellow category, before their final disposal in the visited facilities.

TRIPURA

- A total of 39 health facilities received the Kayakalp incentive during FY 2023-24.
- Barcoding of waste bags was not implemented. The Common Biomedical Waste Treatment Facility (CBWTF) for the health institutions was located 25 kilometers from Agartala (the state headquarters). Deep burial pits were utilized for the disposal of biomedical waste in most of the visited facilities.

UTTAR PRADESH

- Waste segregation, storage, transportation, and disposal were not consistently followed in the visited health facilities, leading to potential environmental and health risks.
- There was no documentation to verify if the medical and paramedical staff had received adequate training in BMW management. Inconsistent practices and a lack of awareness regarding the proper handling of bio-medical waste were noted.

UTTARAKHAND

- 174 health facilities were qualified in the Kayakalp External Assessment.
- In Dehradun district, 31 health facilities and 5 health facilities in Bageshwar district were incentivized under Kayakalp.
- The biomedical waste disposal protocols were compromised, which increased the possibility of contamination/exposure. The CBWTF did not collect BMW from hospitals in Bageshwar.
- BMW management at the facilities was observed to be poor. The Primary Health Care teams (CHOs and ANMs) were not trained on BMW management.

WEST BENGAL

- Adherence to BMW management was not observed at the AAM-PHCs visited. The biomedical waste was not collected regularly by the hired agency, and hence was dumped on the premises.
- Implementation of barcode technology for BMW monitoring was still pending.
- Colour-coded bins for segregation of BMW were available, and periodic training on segregation practices was in place.

INFECTION PREVENTION AND CONTROL

The reports from CRM teams visiting the states underscored the need to further strengthen the Infection Control Practices at the health facility levels through improved staff knowledge of appropriate practices. In this regard, in-service training on Infection Prevention & Control (IPC) needs strengthening. This has been recommended across the levels of healthcare facilities in most of the visited States.

The reports also emphasized the emerging need to follow IPC protocols for the dialysis units under the Pradhan Mantri National Dialysis Program, which could be achieved with adequate staff training. These may address issues relating to protocols followed for the dialyzer re-use, hygienic storage conditions etc., as reported in some States.

Some of the state reports also mentioned the need to strengthen IPC structures like health facility level Infection Control Committees and teams at all levels of health facilities. Some of the review mission

teams have pointed out marked difference in levels of implementation of IPC practices between NQAS certified and non-certified facilities.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- In DH Aalo, the critical Care unit staff required further training in the IPC protocols and hand hygiene practices.
- Training of staff on IPC along with other topic of importance associated with NQAS standards implementation need to be reinforced.

ASSAM

- The State needs to strengthen capacity building efforts on IPC and BMWM among its health workers.

BIHAR

- Vaccination against Hepatitis B for facility staff has not been completed across all healthcare facilities.

GUJARAT

- Compliance to Infection Control Protocols for RMNCAH+N services needed attention as IPC practices were compromised in some secondary care level facilities.
- Compliance to Biomedical Waste Management rules and staff knowledge of infection control practices were found lacking at AAM – SHC level in both the districts visited.

JAMMU & KASHMIR

- At secondary care level, non-availability of SOPs for disinfection practices and sterilizing methods and Biomedical waste management practices has been flagged as an area of concern.
- Training on IPC practices among health workers needed attention.

JHARKHAND

- Several instances of non-compliance to Infection Control Protocols and Biomedical waste Management rules at health facilities were observed, including poor adherence to RMNCHN+A services, lack of zoning in high risk area, and lack of infection control protocols in dialysis units.
- Infection Prevention & Control Committees were not formed at various health facilities visited.

KARNATAKA

- Good compliance to IMEP guidelines was observed and staff were aware of IPC protocols during the health facility visits.

MADHYA PRADESH

- Lacunae in implementation of IPC practices were observed such as lack of cleaning and disinfection of procedure areas, and disinfection and sterilization of equipment and instruments.

RAJASTHAN

- Several instances of non-compliances in adhering to IPC practices at secondary and primary care facilities were observed.

TRIPURA

- Physical facilities for prevention of infection in patients due to dialyzer reprocessing including proper storage conditions under Prime Ministers National Dialysis Program was lacking.

UTTAR PRADESH

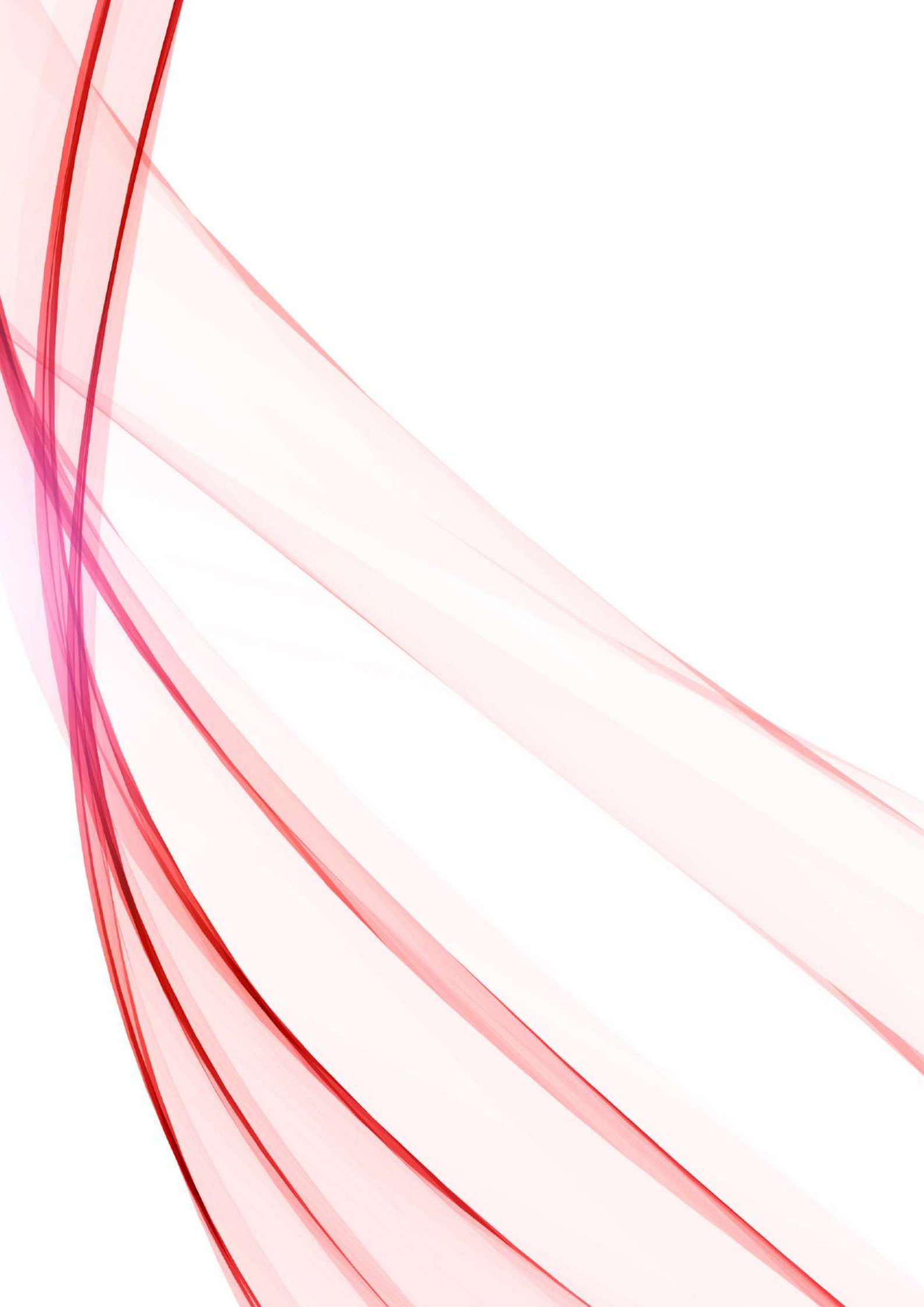
- Compliance gaps in IPC practices in RMNCHA+N services at various levels of facilities at Labour Room level and Delivery Points in Sub-Health Centers were observed.

UTTARAKHAND

- Non-compliance to standard practices for handling of biomedical waste management at health facility levels were noted.

WEST BENGAL

- At secondary care level, the doctors and staff were found to have a good subject knowledge on IPC practices, and hence, adherence to protocols was satisfactory.





LEGAL FRAMEWORK AND ACCOUNTABILITY

BACKGROUND

The legal framework for health supports health systems in various ways, and facilitates implementation of different health programs. In India, a diverse range of laws and regulations have been enacted to safeguard the rights and interests of its citizens in various aspects of healthcare and related fields.

These legislative measures cover a wide range of areas, including the regulation of clinical establishments, protection of women's rights, management of biomedical waste, prevention of gender-based harassment, reproductive rights, healthcare for persons with disabilities, control of tobacco products, and promotion of mental health.

Sixteenth CRM highlights the status and functionality of legal framework across states, with findings and observations derived through visits, engagement with relevant stakeholders, available records and reports, and community interactions in the field.

In majority of states, well established and streamlined legal frameworks and governance structures were found in place. The Clinical Establishments Act, 2010 has been implemented in 16 states, though challenges persist in states like Rajasthan, regarding permanent registration and awareness gaps. Almost all states have established an institutional mechanism under the PCPNDT Act, 1994, with mapping and convergence efforts observed in Gujarat (TeCHO+ mapping) and Uttarakhand (block-wise mapping), while legal action in Odisha has resulted in 78 cases filed and 14 convictions.

However, inconsistencies were noted in the practice of documenting consent in Form C under the MTP Rules across various facilities, with gaps in record-keeping and IEC efforts in states like J&K, Madhya Pradesh, and Rajasthan. Service providers also lack clarity on the provisions of Mental Healthcare Act, 2017 (MHCA). Its implementation is pending in J&K and Rajasthan, as authorities have not been established and notifications for various rules have not been published. With respect to Biomedical Waste Management Rules, 2016, J&K lacks barcoding and GPS tracking, Uttarakhand faces waste disposal issues in Bageshwar, and Rajasthan reports inadequate PPE and immunization for waste handlers. With respect to the Atomic Energy Act, 1962, compliance issues were reported in Tripura and J&K with non-functional X-ray machines and lack of AERB certification.

The inadequate or poor awareness of various health-related legislations was largely attributed to the absence of organized training programs for service providers, leading to gaps in knowledge and implementation. This was particularly evident with respect to POSH Act, 2013, in states like Chhattisgarh, Mizoram, Bihar, and Uttarakhand, where low awareness and the absence of written policies were reported.

However, service providers at the facility level demonstrated a good understanding of crucial legal provisions, including the issuance of disability certificates, birth registrations, confidentiality provisions under the HIV/AIDS (Prevention & Control) Act, 2017, prohibition of sex selection under the PCPNDT Act, and mandatory signages under COTPA.

KEY OBSERVATIONS

- Clinical Establishments Act, 2010: Implemented in (Arunachal Pradesh, Bihar, Gujarat, J&K, Karnataka, Madhya Pradesh, Mizoram, Odisha, Tripura, Uttarakhand, Chhattisgarh, Haryana, Rajasthan, and West Bengal); however, online registration is pending in Bihar, Mizoram, and Tripura, while Rajasthan faces challenges with permanent registration issues and awareness gaps.
- Pre-Conception & Pre-Natal Diagnostic Techniques (PCPNDT) Act, 1994: Implemented in (Chhattisgarh, Haryana, Rajasthan, West Bengal, Gujarat, Odisha, and Uttarakhand); however, low convictions reported in Chhattisgarh and Haryana (no cases registered in Haryana); mapping and convergence efforts noted in Gujarat through TeCHO+ and block-wise mapping in Uttarakhand; legal action in Odisha reported with 78 cases filed and 14 convictions.
- Medical Termination of Pregnancy (MTP) Act, 1971 (Amended 2021): Implemented in (Odisha, Karnataka, J&K, Madhya Pradesh, Mizoram, Tripura, Chhattisgarh, Haryana, Rajasthan, and West

Bengal); notable efforts in Odisha, which became the first state to Gazette MTP forms post-2021 amendment; training and awareness gaps identified in J&K, Madhya Pradesh, and Rajasthan, particularly in record-keeping and IEC efforts.

- Protection of Women from Sexual Harassment (POSH) Act, 2013: Implemented in (Karnataka, Odisha, Mizoram, Bihar, Uttarakhand, Chhattisgarh, Haryana, Rajasthan, and West Bengal); active Internal Complaints Committees (ICCs) and awareness efforts noted in Karnataka and Odisha; low awareness and absence of written policies reported in Chhattisgarh, Mizoram, Bihar, and Uttarakhand; structural gaps identified in Rajasthan, where committees exist but lack documentation and proper composition.
- Cigarettes and Other Tobacco Products Act (COTPA), 2003: Implemented in (Arunachal Pradesh, Gujarat, Karnataka, Bihar, Odisha, Uttarakhand, Chhattisgarh, Haryana, and Rajasthan); strong enforcement observed in Arunachal Pradesh, which has tobacco-free public places, and Odisha, which has collected ₹1.8 crore in fines since 2010; weak implementation noted in Bihar due to lack of signages and enforcement, and in Uttarakhand, where tobacco use among health professionals remains a concern.
- Rights of Persons with Disabilities Act, 2016: Implemented in (Arunachal Pradesh, Odisha, Uttarakhand, Tripura, Chhattisgarh, Haryana, Rajasthan, and West Bengal); however, challenges persist in Uttarakhand due to a lack of specialists, in Tripura where only two hospitals issue disability certificates, and in Rajasthan, where implementation is limited to district levels and requires expansion.
- Medico-Legal Care for Sexual Violence Cases: Implemented in (Karnataka, J&K, Odisha, Tripura, Haryana, and Rajasthan); high caseload in Karnataka with approximately 50 cases per month; challenges observed in J&K due to the absence of One-Stop Centers, in Tripura where cases are handled in OPD without dedicated rooms, and in Rajasthan where only one 'One-Stop Center' exists and staff awareness remains low.
- Biomedical Waste Management Rules, 2016: Implemented in (Odisha, J&K, Bihar, Uttarakhand, Mizoram, Chhattisgarh, Haryana, and Rajasthan); notable compliance seen in Bihar, where waste management is being handled well, challenges persist in J&K due to the absence of barcoding and GPS tracking, in Uttarakhand where waste disposal issues persist in Bageshwar; and in Rajasthan where there PPE is not available, and immunization coverage is low for staff handling biomedical waste.
- Registration of Births & Deaths Act, 1969: Implemented in (Odisha, J&K, Uttarakhand, Tripura, Haryana, Rajasthan, and West Bengal); high registration levels noted in Odisha with 6,53,281 births and 4,15,288 deaths recorded in 2023; challenges identified in Tripura due to irregular training and the absence of mechanisms for in-transit and community deaths, and in Rajasthan where increased rural awareness campaigns are needed.
- HIV/AIDS (Prevention & Control) Act, 2017: Implemented in Odisha, J&K, Tripura, Chhattisgarh, and Rajasthan; strong compliance in Odisha with 482 complaint officers and an appointed Ombudsman; challenges identified in J&K, Tripura, and Rajasthan due to absence of standard operating procedures (SOPs) for occupational exposure.
- Mental Healthcare Act, 2017: Implemented in (Gujarat, J&K, Tripura, Chhattisgarh, and Rajasthan); compliance efforts seen in Gujarat, where a Mental Health Authority and Review Board have been established; pending implementation in J&K due to the non-formation of the authority and review board, and in Rajasthan where the rules remain not-notified.
- Atomic Energy Act, 1962 (AERB Compliance): Implemented in J&K, Gujarat, Odisha, Tripura, Uttarakhand, Chhattisgarh, Haryana, and Rajasthan; challenges noted in J&K where some radiology units lack AERB certification, and in Tripura where non-functional X-ray machines and the absence of AERB certification in CHCs were observed.
- Grievance Redressal & Transparency Mechanisms Implemented in J&K, Odisha, Arunachal Pradesh,

Haryana, and Rajasthan; active grievance redressal portals in J&K through JK (e-Samadhan) and Odisha (via the PMO PG portal); challenges reported in Rajasthan where facility-level grievance handling lacks systematic monitoring.

- Institutional Bodies & Citizen Charter Implemented in West Bengal with functional State Health Societies (SHS), District Health Societies (DHS), Village Health, Sanitation & Nutrition Committees (VHSNC), Mahila Arogya Samitis (MAS), and Rogi Kalyan Samitis (RKS); citizen charter displayed in Haryana with service details for transparency.
- Infrastructure Gaps & Accountability Challenges observed in Rajasthan due to deficiencies in water supply, electricity, green initiatives, and low participation of PRI/NGOs in Jan Arogya Samitis (JAS) and Rogi Kalyan Samitis (RKS); regular district-level meetings held in Haryana and Rajasthan, but state-level governing body meetings remain irregular; public-private partnership (PPP) services in Haryana include the availability of CT scan and dialysis services.
- IEC on Patient Rights: Implemented in West Bengal, with notable efforts in Malda district where patient rights are prominently displayed in SDH-Chanchal.

KEY RECOMMENDATIONS

- Strengthen Implementation and Compliance of Key Acts: by expediting the development of an online portal for Clinical Establishments Act (CEA), ensuring regular supervisory board meetings and documentation under the PCPNDT Act, standardizing Form C documentation and expansion of MTP services at CHCs, and operationalizing Internal Complaints Committees (ICCs) under the POSH Act, expediting the approval and implementation of State Mental Health Rules, and ensuring AERB certification, TLD badge maintenance, and periodic audits for radiation safety under the Atomic Energy Act.
- Enhance Awareness and Training on Legal Frameworks by integrating capacity-building sessions on PCPNDT, POSH, MTP, medico-legal care, and other key Acts into routine training programs, ensuring orientation for healthcare personnel at district and sub-district levels, and strengthening awareness campaigns at community and facility levels to improve adherence and implementation.
- Strengthen Bio-Medical Waste Management (BMW) by enforcing proper segregation, labelling, and disposal in line with the BMW Rules, 2016, ensuring regular audits and refresher training for healthcare staff, addressing infrastructure gaps in waste treatment facilities, and improving monitoring mechanisms for compliance and accountability.
- Improve Grievance Redressal and Transparency Mechanisms by establishing systematic documentation and monitoring of grievances, ensuring timely resolution within stipulated timelines, strengthening internal grievance committees through capacity building, and enhancing public accessibility to complaint portals to improve accountability.
- Strengthen Tobacco Control and COTPA Implementation by ensuring proper placement of no-smoking signage, enforcing penalties for violations, generating community awareness on tobacco control, and conducting regular monitoring and enforcement actions to curb tobacco use in public places and near healthcare facilities.
- Enhance Disability Services and Rights Implementation by improving the process of issuing disability certificates, conducting frequent outreach camps for accessibility, fostering interdepartmental collaboration, and ensuring comprehensive assessment and service availability at all levels.
- Strengthen Medico-Legal Protocols and Response to Sexual Violence by ensuring dedicated rooms for handling sensitive cases, conducting regular training for healthcare personnel on medico-legal protocols, strengthening documentation processes, and improving coordination between healthcare, law enforcement, and legal authorities.
- Expedite Implementation of Mental Healthcare and Radiation Safety Measures by notifying State

Mental Health Rules, operationalizing State Mental Health Authorities at all levels, ensuring AERB certification and compliance in radiology units, and conducting periodic safety audits and staff training on radiation protection.

- Improve Institutional Governance and Infrastructure Accountability by ensuring regular governing body meetings, strengthening PRI and NGO participation in JAS/RKS committees, conducting infrastructure gap assessments, ensuring uninterrupted access to water, electricity, and other utilities, and promoting green and climate-resilient healthcare infrastructure in alignment with national standards.

STATE SPECIFIC FINDINGS

ARUNACHAL PRADESH

- The Clinical Establishment Act, 2010 has been implemented in the state. The rules are extended to the whole of the state and are applicable to all clinical establishments in the state.
- The state has reported 0 cases in the last three years regarding violation of provisions of PC-PNDT Act.
- Disability certificates were being issued at the health facilities, however, a fee of Rs 50/- was being charged for them.
- The state actively enforces tobacco control measures, including bans on sale near educational institutions, and public spitting of tobacco products, with designated officers ensuring compliance.
- West Siang's DTCC was recognized for excellence in IEC monitoring during the 2023 Tobacco-Free Youth Campaign.
- Grievance redressal mechanisms and citizen charters were largely absent in Longding district, though available but inadequate at Longding DH.
- Signages, including departmental and no-smoking signs, were missing in CHC Pongchau but were present in all facilities in West Siang district.

ASSAM

- PCPNDT Act, 1994 : The State Supervisory Board reconstitution was proposed in June 2024, IEC/ BCC campaigns and awareness meetings were conducted, an Advisory Committee led by the Health Minister is active, 11 DAC meetings were held in Morigaon, where 30 USG centres are registered (6 cancelled, 21 functional, including 1 govt.), registration certificates are displayed, Form F is available, and villagers know sex determination is illegal but lack awareness of the Act.
- Rights of Persons with Disabilities Act, 2016: Disability certificates are issued through the Social Welfare Department, facilitated by DH Morigaon's medical board, and granted by the Joint Director; and community members are aware of the application process.
- Sexual Harassment of Women at Workplace (POSH Act): Internal Complaints Committees (ICC) are constituted at DH and CHC facilities visited.
- Medico-Legal Care Protocol for Rape and Sexual Violence Cases: DH Morigaon has a designated room for rape and sexual violence cases, equipped with necessary resources.
- Mandatory Services Implementation under MTP Act (2024-2025): Mandatory services implemented in the state as per the MTP Act including Baksa and Morigaon district.
- COTPA ((Prohibition of Advertisement and Regulation Of Trade And Commerce, Production, Supply And Distribution): "No Smoking Area" signage are displayed at the premises of the health facilities. Security Nodal officer is appointed to monitor at Morigaon DH.
- Birth and Death registration has been done at DH, O/O Joint Director Health services of the districts,

SD, CHC and PHC level.

- Both the districts visited under CRM had applied for Bio Medical waste authorization to State PCB.
- The facilities ensure staff's adherence to safety protocols, including the availability of protective equipment (like gloves and masks) and drugs for post-exposure prophylaxis (PEP). Visual reminders and flow charts are displayed in the facility to reinforce these practices.
- The State Mental Health Authority has been notified. Mental health review board has been constituted in the state. The making of state mental health rules is under process.

BIHAR

- Clinical Establishment Act (CEA): enacted with State Council and District Registration Authorities in place, but online portal implementation remains pending.
- PC & PNDT Act: State-level supervisory board constituted with regular meetings; facilities display information, and no cases were registered in either district.
- Medical Termination of Pregnancy (MTP) Act, POSH Act, and Medico-Legal Cases: Committees formed at state and district levels, but meetings are sporadic; POSH Act Internal Complaint Committee is yet to be constituted, posing a critical workplace safety gap.
- Bio-Medical Waste Management Rules (2016): Waste managed well by a hired agency, proper collection and disposal compliance is being ensured.
- Rights of Persons with Disability Act: Disability certificates issued at district hospitals with a structured validation process and interdepartmental camps conducted.
- COTPA (Cigarettes and Other Tobacco Products Act): Poor enforcement observed, with minimal no-smoking signage, absence of monthly compliance reviews, and widespread tobacco spitting and sales near healthcare facilities.
- Registration of Births and Deaths Act: Birth and death registers were maintained across all visited healthcare facilities.
- Medico-Legal Care Protocol for Rape and Sexual Violence Cases: Officials lacked awareness of protocols, highlighting the need for orientation and capacity building.
- Atomic Energy Act, 1962 (AERB Compliance): Some radiology units in the district hospital of Gaya did not have AERB certification, a key requirement for radiation safety compliance. TLD (Thermo Luminescent Dosimeter) badges for radiation monitoring were not available at the visited facilities, raising safety concerns.

CHHATTISGARH

- Clinical Establishments Act, 2010: The state has adopted the Act.
- PCPNDT Act, 1994: State and district-level committees are being formed, meetings and training sessions are planned, and the conviction rate in 2023-24 was negligible.
- Medical Termination of Pregnancy Act & POSH Act, 2013: Both Acts are in place, but written POSH policies were not observed in primary healthcare facilities, and awareness among health staff was low.
- Rights of Persons with Disabilities Act, 2016: The Act is notified, and disability certificates are issued, but community awareness about the process is low.
- COTPA Act, 2003: The Act is notified and shared, state-level meetings are planned, "No Smoking" signages were observed in healthcare facilities, and hospitals and schools were tobacco-free.
- Bio-Medical Waste Management Rules, 2016: Staff vaccinations and health check-ups are done, but waste transport is inefficient, cross-state transportation is restricted, and proper waste treatment

procedures are not being followed.

- HIV/AIDS Prevention & Control Bill, 2017: Awareness is low, and SOPs for safety and occupational exposure are lacking.
- Mental Healthcare Act, 2017: The Act is notified.
- Atomic Energy Act, 1962: TB notification is mandatory, AERB authorization is in place in facilities.

GUJARAT

- PC&PNDT Act: Gujarat has 456 registered ultrasound facilities in Vadodara and 162 in Kachchh. The meetings of State Supervisory Board (first constituted in 2008) are not regular (last met on September 22, 2022). Child Sex Ratio (CSR) mapping is done at district, block, and village levels using Civil Registration System, HMIS, and TeCHO+. Collaboration with the WCD Department includes community awareness activities like puppet shows, role plays, and rallies for gender equality.
- Clinical Establishment Act (CEA), 2010: There are 145 clinical establishments in Vadodara and 96 in Kachchh. The State Council and District Registration Authorities have been constituted, and district-level information is compiled at the state level.
- Mental Healthcare Act, 2017: The State Mental Health Authority was notified on August 7, 2019, and the Mental Health Review Board was constituted on September 3, 2021. State Mental Health Rules have been formulated and sent for legal approval.
- COTPA (Cigarettes and Other Tobacco Products Act, 2003) & PECA (Prohibition of Electronic Cigarettes Act, 2019): The Gujarat Police Department has directed district police to include COTPA and PECA in monthly crime reviews. A monitoring, challan, and reporting mechanism is in place, with periodic enforcement drives. However, signage in facilities lacked information on complaint redressal, and the District Tobacco Control Cell has not conducted necessary training sessions.
- Registration of Births and Deaths (RBD) Act, 1969: The Inter-Departmental Coordination Committee (IDCC), chaired by the Chief Registrar (Births and Deaths) and Commissioner (Health), meets annually. The 'e-Olakh' portal is used for online birth and death registration, with training provided to key officials. A mechanism is in place for documenting in-transit deaths, including autopsy and cause of death.
- POSH (Sexual Harassment of Women at Workplace) Act, 2013: No workshops or awareness sessions have been conducted, leaving staff uninformed about workplace safety and legal provisions.
- Right of Persons with Disability Act, 2016: The frequency of medical camps for disability assessment has been low.
- Accountability Framework: The SHM Governing Body meets quarterly for strategic oversight, with the Executive Committee and Programme Sub-Committees conducting regular progress reviews. The State Health Society operates under the NHM framework, with decentralized leadership at the district level.
- Urban Health Governance: Municipal corporations ensure land availability for health centers, HR recruitment, procurement, and interdepartmental coordination. Training of PRI members is lagging, with only 2.87% expenditure reported for FY 2024-25 (up to October).
- Grievance Redressal: The PMO PG portal is used for lodging and addressing public grievances related to government services.
- Public-Private Partnerships (PPP): Services under PPP mode are monitored through various sub-committees under the Additional Director.
- Health Data Validation: A Data Validation Committee, formed on February 4, 2023, conducts quarterly HMIS data reviews with state and district officials. An automated MS Excel-based

validation tool has been developed, with training provided through regional workshops and state-level meetings.

HARYANA

- Clinical Establishments Act: Enacted; State Council formed, District Registration Authority seen formed in one district (Palwal). Facilities registered were seen with certificates displayed.
- PCPNDT Act: Implemented; community aware, F-forms filled, but sex ratio remains low. 69 ultrasound facilities registered, no cases reported.
- MTP Act: Implemented; DH and 35 private hospitals registered, MTP up to 12 weeks conducted, but reported cases are low (18-23/month).
- Rights of Persons with Disabilities Act: Disability certificates issued every Thursday at DH via Swavlamban Portal.
- POSH Act: Internal Complaints Committee constituted at DH, IEC displayed near biometric attendance.
- Medico-Legal Care for Rape & Sexual Violence: One Stop Centre at DH managed by ECD and District Legal Service Authority (DLSA); workshops conducted, rape kits available, 4 cases reported (Oct 2023 - Sep 2024).
- COTPA Act: Monitoring mechanism in place, District Tobacco Cell active, signage displayed, no smoking observed in public areas.
- Birth & Death Registration : All PHCs, CHCs, and municipal bodies register births and deaths; ASHAs support the process, and online registration is operational in secondary care facilities.
- Bio-Medical Waste Management Rules, 2016 : Implemented by hired agency in Palwal; waste collected daily at DH, weekly at PHCs, remote SHCs/PHCs transport waste to CHCs. CBWTF in Faridabad (within 75 km).
- Atomic Energy Act, 1962: CT scan and X-ray unit at DH Palwal are AERB-certified.
- Grievance Redressal Committees formed; complaints mainly verbal, only few written.
- PPP Services: CT Scan and Dialysis available on PPP mode.
- Citizen Charter: Available, with service information displayed.
- HMIS (e-Upchaar): UHID assigned to patients for EMR retrieval, lab and digital X-ray reports integrated, reports accessible online, but X-ray films only for medico-legal purposes.

HIMACHAL PRADESH

- Statutory & Legal Compliance: BMW authorization exists in all facilities for storage and disposal. Fire extinguishers and the related mechanisms in place in all facilities except AAM-SC Nari and Civil Hospital. None of the facilities have Fire NOC/Compliance certificate but AAM-SC Bhira and DH have applied for it.

JAMMU AND KASHMIR

- Clinical Establishment Act: Implemented in J&K (post-Article 370 abrogation) via Presidential Order (May 2020), with district-level implementation through the Jammu & Kashmir Clinical Establishments (Registration & Regulation) Rules, 2020. The Directorate of Health Services heads the State Council, and Chief Medical Officers lead District Registration Authorities. Online registration ensures transparency, with certificates displayed at clinics.
- PCPNDT Act: The Act, is enforced in J&K. Baramulla District has 77 registered USG centers, with no violations reported in 2024. Supervisory board meetings are held regularly, and facilities display

mandatory public information boards. Pregnant women did not report knowledge of foetal sex during interactions. The Act is also being implemented in District Reasi.

- MTP Act, 1971: Awareness of the Act and its amendments was mixed in Baramulla, requiring further training, whereas Reasi showed satisfactory awareness among doctors. Necessary formats for MVA and MMA were available at visited facilities in Baramulla.
- Disability Act, 2016: Disability-friendly services were available at visited facilities. Disability certificates are provided after approval from the district-level committee.
- Sexual Violence & Rape: One Stop Centres had no designated rooms in visited facilities, but SoPs were issued at district hospitals to ensure informed consent, privacy, and victim counseling.
- Biomedical Waste Management Rules: Implementation of BMW Rules 2016 was not satisfactory in Baramulla and Reasi. Staff were unaware of proper procedures, and waste management was inadequate in CHCs and DHs. In Baramulla, waste is outsourced, but burial pits lack Pollution Control Certificates. Chlorinated plastic bags were not used, and barcode/GPS systems were not initiated. In Reasi, health facilities are covered under the MoA signed with hired agency, which has runs a common Bio-Medical Waste Treatment Facility in Samba.
- COTPA Act: Standing instructions from DHS J&K mandate weekly enforcement drives, with reports due by the 28th of each month. “No Smoking Area” boards were present in Baramulla but not in some visited Reasi facilities. While COTPA enforcement activities occur in Reasi, including raids and fines, compliance in health facilities was lacking.
- PECA Act: Awareness was poor, requiring follow-up training. Birth and death registrations are done through an online portal, with certificates issued via the municipal/panchayat registrar general portal.
- HIV & AIDS Bill, 2017: Implementation is ongoing, but staff awareness at facilities needs improvement. District Magistrates are designated Ombudsmen under the Act.
- MHCA Act, 2017: J&K has notified the State Mental Health Rules, but the State Mental Health Authority and Mental Health Review Boards are yet to be formed. The Drugs and Cosmetics Act, 1940, is in force in Reasi, under the Drug Controller of J&K, who also oversees drug licensing.
- Grievance Redressal Mechanism: District Reasi follows the JK e-Samadhan portal, which provides the first reply within 15 days of grievance filing. Complaint boxes are available at health facilities. In some cases, complainants directly approach medical officers for quick resolution.

KARNATAKA

- PoSH Act: Internal Complaints Committees were established at multiple levels, with awareness sessions conducted to ensure staff familiarity. The committee members’ list was circulated for accessibility.
- MTP Act: Regular awareness sessions were held for healthcare teams, and patients were informed about the Act, signing Form 16 to acknowledge that sonography was conducted solely for medical assessment.
- COTPA: “No Smoking” signs were prominently displayed, tobacco violations were recorded, and coordination with local authorities ensured compliance. Panchayat meetings were conducted to raise awareness about tobacco and alcohol risks.
- Medico-Legal Care for Rape & Sexual Violence: The district hospital had a designated space for such cases, handling around 50 monthly. A seven-member committee oversaw medical and legal procedures, with PHC-level cases referred to the district hospital.
- Sakhi One Stop Centres: These centres, supported by the WCD Ministry and Karnataka government, provided integrated assistance to women facing violence in both districts.

- Compliance with Key Acts: The state adhered to various regulations, including the Karnataka Private Medical Establishment Act (2011), PCPNDT Act (1994), Radiation Prevention Act (2004), POCSO Act (2012), Epidemic Disease Prevention Act (1897), and the Karnataka Prohibition of Violence Against Medicare Service Personnel Act (2009).

MADHYA PRADESH

- Clinical Establishment Act (CEA), 2010: The state follows the Madhya Pradesh Upcharya Agriha Act (1973) as CEA, with the revised 2022 version in place. However, district-level awareness remains limited.
- PCPNDT Act, 1994: A district-level committee is in place, with enforcement actions taken against two private USG centers in Rewa. While functional USG services were available in DHs, CHCs, and some PHCs, DH Rewa had inadequate space for USG, DEO workstation, and colposcopy.
- MTP Act, 1971: Information about the Act was not displayed outside most facilities in Balaghat and Rewa.
- COTPA, 2003: IEC materials were properly displayed, a challan system enforced compliance, and tobacco cessation services, including nicotine replacement therapy, were available at DHs.
- PoSH Act: Awareness was low, with Internal Complaints Committees established in only a few facilities. No records were available on meetings, training, or complaints filed.

MAHARASHTRA

- Clinical Establishment Act, 2010: Maharashtra follows the Bombay Nursing Home Registration Act, 1949, with District Registration Authorities in place; OPD clinics are not registered, no monthly reporting mandate, and Akola has 433 hospitals registered, though the online portal is non-functional.
- PCPNDT Act, 1994: Akola has mapped low child sex ratio blocks, conducted IEC campaigns, appointed 10 Appropriate Authorities and an 8-member Advisory Committee, registered 188 sonography centers with mandatory F-forms, and reported no violations in the last year.
- Rights of Persons with Disabilities Act, 2016: GMC issues disability certificates.
- POSH Act, 2013: An Internal Complaints Committee (ICC) with 10 members (8 women, 1 NGO rep) is constituted, with a written policy on sexual harassment displayed at workplaces, but no complaints were received in the last year.
- Medico-Legal Care for Rape & Sexual Violence: A One Stop Centre (OSC) at Akola District Women's Hospital follows SOPs for consent, evidence collection, and medical care, handling 7 rape, 41 POCSO, and 31 child marriage cases in 2023-24, with training conducted on MoHFW protocol & POCSO Act.
- COTPA, 2003 & PECA, 2019: No-smoking signage is displayed in health facilities, enforcement drives are conducted, tobacco laws are included in monthly crime review meetings, and the District Tobacco Control Cell has trained police, education officials, and PRI members.
- Registration of Births & Deaths Act, 1969: All facilities report births and deaths through the CRS Portal, with mass IEC campaigns involving panchayats/municipalities and training conducted for Registrars and stakeholders.
- HIV/AIDS (Prevention & Control) Act, 2017: SOPs for infection control and post-exposure prophylaxis are in place, with a Complaints Officer appointed to handle violations.
- Mental Healthcare Act, 2017: The State has notified the Mental Health Authority & Review Boards.
- Atomic Energy Act, 1962: X-ray departments are not fully AERB-compliant, some machines lack certification, TLD badges are not available for technicians, and biomedical waste disposal has

been outsourced to a hired agency.

MIZORAM

- Clinical Establishment Act (CEA), 2010: Adopted in 2014; state council exists, but no district registration authority. Manual state register maintained with 638 registered CEs, while an online portal exists but has not been updated. CEA certificates are displayed in most government facilities.
- PCPNDT Act, 1994: Sex ratio: 975; State Supervisory Board meetings resumed in 2024 after a gap since 2019. A total of 66 USG facilities are registered, with certificates displayed in English & local language. No cases have been registered or convicted in the last year. However, community awareness campaigns on the Act are lacking.
- MTP Act, 1971: MTP services are available with 80 trained providers (46 active). RMPs are trained, and regular online webinars are conducted by FOGSI and Kolasib OBG specialists.
- Rights of Persons with Disabilities Act, 2016: Beneficiaries are aware, and the Swavlamban portal is available. Disability certificates are issued at District Hospital Kolasib.
- PoSH Act: An Internal Complaint Committee is formed with trained members, and quarterly training is conducted. However, no complaints registered in last year.
- Medico-Legal Care for Rape & Sexual Violence: A circular has been issued, and One-Stop Centres are operational. SOPs and reporting formats are available, with active POCSO cases reported in Kolasib & Lunglei. Training has been conducted on MOHFW protocol for sexual violence & POCSO Act.
- COTPA Act, 2003 & National Tobacco Control Program: “No Smoking” signs are displayed, and a monitoring & challan system is in place. Tobacco cessation services are available at DH Kolasib. Although public awareness exists, rampant smoking & chewing persist, with fines imposed on offenders.
- Prohibition of Electronic Cigarettes Act, 2019: The Act is included in crime review meetings, with a functional challan system. Despite an awareness drive in October 2024, e-cigarette use remains widespread.
- Registration of Birth & Death Act, 1969: Reporting is conducted up to PHC level, with community deaths reported through trained local registrars.
- Biomedical Waste Management Rules, 2016: Colour-coded bins and liquid waste disposal systems are available in all healthcare facilities. However, no Common Biowaste Treatment Facility exists, leading to disposal via deep burial and sharp pits. Kolasib DH’s deep burial pits are non-compliant with BMW guidelines, and its incinerator is non-functional as per pollution control board instructions. AAM-SC & UPHCs lack a proper BMW disposal mechanism.
- Atomic Energy Act, 1962: Radiology units are AERB-certified, and TLD badges & lead aprons are available but underutilized. In Kolasib DH, the radiology unit is situated in a high-patient flow area due to ongoing restructuring.

ODISHA

- Clinical Establishment Act (CEA), 2010: New/renewal registration through a portal (CEMSO).
- PCPNDT Act, 1994: As of 30th June 2024, 1623 ultrasound centers are registered in Odisha, 78 cases registered under the Act, leading to 14 convictions. State Supervisory Board to be reconstituted, low SRB districts mapped in HMIS, IEC/BCC materials distributed, and appropriate authorities with district advisory committees appointed.
- MTP Act, 1971: Odisha became the first state to officially notify through gazette, MTP forms post-2021 amendment, and establishing Medical Boards for abortions beyond 24 weeks in 12 MCH institutions; MMA drug kit included in the Essential Drug List (EDL); between April-Sept 2024-25.

- PoSH Act, 2013: ICC reconstituted in Koraput on 28th May 2023; ICC also constituted in Sambalpur.
- COTPA Act & PECA 2019: 40 enforcement squads across 30 districts; 247 enforcement movements in 2024. Over 1 lakh challans issued, collecting ₹1.8 Cr in fines. 5 cases forwarded to court under Section 7.
- HIV/AIDS (Prevention & Control) Act, 2017: SOP on a safe working environment followed state-wide. 482 complaint officers appointed; State Ombudsman in place.
- AERB Clearance: not in place for MCH Koraput, MCH Bhawanipatna, MCH Balangir, MCH Baripada, MCH Balasore, Jharsuguda Cancer Hospital (PPP Mode), and Govt. Medical College Talcher.
- Registration of Birth & Death Act, 1969: Registrars designated at DH, SDH, and CHC levels. In 2023, births and deaths registered: Koraput (27098/13697), Sambalpur (20171/16348), Odisha (653281/415288).
- Biomedical Waste Management Rules, 2016: MoU in place with 2 agencies. IEC on BMW management displayed at all health facilities, adhering to GoI guidelines.

RAJASTHAN

- Clinical Establishments Act (2010): Rajasthan notified the Act in 2013, but full implementation remains a challenge. To date, approximately 5,200 provisionally registered establishments, only few have transitioned to permanent registration due to limited awareness and enforcement.
- PCPNDT Act: Compliance with the Act is observed, with mandatory Form F maintained. However, limited USG availability remains a concern.
- Rights of Persons with Disabilities Act (2016): Implementation is limited to districts, leaving rural areas underserved.
- COTPA (2003): Effective implementation includes IEC materials, tobacco cessation counselling, and a challan system.
- MTP Act: Awareness and record-keeping gaps exist despite the availability of MVA equipment at CHCs and SDHs.
- POSH Act (2013): Internal complaints committees exist at higher level healthcare facilities, but they lack proper composition and documentation.
- HIV Prevention and Control Bill (2017): The absence of SOPs for occupational exposure and designated Complaints Officers weakens implementation.
- Biomedical Waste Management (BMW) Rules (2016): Gaps include: lack of PPE, immunization for waste handlers, and pre-treatment of highly infectious waste.
- Medico-Legal Protocol for Sexual Violence: Awareness of One Stop Centres (OSCs) and the POCSO Act is limited among healthcare workers.
- Mental Health Act (2017): Rajasthan has formed a Mental Health Authority, but operational rules are pending.
- Atomic Energy Act (1962): X-ray services function at SDHs, but radiation safety measures, including TLD badge allocation, are lacking.
- Registration of Births & Deaths Act (1969): Facilities maintain records and issue birth certificates. Awareness campaigns, particularly in rural areas, can improve registration coverage.

Accountability Framework

- Rajasthan Medical Relief Society (RMRS): NGOs and social activists have been excluded from committees. Female representation is also low.
- District Health Society Meetings: Conducted regularly, but the last State Governing Body meeting

was in May 2023, indicating lapses in compliance.

- Grievance Redressal: The “181” portal centralizes complaints but lacks systematic record-keeping. Complaint boxes exist but are emptied only monthly, affecting timely resolution.
- Infrastructure Gaps: Issues include inadequate water/electricity supply and lack of climate-resilient healthcare infrastructure. Sustainable practices need prioritization.

TRIPURA

- Clinical Establishment Act, 2010: Adopted in December 2018; State Council and District Registration Authorities established; 586 clinical establishments registered, but data collection remains manual.
- PCPNDT Act, 1994: 151 ultrasound facilities (31 government, 120 private); low Child Sex Ratio mapping conducted; IEC/BCC campaigns initiated; limited public awareness; State Supervisory Board inactive.
- MTP Act, 1971: Functional MVA/EVA equipment available at the State Hospital level; trained gynecologist at CHC Kherangbar, but MTPs not performed.
- Rights of Persons with Disabilities Act, 2016: Only two hospitals (GB Medical College & IGM) issue disability certificates; CHC-level awareness exists.
- POSH Act, 2013: ICC constituted at CHC level but not publicly displayed; no training conducted; no complaints received; no records for awareness campaigns found
- Medico-Legal Care for Sexual Violence Cases: No dedicated room; cases handled in Gynae OPD; consent and records maintained; no training conducted on MoHFW protocol.
- COTPA, 2003 & NTCP: Public signages lack complaint officer details; monthly district-level meetings held; 11 tobacco cessation centres; 2023-24 state training conducted; no PECA cases or awareness programs.
- Registration of Births and Deaths Act, 1969: Birth/death registration through CSR portal; 1351 institutions registered; no mechanism for community or in-transit deaths.
- Bio-Medical Waste Management Rules, 2016: PPE provided; no health check-up records; liquid waste treatment not recorded; no ETPs at CHC; barcoding absent; CBWTF 25 km from Agartala.
- HIV/AIDS Act, 2017: Gazette notification issued (28/10/2022); Ombudsman appointed; no SOPs on workplace safety or PEP availability.
- Mental Healthcare Act, 2017: Mental Health Authority & Review Board formed in 2019; Mental Health Rules notified in May 2024 but not yet implemented at the district level.
- Atomic Energy Act, 1962: TLD (Thermoluminescent Dosimeters) badges available; some radiological units lack AERB certification; X-ray machine malfunctions seen; State Hospital licensed, but CHCs lack authorizations; TB notifications limited to the public sector.

UTTARAKHAND

- Clinical Establishments Act, 2010: Adopted; authorities functional; registrations completed; no major complaints in the past year.
- Registration of Birth & Death Act, 1969: Online certificates issued; delays require mothers to revisit; home births registered with ASHA/ANM assistance.
- Disability Act, 1995: District panels issue certificates; CMO coordinates with medical colleges where specialists are unavailable.
- POSH Act, 2013: Committee constituted; workshop held in Bageshwar, but no meetings or staff awareness; no complaints registered.
- Biomedical Waste Management: Disposal protocols compromised; Bageshwar not covered by

CBMWTF; Hep. B vaccination for handlers inconsistent.

- COTPA, 2003: Tobacco use observed among public and health professionals; statutory warnings displayed; sporadic de-addiction activities.
- MTP Act, 1971: Amendments known to doctors; mandatory notice displayed in hospitals.
- PCPNDT Act, 1994: Low sex ratio in Bageshwar; only one USG center registered; mandatory certificates and sex ratio mapping in place.
- AERB Licensing: X-ray units licensed; TLD badges used by technicians but not interns.
- Mental Healthcare Act, 2017: State rules notified; authority in place; consent forms available; essential psychiatric medicines unavailable; no psychiatrist in Bageshwar.
- Medico-legal Protocol for Sexual Violence: Printed formats available; doctors oriented; One Stop Centre functional.
- Fire Safety Audit: Completed at DH Dehradun and CHCs; ongoing at DH Bageshwar.
- HIV Act, 2017: SOPs in place at DH Dehradun; relevant IEC messages displayed.

UTTAR PRADESH

- e-Voucher Scheme for High-Risk Pregnancies: Launched for USG services at empanelled centers; vouchers issued at ₹1/-; beneficiaries unaware of the scheme.
- PCPNDT Act: Accreditation expired (2017-2022); renewal application submitted but pending.
- Bio-Medical Waste Management (BMW) Rules, 2016: There were significant gaps in the implementation of BMW management practices across healthcare facilities. Waste segregation, storage, transportation, and disposal protocols not consistently followed, leading to environmental and health risks.
- There was no documentation to verify that medical and paramedical staff had received adequate training in BMW management. Inconsistent practices and a lack of awareness regarding the proper handling of bio-medical waste, was observed.
- The facilities showed signs of non-compliance with the Bio-Medical Waste Management Rules, 2016, especially in waste segregation, labelling, and disposal.

WEST BENGAL

- Legal framework and accountability: Both the districts are largely compliant with state specific legal frameworks like: Clinical Establishment Act, Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT), Medical Termination of Pregnancy Act (MTP), Sexual harassment at workplace Act, Medico-legal protocol, right to person with disability act, Birth and Death Registration.
- Institutional structures - SHS, DHS, VHSNC, MAS, RKS were in place.
- In Malda district, IEC regarding Patient's Rights was seen widely displayed.



**EMERGENCY COVID
RESPONSE PACKAGE II
(ECRP II)**

16th

BACKGROUND

The India COVID-19 Emergency Response and Health System Preparedness Package: Phase-II was approved by the cabinet on 08th July 2021 amounting to Rs.23,123 Crore with a central share of Rs.15,000 Crore and a state share of Rs.8,123 Crore. To provide support to Central hospitals agencies and to States/UTs Governments to augment their existing response to the second wave and the evolving pandemic, including at district and sub-district levels in peripheral facilities. The ECRP-II has the Central Sector (CS) and Centrally Sponsored Schemes (CSS) components.

The scheme aimed to accelerate health system preparedness for immediate responsiveness for early prevention, detection, and management of COVID-19, with the focus on health infrastructure development including for paediatric care and with measurable outcomes.

Under CSS components of the ECRP-II, a total of Rs.12,740.22 Crores released to the States/UTs as the central share. The CSS components include support to States/UTs level through NHM Framework with a State Share as is applicable in NHM.

Under the Central Sector (CS) components of ECRP-II, a total of Rs.1508.59 Cr has been released to the central institutions/agencies. The activities are implemented using existing mechanism of Central Procurement Division (CPD), Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), NCDC, Central Hospitals and Public Health Division and Allied Health Services division of the MoHFW.

KEY OBSERVATIONS

- Despite the successful control of Covid-19 in many States/UTs, the utilization of the released ECRP-II fund continues to be a challenge. As per the latest data (as of February 21, 2025) from the PMS portal, only 61.8% of the funds have been utilized by all the States/UTs.
- Medical Gas Pipeline System (MGPS) was found lacking in Gujarat Kachchh district hospital in spite of having a PSA plant. Jharkhand had a functioning oxygen plant but lacked dedicated personnel, safety protocols, and proper storage. Jammu & Kashmir had a non-functional PSA oxygen plant. The PSA plant in the state of Bihar was found non-functional. Other states are still in the process of installing or completing Medical Gas Pipeline Systems (MGPS).
- Odisha demonstrates good practices with a well-maintained and regularly tested PSA plant. Karnataka had utilized ECRP-II funds for establishing paediatric care and ICU beds, though LMO plant installation was behind schedule.
- Due to the cost-effective functional reasons, most of the LMO (Liquid Medical Oxygen) plants in various districts were currently operating underutilized conditions. This was primarily due to limited demand for oxygen supply in these areas, resulting in the plants not reaching their full capacity utilization.
- The efforts were being made to enhance the efficiency and utilization of these plants by strengthening tele-consultation services and implementing the Hospital Management Information System (HMIS) across District hospitals.
- The shortage of Covid-19 patients in healthcare facilities had led to a decreased demand for rapid antigen test (RAT) and reverse transcription polymerase chain reaction (RT-PCR) testing kits, as well as the recommended medications for Covid-19 treatment. As a result, these essential supplies were not as readily available as they were during the peak of the pandemic.
- The approved Critical Care Blocks were being established at the time of the visits, but due to the complex nature of the tender process, unpredictable climate conditions, and the need to properly survey and prepare the land, the timeline for completion has been extended.
- Most of the states had successfully installed the facilities such as RT-PCR laboratory, MGPS, Paediatric ICU/HDU, etc. However these facilities were reported to be underutilized due to various reasons like unavailability of reagents, non-functioning equipment/unit, etc.

- Few states had reported pending construction or delay in construction due to reasons like contractor issues and site change in Assam, administrative delays in Bihar, replacement of agency and non-availability of land in Uttarakhand.

KEY RECOMMENDATIONS

- The state should ensure effective utilization of funds in order to expedite the process for the benefit of all beneficiaries.
- Given the flexibility granted to the states to re-appropriate any unused funds or savings to different activities within the approved components of ECRP-II, states may expedite optimization and utilization of resources across various project activities in alignment with the GoI guidelines.
- The state to ensure that the PMS portal is kept up-to-date for further effective monitoring of the physical and financial progress of the state.
- To expedite the operationalization of ECRP II components, timely reporting should be enhanced and robust laboratory linkages be established to ensure seamless service delivery across districts.
- States to ensure availability of MGPS and bedside piped oxygen delivery system across facilities.
- States should invest in CMC for the active PSA plants installed through PM CARES and include their maintenance budget in the state BMMP program. The PSA plants procured through CSR/state funds should be maintained through State resources.
- AMC is recommended for the PSA plants not in use. Mock drills for functionality of the PSA/LMO plants should be carried out once in six months or earlier as per DGHS guidelines.
- States to ensure separate tender for engaging PPP service provider including trained oxygen plant operators for safe use of the PSA plants.

STATE-SPECIFIC FINDINGS

ARUNACHAL PRADESH

- The DH in Longding district was functional with a capacity of 50 beds, of which 27 beds were laid down. 10 beds for male and 10 beds for female were earmarked. The hospital has a permanent G+2 building. The hospital doesn't have an MGPS; oxygen was provided through cylinders.

ASSAM

- Under the Emergency COVID Response Package-II (ECRP-II), the Ministry of Health and Family Welfare (MoHFW) Approved (RE) a total of 812.46 crore (Central Share-731.22, State Share – 81.25 Crore) rupees and all Central share had already released on March 2022 to the state of Assam. However, as of November 23, 2024, the total expenditure reported by the state stands at only Rs 379.79 crore which reflects a utilization rate of approximately 46.75 percent of the allocated funds.
- Under the ECRP-II program, in the district of Morigaon, the civil Hospital received approval for 1 support for Liquid Medical Oxygen Storage complete with MGPS. This support included site preparedness and installation. However, despite the availability of the center, it was currently not being utilized due to certain cost-effective functional reasons.
- The district hospital had a bed capacity of 200 with bed occupancy rate more than 80% consistently. The hospital had two operating tables in its OT – one designated for gynaecological procedures and the other for general surgeries. Furthermore, there was a dedicated Ophthalmic OT within the hospital.
- The installation of the LMO tank with fencing and safety signages. located in an isolated place in the hospital premises, with a capacity of 13 Kilo Liter was completed in 2022. The LMO tank

was connected to 25 bedded COVID centre (former DEIC) with oxygen outlets through Oxygen Manifold System & MGPS. It was observed that around 10-15 oxygen ports were placed in lobby area which cannot be used under normal conditions.

- Within the hospital premises, the construction of a new 48-bed Maternal and Child Health (MCH) unit and a 19-bed Intensive Care Unit (ICU) has been completed. The necessary equipment was in place, however these units were scheduled to be operationalised in October 2023. One 1000 LPM PSA plant has been installed between the newly constructed 46-bed MCH building and the 19-bedded ICU. Running of PSA plant may be difficult due to vibration & noise pollution at present location. The Diesel Generator set of the PSA plant was under breakdown.
- Projects like oxygen-supported beds, RT-PCR labs, and LMO tanks have achieved 100% overall progress. Completed works include a 20-bedded ward at Goreswar CHC and a 6-bedded ward group in Baksa District, both handed over. Several 6-bedded ward projects were ongoing, with completion rates ranging from 20% to 85%, and financial progress also lagging in some.
- Challenges include stalled work on one project due to contractor issues and site changes, requiring interventions from the state level.
- The state should prioritize its efforts on properly mapping out funds and ensuring effective utilization of the remaining approved amount in order to expedite the process for the benefit of all beneficiary.

BIHAR

- RT-PCR laboratory functions were limited to COVID-19 testing due to the unavailability of reagents for other diagnostics in both the districts.
- Medical Gas Pipeline System (MGPS) at district hospital were installed but underutilized, with oxygen cylinders used sporadically.
- 32 bedded pediatric unit was utilized effectively for pediatric care in the medical college at Gaya district.
- 100 bed field hospital repurposed for diagnostics and dengue/ malaria cases but has a 70% bed vacancy rate in Gaya district. A 50-bedded field hospital at CHC Rampur was fully equipped with air conditioners, MGPS, furniture and utilities but remains unused.
- 30 bedded ICU unit construction remains incomplete due to administrative delays in Gaya district. 30 bedded prefabricated CHC structure remains unutilized due to low patient inflow, showcasing a mismatch between infrastructure development and actual needs in Kaimur district.
- No progress on the construction of state approved sub- centers, delaying access to primary healthcare in underserved areas in Kaimur district.
- Teleconsultation hub requires significant strengthening to improve access to specialist consultations in Gaya district.
- There is critical need to improve financial management and utilization of health funds in both the districts.
- Expedite the utilization of funds under ECRP II and fully leverage it to strengthen infrastructure, including Sub- Centers, CHCs and district hospitals and avoid penalties due to low fund utilization.

CHHATTISGARH

- Paediatric HDU/ ICU unit was approved under ECRP II. At Gariyaband district hospital, construction of paediatric HDU/ ICU was approved, but has not been initiated. While Jashpur district had a functional unit. High stillbirth rates, especially in SHCs, and no DEIC at the district hospital were observed.

- The State has constituted the State Level Committee and also has uploaded physical and financial progress on NHM PMS portal.
- The Hospital Management Information System had been installed and was in place during the visit.

GUJARAT

- Good oxygen availability through pipeline was seen in Vadodara but not in Kachchh (even with a PSA plant).
- Oxygen availability through pipelines should be ensured in Kachchh.

HARYANA

- Emergency COVID Response Package established but non-functional due to lack of HR.
- Medical Gas Pipeline System (MGPS) was available at the facility.
- Hospital Management Information System implemented in district hospital.

JAMMU & KASHMIR

- Rs. 428.40 Cr was allocated to Jammu & Kashmir including State & UT share under ECRP-II. State has completed the majority of the work, only CCB work was ongoing.
- The 50 bedded CCB was under construction at District Hospital Reasi & MCH Baramulla from 09.07.2024 and was estimated to be ready by December 2025.
- The DH Reasi had one prefabricated structure of 8 bedded wards under ECRP II, but it was not functional.
- LMO tanks with MGPS were appropriated for oxygen generation plants. But the same was non-functional in CHC.
- UT had also utilized ECRP-II funds for operationalization of HMIS E -Sahaj in health facilities.
- The DH is although self-sufficient in oxygen supply but the defunct 500 litres oxygen plant should be repaired and used intermittently for saving the infrastructure.

JHARKHAND

- Under ECRP, funds to the tune of Rs. 457.56 cr (ECRP-I Rs. 74.22 cr. & ECRP-II Rs. 383.34 cr.) has been released to the State.
- Medical Gas Pipeline System (MGPS): The construction of the Medical Gas Pipeline System at Sahebganj Sadar Hospital and the Sub-Divisional Hospital (SDH) in Rajmahal was still in progress. This essential system was designed to provide uninterrupted medical gases to critical areas like the Emergency Room (ER), Operating Theatre (OT), and Labour Room (LR). However, with construction yet to be completed, the region continues to face challenges in offering critical care services.
- In East Singhbhum, an oxygen plant was present, but no dedicated personnel were found at the site. IEC on hazardous operation and guidelines for usage was lacking in most sites. Filled oxygen cylinder kept in open space was accessible to the general public and sign of Biohazard was not used. Empty oxygen cylinders were found near patients in the ward.
- Hospital Management Information System (HMIS): The implementation of the Hospital Management Information System, which was intended to streamline hospital operations and patient data management, has not been fully realized. Therefore, there was incomplete rollout of HMIS across the district's hospitals may hinder the efficiency of healthcare delivery and limit data-driven decision-making.

- Critical Care Block (CCB): A Critical Care Block (CCB) was under construction at Sahebganj District Hospital, but it was not yet operational.
- Dedicated Paediatric Care: There was a need to ramp up infrastructure for paediatric care in the region. Establishing a centre of excellence in paediatric healthcare would ensure that children receive specialized and high-quality care, ultimately improving health outcomes for younger residents.
- Strengthen Medical Gas Pipeline System: To provide optimal care, the Medical Gas Pipeline System should be strengthened in high-risk areas such as the ER, OT, LR, and CCU. This infrastructure is crucial for ensuring that critically ill patients receive the necessary medical gases for their treatment.

KARNATAKA

- The state has received the complete grant allocated for 2022-23 under 15th FC, but there has been a slow utilization of funds. Out of total funds (Rs. 84,006 lakhs) allocated under ECRP II 87% of the funds has been utilized.
- The state has utilized the ECRP II funds to establish Paediatric Care Units and Paediatric Centre for Excellence in Medical Colleges, 800 new ICU beds added in 14 medical colleges, Hospital Management Information System for 4 DH, 12 Taluka Hospitals, 207 CHCs, and 2 MCH.
- Strengthening of telemedicine infrastructure in 1 hub, 801 PHCs and 2123 HWCs in 11 districts was also supported under ECRP II.
- Additional 13 KL Liquid Medical Oxygen plants for 08 medical colleges have been proposed however, installations have only been done in 06 medical colleges.
- The state may expedite the expenditure under the ECRP-II funds as the deadline for the implementation phase was 31st December 2024.

MIZORAM

- There has been only 68% utilisation of the ECRP II funds as per the records.

ODISHA

- Under ECRP II, Pressure Swing Adsorption (PSA) oxygen plant had been installed in the district of Sambalpur on September 29, 2021, by Trident Pneumatics Pvt. Ltd., the plant has a capacity of 960 LPM and supplies oxygen to 74 beds.
- Regular supervision and preventive maintenance were being conducted by engineers and technicians. Additionally, the PSA plant operates 24/7 with the help of three oxygen plant operators.
- To ensure preparedness in case of emergencies, regular mock drills must be conducted by an expert team.

RAJASTHAN

- Under ECRP funds to the tune of Rs. 1291.27 Cr had been released to the state. Release of funds under ECRP phase II was as per the approved Centre-State funding under NHM.
- Out of total funds only 68% had been utilized.

UTTAR PRADESH

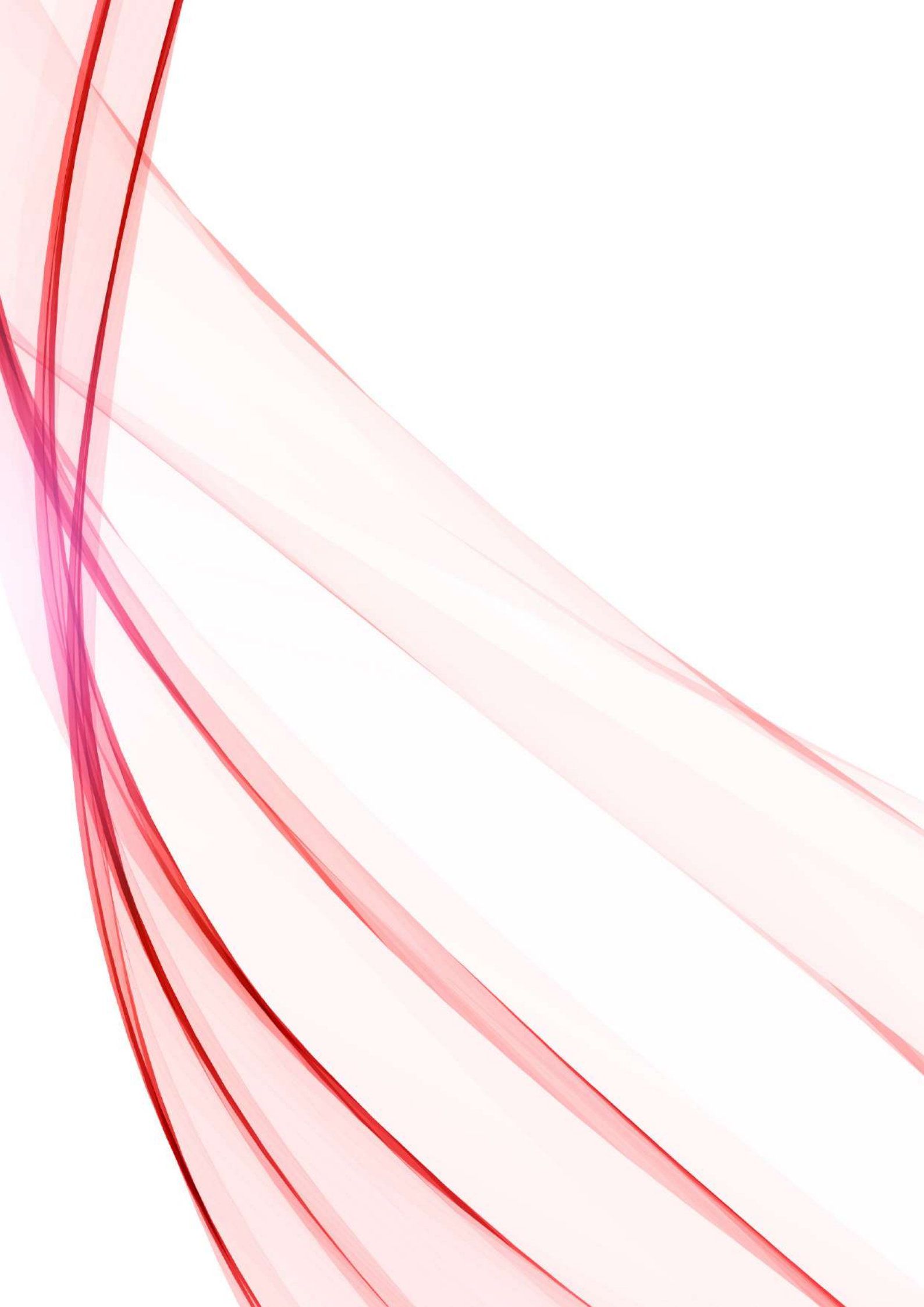
- Use ECRP funds to expand bed capacity and address high occupancy rates in SNCUs.
- The unspent balance under ECRP-II requires settlement, with civil construction work pending at 57 units under the Emergency COVID Response Package (ECRP-II) until FY 2024-25.

UTTARAKHAND

- Management of critical paediatrics cases suffers in both districts; while 32 bedded paediatric HDU/ICU was being established at Bageshwar from ECRP funds. The functionality of the paediatric HDU/ICU unit was compromised at Dehradun district due to non-availability of sufficient staff, though the equipment were available and installed including ventilators.
- Infrastructure development, especially out of funds from 15FC/ECRP and PMABHIM – timely completion of projects was affected by non-availability of land and replacement of agencies.

WEST BENGAL

- In Malda district 24 Bedded High Dependency Unit was sanctioned to SDH-Chanchal. The State needs to finish the renovation work and operationalize these HDU wings. It was noticed that the 12 bedded Paediatric Intensive Care unit was functional with 16 beds. Liquid Medical Oxygen Plant was Functional with 10000 litre capacity. And ICU beds at Trauma Care Centre were non-functional at the time of visit.
- Expedite the operationalization of the ECRP-II component, enhance timely reporting, and establish robust lab linkages to ensure seamless service delivery across districts





HEALTHCARE FINANCE

16th

NATIONAL OVERVIEW

Healthcare financing plays a key role in achieving better health outcomes. Since the inception of the National Health Mission (NHM), and its earlier form, the National Rural Health Mission (NRHM), the Ministry of Health and Family Welfare (MoHFW) has released ₹ 3.55 lakh crore till 2023-24¹. In 2022-23 under NHM, Centre released ₹30,908 crore and in 2023-24 it released ₹32,997 crore². Efficient use of these funds is crucial for delivering quality health services. To ensure timely and accurate fund flow at all levels—districts, blocks, and healthcare facilities—states are encouraged to strengthen their financial management systems through the Single Nodal Account (SNA). This helps improve monitoring and transparency in fund utilization.

The NHM funds states through annual budgets based on their Program Implementation Plans (PIPs), allowing them to design health interventions tailored to their population's needs. Both Central and State governments share funding in a 60:40 ratio for most states, 90:10 for hilly and Northeastern states, and 100% for UTs without legislatures.

Post-COVID, efforts to build a resilient health system have prioritized strengthening local bodies. Under PM-ABHIM, ₹64,180 crore has been allocated, while the Fifteenth Finance Commission has recommended ₹70,051 crore for the health sector^{3,4}. These additional resources focus on boosting healthcare by expanding through building new Sub Health Centres (SHC), Block Public Health Units (BPHU), Urban Ayushman Arogya Mandir (AAM), Integrated Public Health Labs (IPHL), Critical Care Blocks (CCB), etc., complementing NHM's efforts.

According to the National Health Accounts (NHA) Estimates for 2021-22, state government health spending (GHE) in the visited CRM states ranged from 8.0% to 12.6% of general government expenditure (GGE). States like Madhya Pradesh, Karnataka and Jammu Kashmir allocate just over 8% of their budgets to healthcare, while Jharkhand spends the highest among the CRM visited states to the tune of 12.6 % which is double of the national average. Although government health spending is increasing nationwide, states must further scale up investments to meet the National Health Policy 2017 targets.

Table 1: Government Health Expenditure across the States as per NHA 2021-22

State	Government Health Expenditure (GHE)	District-1	District 2
	% of GSDP	% of GGE	Per Capita Rs.
Arunachal Pradesh	4.5	7.0	7,825
Assam	2.3	9.4	2,753
Bihar	2.5	9.0	1,320
Chhattisgarh	2.2	10.3	2,940
Gujarat	1.0	10.3	2,769
Haryana	1.1	8.9	3,237
Himachal Pradesh	2.2	9.3	5,581
Jammu and Kashmir	3.0	8.6	4,336
Jharkhand	2.5	12.6	2,322

¹ <https://sansad.in/getFile/loksabhaquestions/annex/1714/AU1086.pdf?source=pqals>

² https://sansad.in/getFile/annex/265/AU900_U3QuW6.pdf?source=pqars

³ <https://pib.gov.in/PressReleasePage.aspx?PRID=1776530>

⁴ <https://pib.gov.in/PressReleasePage.aspx?PRID=2001817>

Karnataka	1.1	8.5	3,259
Madhya Pradesh	1.6	8.0	2,083
Maharashtra	1.2	9.1	2,872
Mizoram	3.4	10.0	9,570
Odisha	2.1	10.7	3,067
Rajasthan	1.8	9.4	2,755
Tripura	2.2	7.9	3,473
Uttar Pradesh	1.8	8.5	1,497
Uttarakhand	1.6	9.3	3,946
West Bengal	1.8	10.6	2,454
India	1.84	6.12	3,169

Source: National Health System Resource Centre (2024). National Health Accounts Estimates for India (2021-22), New Delhi, Ministry of Health and Family Welfare, Government of India.

Out-of-pocket expenditure (OOPE) in India has been steadily declining, due to prominent NHM initiatives like free essential drugs, free diagnostics initiatives, ambulance services, blood services, and patient transport, etc. These efforts aim to directly reduce the OOPE and make public healthcare more accessible and affordable.

As per the National Health Accounts (NHA) Estimates 2021-22, most CRM-visited states have OOPE below the national average of 39.4% of the Total Health Expenditure (THE). However, Uttar Pradesh and West Bengal have higher OOPE at 63.7% and 58.3%, respectively.

Table 2: Out of Pocket Expenditure across selected states as per NHA 2021-22

State	Out of Pocket Expenditure (OOPE)	District-1	District 2
	Per Capita (Rs.)	% of GSDP	% of THE
Assam	1,180	1	27.6
Bihar	984	1.9	41.3
Chhattisgarh	1,419	1	29.2
Gujarat	1,942	0.7	35
Haryana	2,647	0.9	37.5
Himachal Pradesh	3,844	1.5	39.6
Jammu and Kashmir	1,581	1.1	25.9
Jharkhand	2,243	2.4	47.5
Karnataka	1,933	0.7	25.4
Madhya Pradesh	1,739	1.3	43.3

Maharashtra	3,184	1.3	38.1
Odisha	2,133	1.5	37.1
Rajasthan	2,048	1.3	37.1
Uttar Pradesh	3,014	3.5	63.7
Uttarakhand	1,560	0.6	26.9
West Bengal	4,010	2.9	58.3
India	2,600	1.51	39.4

Source: National Health System Resource Centre (2024). National Health Accounts Estimates for India (2021-22), New Delhi, Ministry of Health and Family Welfare, Government of India.

KEY OBSERVATIONS

SINGLE NODAL ACCOUNT IMPLEMENTATION

- The SNA is operational in all CRM-visited states and integrated with the Public Financial Management System (PFMS) and State Treasury. Expenditures are being tracked through PFMS. Unlike previous years, this year, the SNA has been implemented up to the block level in most states, which is a significant step toward decentralizing fund management and ensuring better financial flow to lower levels. This expansion allows districts and blocks to access funds more efficiently, reducing delays and improving the implementation of healthcare programs.

DIRECT BENEFIT TRANSFER (DBT) PAYMENTS

- In the majority of states there have been significant delays in payments under JSY, JSSK, NTEP, and ASHA even after the use of Direct Benefit Transfers (DBT). The primary reasons for these delays include late submission of beneficiary documents, missing or incorrect details, invalid bank account information, and procedural issues such as the unavailability of joint signatories required for approval. Additionally, validation failures in the PFMS system further contribute to these bottlenecks, delaying financial support.

HUMAN RESOURCES - FINANCE PERSONNEL

- Many states, especially Maharashtra, Gujarat, Uttar Pradesh, Jharkhand, Karnataka, and Jammu and Kashmir, face shortages of finance staff at district and block levels. This hinders the financial flow and mechanism in the system leading to delays in payments.

FUND TRANSFER DELAY

- The SNA has significantly reduced delays in fund transfers. In states like Uttar Pradesh, Gujarat and Odisha, funds were transferred within 40 days, while in some states such as Chhattisgarh and Himachal Pradesh, delays ranged from 50 to 80 days.

AUDITING AND INTERNAL CONTROL MECHANISM

- Compliance with accounting mechanisms has improved, with most states completing statutory audits for 2023-24. However, states like Jharkhand, Mizoram, Karnataka, Bihar, Himachal Pradesh and Uttar Pradesh have yet to submit their audit reports. Additionally, concurrent audits, which play a crucial role in identifying and addressing financial discrepancies at district and block levels, require further strengthening. Many of these audits highlight key observations and areas for

improvement, but compliance with these recommendations remains weak.

COST OF CARE

- Despite various government initiatives aimed at making healthcare services free and accessible, OOPE remains a significant burden for patients in many states. The major expenditure incurred by patients are on medicines, diagnostic tests, and transportation to healthcare facilities. States that have effectively implemented free healthcare schemes, such as JSY, JSSK, and free drugs and diagnostics, have reported lower OOPE, demonstrating the positive impact of these programs. However, in states like West Bengal, Gujarat, and Arunachal Pradesh, patients continue to bear high healthcare costs, indicating gaps in the availability and accessibility of free health services.

NHM FUND UTILIZATION

- Some states reported low fund utilization for FY 2023-24 such as Arunachal Pradesh and West Bengal. One of the major causes for delays in fund release is lack of awareness about routine activities. Some of the states with higher fund utilization rates are Odisha (107%), Mizoram (98%) and Uttarakhand (85.68%).

KEY RECOMMENDATIONS

EXPEDITE SNA IMPLEMENTATION AT LOWER LEVELS

The SNA should be fully implemented at all levels (facility level- SC and PHC) to ensure funds are efficiently allocated and healthcare programs run smoothly without financial bottlenecks.

ADDRESS DELAYS IN DBT PAYMENTS

Challenges in DBT, such as incorrect documents, failed transactions and delays, should be identified and resolved through follow-up mechanisms, ensuring that beneficiaries receive timely payments.

ADDRESS HUMAN RESOURCE SHORTAGES

There is an urgent need to fill vacancies for finance and accounts staff at all levels and provide regular training to enhance their capacity for managing expenditures, reporting, and maintaining financial accountability.

ENSURE TIMELY FUND RELEASE

Delays in transferring funds from the State Treasury to the SNA must be addressed to ensure financial resources reach the district, block and facility level on time, enabling better fund utilization and uninterrupted program implementation.

ENHANCE FINANCIAL COORDINATION

Effective coordination between state, district, and block finance teams is essential, and clear communication channels should be established to prevent delays and inefficiencies in fund management.

IMPROVE AUDITING AND INTERNAL CONTROL MECHANISM

Timely statutory and concurrent audits should be conducted at all levels, with prompt submission of reports to the Government of India, ensuring adherence to financial guidelines and corrective actions when necessary.

STRENGTHEN FINANCIAL RECORD KEEPING

Proper accounting mechanisms should be enforced by ensuring all financial transactions are well-documented, bank statements are reconciled periodically, and utilization certificates are maintained to improve transparency and accountability, especially at the sub-district level facilities.

REDUCE OUT OF POCKET EXPENDITURE (OOPE)

Strengthening the availability of free drugs, diagnostics, and ambulance services at public health facilities and ensuring the effective implementation of schemes like JSSK, Free Drugs & Diagnostics, and free ambulance services will help reduce financial burdens on patients. Further, proper monitoring of private providers in PPP mode should be done at regular intervals to restrict the patients from spending out of their pockets.

MONITOR FINANCIAL PERFORMANCE REGULARLY

Regular monitoring at district and block levels should be strengthened to track fund utilization, identify reasons for underperformance, and provide necessary support for optimal utilisation of funds.

STATE FINDINGS AND OBSERVATIONS

ARUNACHAL PRADESH

- The SNA has been implemented across all levels of health facilities. The district officials reported that they received only a fraction of the approved funds, restricting their ability to function and forcing them to prioritize only the most urgent expenditures.
- Health facilities faced delays in receiving RKS/JAS funds, which affected their ability to operate smoothly. On a positive note, untied funds for VHSNC were disbursed on time.
- Issues with DBT continue to persist, with 40% of JSY beneficiaries not receiving their payments due to errors in bank account details recorded during ANC checkups. Addressing these errors is essential to ensure timely support for beneficiaries.
- ASHA workers, reported delays of over three months in receiving their payments.
- The financial audit for FY 2023-24 has been completed, but the concurrent audit for FY 2024-25 is still pending.
- Patients at several health facilities were still being charged for essential healthcare services, leading to significant out-of-pocket expenses.

ASSAM

- The State has successfully implemented the SNA across all districts following DoE guidelines, using a Zero Balance Account for NHM activities. However, a separate physical account is maintained for untied grants under the Hospital Management Society (HMS) to ensure flexibility in fund utilization.
- Due to the absence of nearby bank branches at the facility level, payment advice is submitted to the bank weekly, which may contribute to minor delays but ensures systematic fund transfers.
- VHSNCs currently operate with only physical bank accounts, receiving direct fund transfers from the block level. However, implementing the SNA SPARSH system at the VHSNC level remains a challenge for the State, requiring further efforts to ensure seamless financial integration at the grassroots level.

BIHAR

- There are significant backlogs in beneficiary payments. Despite sufficient funds being available, payments are delayed by 7–12 days due to issues such as incomplete or missing bank details.

Under Nikshay Poshan Yojana there is slow validation of bank details which has led to delay in the disbursement of benefits.

- The financial audit report for FY 2023–24 remains pending beyond its July 31, 2024, deadline.
- Funds remain parked in VHSNC accounts instead of being transferred to the SNA, violating Department of Expenditure (DoE) guidelines.
- While ASHA incentives have been processed, they are still being disbursed under an obsolete scheme code (9156) in the ASWIN portal, causing discrepancies between PFMS records and actual expenditures.
- The District Hospital in Kaimur lacks proper records of RKS meetings, which impacts transparency in fund utilization.
- Across NHM facilities, cash books inaccurately reflect financial positions, with expenditures sometimes recorded as income, leading to misleading balance sheets.
- Due to non-compliance with audit deadlines and expenditure guidelines, Bihar was penalized with a 1% disincentive, leading to a ₹15 crore reduction in NHM incentive allocations for FY 2023–24.

CHHATTISGARH

- SNA is implemented till the PHC level, ensuring better fund oversight. However, delays in transferring funds from the State Treasury to SNA due to procedural bottlenecks affect the financial fund flow.
- DBT under JSY and NTEP is functional but faces delays due to mismatched bank details, dormant accounts, and errors in the Nikshay portal requiring central-level resolution. While ASHA payments and DBT verification processes are in place, some payments still face administrative delays.
- Fund utilization remains slow due to procurement delays and procedural hurdles. The statutory audit for FY 2022-23 is completed with a delay due to the 2023 elections, and for FY 2023-24, the audit is in the final stage.
- A software system tracks OOPE, but many patients still spend OOP at public facilities. To reduce OOPE, the State is expanding Hamar Labs (IPHL/BPHU) at district and block levels.
- Training for financial personnel on 15th FC, PM-ABHIM, PMS Portal, and SNA SPARSH should be conducted to enhance financial management and compliance.

GUJARAT

- The state implemented SNA, complying with DoE guidelines, and refunded ₹8.2 crores in unspent funds by April 2022. Financial management relies on Canara Bank's CAN-GBMS, with manual and Excel-based record-keeping, while PFMS remains underutilized, and SNA Sparsh onboarding is in progress.
- DBT payments for JSY and JSSK are usually processed within 15 days, but delays occur due to missing joint signatories and PFMS validation failures. ASHA payments face delays of 15 days to 3 months, primarily due to late receipt of the state's top-up amount.
- Statutory Audit Reports have not been presented to the SHS Governing Body for the past four years, and delays in appointing auditors through the GeM portal have further hindered submission to the GoI. The appointment of a Concurrent Auditor is still pending due to the revisions of the scope under NHM guidelines.
- The lack of dedicated finance staff at PHCs, CHCs, and SDHs has led to inefficiencies, with 'Accountants cum Computer Operators' managing data across 52 portals. Vacancies in finance positions have weakened internal controls, as PFMS Maker and Checker roles are often handled by the same individual.
- OOPE were primarily reported for high-risk pregnancies and C-sections due to gaps in public

obstetric services and diagnostics. Delays or rejections of financial benefits (JSY, JSSK, PMMVY) were also noted due to Aadhaar mismatches post-marriage.

HARYANA

- No delay found in receipt of funds and release of funds. Statutory and concurrent audit report submitted.
- Significant underutilization of funds was noted in NCD, NVBDCP, Nutrition, HRH, CPHC, IT interventions, and referral transport.
- While 73–90% of beneficiaries received DBT payments, up to 27% did not receive timely disbursements.
- Most patients reported no OOPE, except for transportation costs due to a lack of awareness regarding free ambulance services

HIMACHAL PRADESH

- The SNA is fully implemented at the District Health Society (DHS) level. Both Central and State shares are claimed together and transferred simultaneously by the treasury, facilitating timely approvals and fund utilization. Additionally, the State provides top-up funds for certain activities, enhancing program implementation beyond the mandated share.
- There has been a delay in the submission of the statutory audit report for FY 2023-24, affecting financial transparency and compliance. Additionally, late appointments of Concurrent and Statutory Auditors in FY 2023-24 and 2024-25 may have impacted regular financial monitoring. TDS returns were not available at the facility level, highlighting the need for improved record-keeping and timely tax compliance.
- Beneficiaries under JSY and JSSK faced delays in receiving their entitled payments and benefits. The primary reason cited was the late submission of required documents, leading to processing delays.

JAMMU AND KASHMIR

- Delays were observed in the DBT payments of different beneficiaries as well as delay in the payment of ASHA incentives.
- Untied funds have not been released for the last two years.
- There are frequent updation in Statutory Enactments. It is observed that there is a lack of knowledge about enabling provisions, threshold limits, applicable rates, timelines, etc.
- Due to the reduction in Resource Envelop (RE) from Record of Proceeding (RoP), proportional expenditure on the programme was not incurred as envisaged.
- Lack of knowledge among accounts personnel about their work and functioning. Thus, needing training and capacity building.

JHARKHAND

- The State has not submitted the audit report for FY 2023-24, and expenditure under Infrastructure Maintenance (IM) remains unreported for FY 2023-24 and up to Q2 of FY 2024-25. Additionally, there is a miscalculation in arrears and unspent balances, requiring urgent reconciliation.
- It was observed that there is a diversion of NHM funds such as JSY payments transferred to RKS accounts which is against guidelines. Thus, this should be rectified immediately. Facility-level bank accounts must be closed as per SNA norms, and RKS should have separate audits.
- Human resource positions related to accounts and finance are vacant and should be filled

immediately.

- Regular facility visits by finance personnel should be mandated for better hand-holding and financial monitoring at the ground level. State-level training programs should be conducted to strengthen financial management at all levels.
- The State has utilized only 8.29% of the allocated funds under the Mother Sanction, slowing further fund releases. Monthly expenditure reporting should be mandated in all health facilities, and advance settlements must be expedited using e-Vittaprabha to ensure smoother financial operations.

KARNATAKA

- While financial records were systematically maintained at visited facilities, several key positions at the state level remained vacant for over two years, and CHCs lacked essential accountants as per IPHS norms.
- No Concurrent Auditor was appointed for FY 2023-24. The statutory audit report for FY 2023-24 had not been submitted despite the deadline passing.
- Despite the ASHANIDHI App ensuring transparency in ASHA payments, delays were noted in DBT payments under JSY, with 20% of payments pending in Lady Goschen Hospital, Dakshin Kannada.

MADHYA PRADESH

- The bottom-up approach for PIP preparation was not followed, with BMO/MOICs unaware of financial processes and budgets. Financial records, including cash books and ledgers, were not maintained at CHCs, PHCs, and UPHCs, leading to low expenditure reporting and fund release delays. TDS deductions were not done at DH and UPHCs, indicating poor awareness of statutory liabilities.
- Funds to VHSNCs, UPHCs, and Sanjeevani hospitals were delayed due to low reporting of expenditure.
- DBT payments through the NIKSHAY portal were not reflected in district expenditures due to system integration issues.
- JSY and ASHA incentive payments faced significant delays, with some facilities diverting NHM funds to RKS accounts for cheque payments, violating NHM guidelines. The RKS audit had not been conducted separately at CHC levels since 2017.
- Concurrent auditors for FY 2024-25 had not been appointed, and DAM/BAM officials were not conducting regular field visits for financial checks.
- Beneficiaries in PNC wards reported receiving JSSK benefits, but JSY payments were delayed. Poor response from 108 services forced some to incur OOE. Despite the e-Rupi initiative for USG, many beneficiaries still paid ₹1,500–3,000 for services and transportation.

MAHARASHTRA

- Beneficiary payments under JSY & JSSK are up to date, and NHM staff salaries are released at the district level. ASHA payments are processed efficiently at the block level. However, there is a delay in document submission and incomplete verification hinders financial processes.
- Financial records, including Cash Book and Bank Reconciliation Statements (BRS), are updated, with PFMS implemented at the facility level and Tally Software at the block level.
- Statutory and Concurrent audits for the relevant financial years have been completed.
- Central allocation is insufficient to meet the state's expenditure requirements under NHM.
- Vacancies of human resources in key financial positions affect efficiency at CHC and PHC levels.

MIZORAM

- There are significant delays in CSS fund disbursement at the state treasury level, exceeding 40 days instead of the mandated 21 days, and funds from the state treasury take up to 90 days to release.
- Statutory and concurrent audits are pending due to the unavailability of designated officials, resulting in delays in Utilization Certificate (UC) submission. Since up to 50% of CSS funds can be claimed without UCs, it is crucial to appoint auditors immediately and expedite audit completion.
- While SNA and PFMS integration is functional at the district level, PHCs and CHCs face issues due to poor network connectivity, disrupting financial transactions.
- HR salary payments and ASHA incentives are delayed beyond 15 days, affecting workforce motivation to deliver services. Additionally, DBT disbursement faces challenges due to mismatched beneficiary names in government IDs, particularly in southern Mizoram among Chakma and Bru communities.
- Several financial discrepancies, such as non-deduction of TDS at DH and UPHC levels and misuse of NHM funds for JSY payments through RKS accounts, violate NHM guidelines.

ODISHA

- Odisha has effectively implemented the SNA at the State, district, and block -up to UPHC levels, ensuring compliance with NHM guidelines. The SNA is integrated with PFMS and the State Treasury, with zero-balance subsidiary accounts mapped at sub-district levels for seamless fund management.
- The average transfer time from the State Treasury to the SNA is 22 days, ranging from 9 to 62 days in 2024-25. Some delays occurred due to the election year and government transition. However, NHM funds, along with the State share, are efficiently transferred together in one go.
- No pending releases of central or State shares from the State treasury to the SNA have been reported. Concurrent audits are conducted regularly, and separate audits for RKS were completed for 2023-24. The concurrent audit report has been submitted to the Government of India on time. The Statutory Auditor was appointed through an open tender, but the process was delayed due to the 2024 General Elections.
- Delays in beneficiary payments in DBT mode persist due to issues such as non-submission or loss of documents, incorrect or invalid bank details, and difficulties in processing payments for inter-state migrants and labourers. Additionally, delays in Aadhaar seeding updates from NPCI further hinder timely disbursements.
- There are some finance and account positions vacant in the state.
- The Audited Statement of Expenditure (ASE) and Utilization Certificate (UC) for 2021-22 and 2022-23 under IM are yet to be submitted to the Government of India. Additionally, the Certified Statement of Expenditure and Provisional UC for 2023-24 under IM is still pending.
- Aadhaar-based DBT is not yet 100% under JSY and Family Planning. This is primarily because ANMs and ASHAs do not consistently ensure Aadhaar-linked bank accounts for pregnant women during VHNDs. Strengthening awareness and training at the community level is essential to improve Aadhaar seeding rates.

RAJASTHAN

- Timely disbursement of ASHA incentive and beneficiary payments under schemes like JSY and JSSK was done in the state.
- Cash book and Bank Reconciliation Statement (BRS) were updated and the use of PFMS up to the facilities level was done. Additionally, there was the use of Tally Software up to the Block level. However, integration of financial software needs to be done up to the lower level.

- There are a few vacant posts of finance personnel which need to be filled and timely training on accounts and financing needs to be done, and the focus is needed on providing regular support to district and block level.
- OOPE is observed for transportation services thus it can be checked by improving referral services through 108/104 ambulances.

TRIPURA

- ASHA workers highlighted that their honorarium has not kept pace with inflation and increasing workload, making it difficult to sustain their livelihoods.
- MPWs and ANMs expressed concerns over unequal incentive structures, stating that they perform extensive fieldwork but receive fewer benefits than CHOs.

UTTAR PRADESH

- The state has implemented the SNA up to the block level.
- The audit reports for FY 2022-23 and 2023-24 have not been received from the statutory auditor. The concurrent audit system has not been implemented for FY 2023-23 and FY 2024-25.
- No major delays were observed in fund transfers from the State Treasury to SNA.
- Several key finance staff positions remain vacant for over a year.
- Pending payments of JSY have been noticed.
- Statutory & Concurrent auditor appointments are in progress.
- Income Tax and GST, and TDS returns are being filed on time.
- Inactive bank accounts have been closed, and all accounts operate under joint signatories for accountability.
- Expenditures under NHM and PM-ABHIM are systematically recorded in PFMS up to the block level.

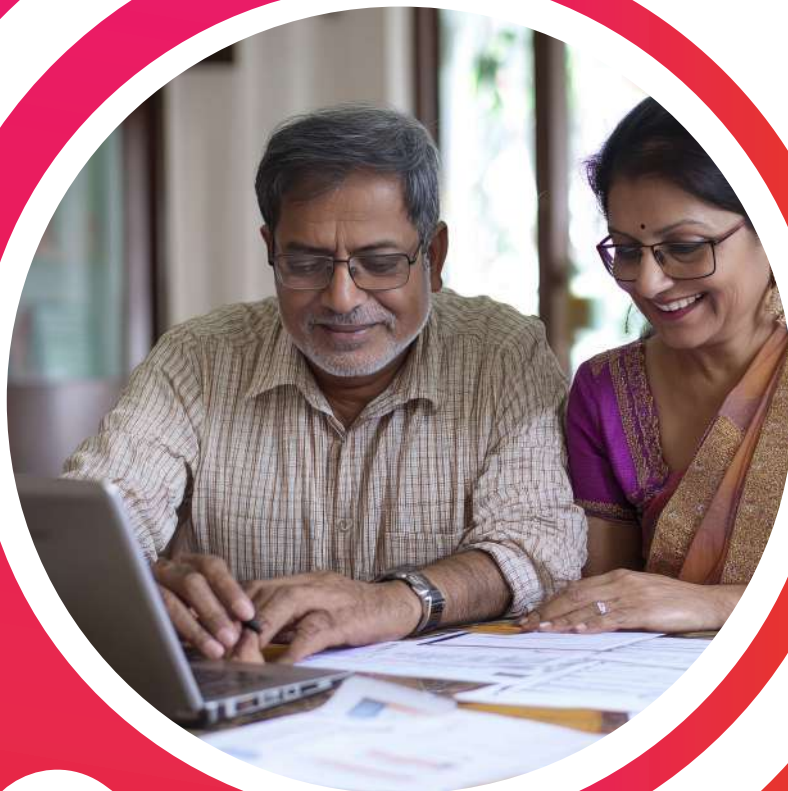
UTTARAKHAND

- The state has implemented SNA since 2021.
- Almost 85.84% of the funds utilised in FY 2023-24 and 85.68% expenditure has been done against the fund released in FY 2024-25.
- OOPE reported during community interactions – especially on medicines and user charges. The outsourcing of diagnostic services has created a market where patients choose outsourced services which are free over in-house services and the in-house services remains underutilized.

WEST BENGAL

- The SNA was implemented in the State and integrated with the PFMS.
- There was a delay of an average of 33 days and 56 days to receive the Central share and State share respectively from the State treasury to the State Health Society (SHS) for FY 2022-23. For the FY 2023 -24, there was 15 15-day delay on average to receive the Central share and State share from the State treasury to the SHS.
- It was noticed that due to the financial crunch in the State regular DBT payments were not possible in FY 2023-24 and FY2024-25.
- The Statutory Audit was currently in process and the GB meeting was not conducted in the last 2 years. The submission of the Statutory audit report to GOI for FY2023-24 was also pending. No actions were taken on the observation reported by the Concurrent Auditors in the district for the last two quarterly reports.

- Manual accounting was followed below the block level in the facilities visited.
- In the SDH there was evidence of OOPE on medicines and consumables.
- Ensure financial transparency and accountability by booking pending payments, submitting statutory audit reports, conducting prescription audits, introducing digital accounting solutions, and building the capacity of finance staff through comprehensive training.



**PRADHAN MANTRI-
AYUSHMAN BHARAT HEALTH
INFRASTRUCTURE MISSION
(PM-ABHIM) AND FIFTEEN FINANCE
HEALTH SECTOR GRANTS (FC-XV)**

BACKGROUND

Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) is a Centrally Sponsored Scheme (CSS) with certain Central Sector Components with a total outlay of Rs. 64,180 Crores for the scheme period (2021-22 to 2025-26). The scheme envisages to strengthen the Public Health Infrastructure and build more resilient systems to integrate and strengthen health service delivery and public health action. The measures under the scheme are aimed at strengthening health systems and institutions in order to provide a continuum of care at all levels, namely primary, secondary, and tertiary, as well as preparing health systems to respond effectively to current and future pandemics and disasters.

Under the scheme, technical and financial support is being provided to States/UTs for Construction of Building less Sub-Centres and Establishment of Urban Ayushman Arogya Mandirs (UAAM), Block Public Health Units at the block level, Integrated Public Health Labs. in each district in the country and Critical Care Hospital Blocks in all districts with population more than 5 lakhs. The objective of the scheme is to fill critical gaps in health infrastructure, spanning both the urban and rural areas.

The Finance Commission is a constitutional body formed by the President of India to give suggestions on centre-state financial relations. The 15th Finance Commission (XV-FC), chaired by Mr. N.K. Singh, submitted its final report with recommendations for the period 2021-26, which was tabled in Parliament on February 1, 2021. The XV-FC, for the first time recommended health grants through local governments to the tune of Rs 70,051 crores over the five-year period from FY 2021-22 to FY 2025-26 to facilitate strengthening of health system at the grass-root level. The health grants are being provided for: (i) conversion of rural sub-centres and primary healthcare centres (PHCs) to Ayushman Arogya Mandir (AAM) (ii) support for diagnostic infrastructure for primary healthcare activities, and (iii) support for urban AAM, sub-centres, PHCs, and public health units at the block level.

KEY OBSERVATIONS

- State and District level committees have been established to oversee the implementation of grants under PM-ABHIM and the XV Finance Commission.
- Site identification and gap assessment for the targeted facilities up to 2024-25 have been completed in most of the States. However, in most states, the tendering process and work allocation were still pending.
- Fund utilization remains low, preventing states from accessing further funds due to low expenditure and non-compliance with the Department of Expenditure's conditions.
- Some states have experienced delays in project execution due to inefficiencies in their medical services and infrastructure corporations.
- While states are updating physical and financial progress on the PMS portal, the frequency of updates may require reassessment.
- Considerations such as integration with existing buildings and the total area of health facilities have often been overlooked.
- The cost of civil construction varies across states, with particularly high costs in hilly regions, forcing states to compromise on desirable infrastructure components.
- Gradual progress in the operationalization of Urban Ayushman Arogya Mandir (UAAM) in line with set targets was observed, however, a comprehensive plan is needed to expand the range of Comprehensive Primary Health Care (CPHC) services at these centres.

KEY RECOMMENDATIONS

- All states should conduct orientation and sensitization programs for district health officials on the XV Finance Commission (XVFC) and PM-ABHIM.

- Joint orientation sessions should be organized for program staff, architects, engineers, and doctors to ensure effective implementation.
- States must hold regular review meetings to assess the progress of work related to PM-ABHIM and XVFC.
- Timely updates on physical and financial progress should be made on the PMS portal to ensure real-time status availability.
- States should initiate activities promptly and report fund utilization to secure timely grants from the Ministry.
- During site selection for IPHLs, CCBs, and BPHUs within existing health facilities, linkages with current structures and potential for vertical expansion should be prioritized over horizontal expansion.
- Sufficient space for open areas, greenery, and parking should be incorporated when identifying sites and designing layout plans for new construction or renovations of IPHLs, CCBs, and similar facilities.
- States must ensure that all critical components are included in layout plans, providing adequate functional space as per the prescribed guidelines.
- A roadmap should be developed to expand the scope of services at UAAM, covering all twelve Comprehensive Primary Health Care (CPHC) service packages.

STATE SPECIFIC FINDINGS

ASSAM

- The implementation of the PM-ABHIM (Pradhan Mantri Ayushman Bharat Health Infrastructure Mission) in Assam has faced several challenges, despite the state's efforts to strengthen its healthcare infrastructure.
- One of the significant challenges to the implementation of the PM-ABHIM (Pradhan Mantri Ayushman Bharat Health Infrastructure Mission) in Assam is the non-availability of land for setting up healthcare infrastructure, especially in remote and flood-prone areas. This issue has been a critical bottleneck in the timely execution of the scheme.
- The time taken between the foundation stone laying and the actual implementation of healthcare infrastructure under the PM-ABHIM in Assam has been a notable challenge.
- The tendering process is slow, especially due to disputes over contracts, lack of qualified contractors, or challenges in finalizing bids.
- Constructing healthcare facilities in ecologically sensitive or areas protected under environmental laws (such as wildlife sanctuaries or forest reserves) could lead to legal challenges or require lengthy environmental clearances.
- Weather-related challenges such as flooding, heavy rainfall, landslides, high humidity, and temperature extremes significantly affect the implementation of PM-ABHIM in Assam.
- The PM-ABHIM program faces substantial challenges in Assam related to the availability and management of engineer mobility funds. These challenges include insufficient allocation of funds, logistical difficulties due to the state's terrain, delays in fund disbursement, and the limited ability of engineers to travel to remote or flood-affected areas.
- Under the Fifteenth Finance Commission (15th FC) tenders had been floated for FY 2021-22 & 2022-23 only and floating of tenders for FY 2023-24 was under process. Finalization of sites for FY 2023-24, 2024-25 & 2025-26 were also under process.
- In facilities where construction has concluded and the handover process is finished, the primary emphasis should be placed on ensuring functionality and operational effectiveness as the utmost

priority.

- In facilities where the work has been finished but the handover is still in progress, it is essential to maintain diligent oversight to ensure timely handover of completed construction works.
- New construction buildings to adhere closely to the IPHS facility construction layout, which outlines key guidelines and practices to optimize the design, functionality, and overall efficiency of the structures being developed.
- The state should create a detailed timeline for funding allocation and streamline the construction of facilities and regularly monitor the progress to ensure timely completion.
- The state should thoroughly analyze the specific challenges present within the local area regarding construction before implementing tailored actions that align with the unique requirements and demands of the community.
- It is essential to regularly schedule physical or virtual meetings with infrastructure contractors to discuss project progress and set deadlines for work completion.
- Close monitoring is crucial to effectively oversee the quality of the infrastructure and ensure that the proposed infrastructure plan layout is accurately implemented and aligned with the approved standards.

BIHAR

- The assessment of PM-ABHIM, and XV FC implementation in Kaimur and Gaya highlights a gap between infrastructure availability and utilization.
- While progress has been made in diagnostic services, reagent shortages, underutilization of resources, and administrative delays impede the health system's effectiveness.
- Despite state approvals over 2–3 years ago, many projects remain stalled, including the 30-bed ICU in Gaya and Sub-Centre construction.
- No Block Public Health Units (BPHUs) or Integrated Public Health Laboratories (IPHLs) exist, delaying integration with the Integrated Health Information Platform (IHIP) and reducing disease surveillance capabilities.
- Diagnostic Labs at CHCs were equipped with semi-auto chemistry analysers, TruNaats, and X-ray machines but underutilized due to reagent shortages, impeding their ability to meet IPHS standards.
- IPHL funds can be utilized to address reagent shortages at CHC and DH labs to fully utilize existing diagnostic tools and expand testing capabilities.
- State to expedite establishment of BPHUs, installation of a fully automated analyser at DH labs. and integrate them with IHIP to ensure timely disease tracking and outbreak response.
- Rationalize the use of underutilized infrastructure, such as MGPS, field hospitals, and prefabricated CHC structures, based on healthcare needs.
- Prioritize operationalization of ICU units and paediatric units in underutilized facilities.
- Resolve delays in infrastructure development, such as the completion of the 30-bed ICU in Gaya and Sub-Centre construction in both districts.
- Utilize funds from PM-ABHIM and XV FC to strengthen and enhance diagnostic infrastructure and meet IPHS standards and improve disease surveillance capabilities
- Addressing the challenges through better resource utilization, completion of pending projects, and strengthening disease surveillance will be essential for improving healthcare delivery and resilience in the State

HARYANA

- Gap assessment for Building less SHC's, PHC's and CHC's has been completed but work has not been initiated.
- Site for construction of Critical care block had been identified but construction work was yet to be started
- 5 Block public health units are approved but construction is yet to be started.
- 4 U-AAM were approved under PM-ABHIM, of which 2 UAAM buildings are finalised but yet to be made operationalized as per the IPHS norms. Recruitment of staff and Medical Officer was in progress.
- Integrated Public Health Laboratory was available at District Hospital, but all the tests were not being done and the staff were not aware about the concept of IPHL
- No outbreak investigations were conducted, and surveillance activities were minimal.

JAMMU AND KASHMIR

- 20 IPHLs have been approved for UT of J&K and tender has been floated for all 20 sites.
- Work has been awarded for 11 IPHLs and initiated at 9 sites. Work for remaining 2 IPHLs was expected to be awarded by the end of November 2024
- For the remaining 9 IPHLs, tenders were floated, bids opened on 15th Oct, Technical and Financial Evaluation completed and work was to be awarded to L1 Bidder.
- IPHL at District Hospital Reasi was under construction and was expected to be completed by December 2025.
- 287 BPHUs have been approved for the UT, survey was completed for 230 sites.
- work has been awarded for 20 BPHUs and completed for 8 BPHUs.
- For 91 BPHUs tenders were floated, bids opened in October, Technical & Financial evaluation completed and work was to be awarded to L1 Bidder.
- 69 UAAMs approved up to 2024-25, out of which survey completed for 59 sites and 30 UAAMs have been made functional.

JHARKHAND

- Critical Care Block (CCB) was under construction at Sahebganj District Hospital and not yet operational and local residents requiring intensive medical care continue to face limited access to advanced treatments and services.
- The Integrated Public Health Laboratory (IPHL) and Block Public Health Units (BPHU), two key facilities for public health monitoring and disease diagnostics, were yet to be functional in District.
- A thorough gap assessment is needed to identify and address the lack of proper buildings at Sub-Health Centres (SHCs) and Primary Health Centres (PHCs).
- It is essential to fast-track the construction and functionality of critical healthcare facilities such as the Integrated Public Health Laboratory (IPHL), Critical Care Block (CCB), and Block Public Health Units (BPHU).
- Completing these projects will enhance the district's capacity to provide essential healthcare services, including diagnostics and critical care.

KARNATAKA

- Under PM-ABHIM, the state has operationalized 511 AAM-USHCs (Namma Clinics) out of 817. The progress on IPHL was slower with only 6 being operationalized out of 30, however, work has been

completed for 9 more IPHLs.

- State has received the full grant for 2021-22 under 15th FC but has been slow in using the funds, with only 27% of the allocated funds for FY 2022-23 and FY 2023-24 released by the Gol.
- The state has primarily utilized the funds to support the diagnostic infrastructure in primary healthcare facilities and the construction of BPHUs, AA-USHCs and AAM-SHCs, etc.
- None of CCBs proposed have been operationalized.
- The work on the CCB proposed in DH in Dakshin Kannada and Ballari had not been started during the time of the CRM visit.
- In addition to the AAM-USHCs (U-AAM), the state was also utilizing the PM-ABHIM funds for the operationalization of 300 Ayushmani Clinics which would focus on provision of healthcare services like gynecology and others to women from low-income groups. 138 of them had been operationalized till Oct 2024.
- State should submit the grant release proposal for the components under the 15th FC for the award period FY 2022-23 and 2023-24 at the earliest.

MADHYA PRADESH

- Under PM-ABHIM, in Balaghat district, construction was underway for a Critical Care Block (CCB) and an Integrated Public Health Laboratory (IPHL), with 50% of the work completed for both projects. Out of 6 approved Block Public Health Units (BPHU), 2 have been successfully completed.
- In Rewa district, 1 CCB and 1 IPHL have been approved, for 1 CCB the work was awarded and for 1 IPHL the work was in progress. Additionally, out of 5 approved BPHU, none had been completed.
- Under XVFC, in Balaghat district, 20 building-less Sub-Health Centres (SHCs) have been approved, with 1 completed; 4 building-less Primary Health Centres (PHCs) have been approved, but none were completed; and 3 Block Primary Health Units (BPHU) have been approved, with 1 completed.
- In Rewa district, 125 building-less SHCs have been approved, with 1 completed; 5 building-less PHCs have been approved, but none was completed; 4 building-less Community Health Centres (CHCs) have been approved, but none are completed; and 2 BPHU have been approved, with 1 completed.
- No nodal person appointed at the district level for 15 FC & PM ABHIM. Districts were unaware of XVFC and PM-ABHIM finances and components.
- State to expedite the utilization of funds for FY 2021-22 & 2022-23. So that funds for next FY 2023-24 shall be released accordingly.
- State should orient districts regarding FC-XV components and the fund flow.

MIZORAM

- The ongoing projects under P-ABHIM as per the funds up to financial year 2022-23 were at variable stages of completion.
- The civil works and lab equipment procurement for and Champhai was near completion.
- The lab in Siaha has been recently made functional. However, some additional equipment was being procured and IPHL reports were not being generated.
- The tenders for construction of Critical Care Blocks has been floated and work has been allotted.
- For PM ABHIM, the Grant transfer certificate has yet to be processed for the financial year.
- Progress of infrastructure works under XV-FC was on track.
- Construction of 7 BPHUs were completed so far and were fully functional.
- ROPs received for 5 BPHUs (NR) for financial year 2024-26. For BPHU (R), ROP has been received

for 37 BPHUs for financial year 2024-26.

- The diagnostic infrastructure for primary health care, which includes SHC and PHC for recurring and non-recurring components, was at various levels of implementation.
- Under the XV-FC, the work allotment, and its processing at various levels for internal clearance and further implementation of the projects was at a variable pace at all levels. Hence, allotment of new infrastructure projects in the coming years may be carried out after due deliberations, keeping in view the above constraints.

ODISHA

- Under PMABHIM, in FY 2023-24, Odisha made significant progress in utilizing its budget, spending 95% of the available Rs 445.04 Cr.
- For FY 2024-25, the State received Rs 150.82 Cr under the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), with 50% (Rs 75.06 Cr) already spent.
- The PM-ABHIM grant has facilitated various infrastructure developments, including the ongoing finishing work of the Critical Care Block (CCB) at Burla in Sambalpur district.
- Additionally, the construction of the Integrated Public Health Laboratory (IPHL) has been completed.
- Four Sub-Centres (SCs) were also under construction.
- In FY 2023-24 out of the approved budget under XVFC 100% amount of Rs 483.18 Cr was received and Rs 116.09 has been spent amounting to 61% of expenditure.
- In FY 2024-25 NIL amount of grant has been received against the approved budget of Rs 509.56 Cr.
- In Sambalpur district construction work of 3 SHCs is completed out of 9 SHCs and work was in progress in the rest of the SHCs.
- All 15 UAAM sanctioned under XVFC were operational.

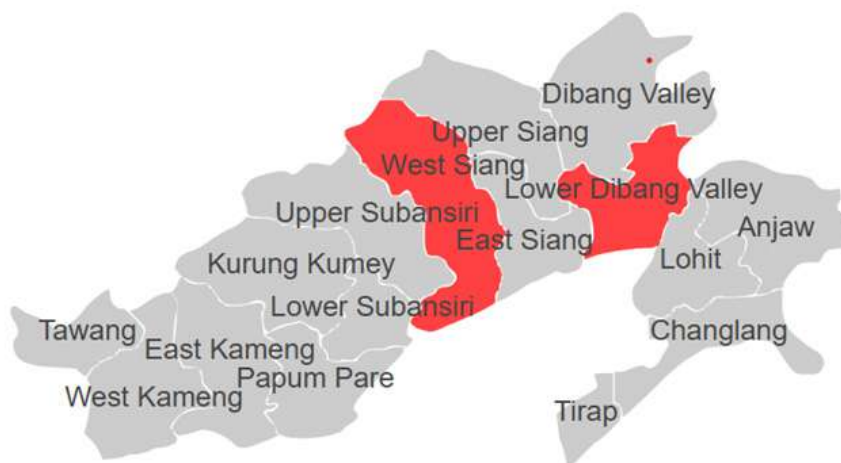
UTTARAKHAND

- Under 15FC grants, the State has received the following amounts in the FY 2021-22 (15009.65 Cr), and FY 2022-23 (3253.56 Cr).
- In the FY 2023-24, though the approved amount is 11458.71, no funds have been received by the State as 50% Expenditure couldn't be done in 2022-23.
- The departments undertaking work under areas of FC are Panchayati Raj (Building –less SHCs, PHCs and CHCs, Block Public Health Units, and Conversion of Rural PHCs and SHCs into AAM); DG Health (Diagnostic Infrastructure – Rural/Urban) and Urban Directorate (Urban Health and Wellness Centre).
- Out of these, expenditure on UHWCs is nil, but tender is in progress.
- Under PMABHIM, 10 DPHL is sanctioned out of which work is initiated in 4.
- Out of the 66 BPHUs sanctioned, 59 is under ABHIM and 7 under 15FC. Out of this, work is completed in 18, and is in progress in 31.
- There are land issues with 2 project sites.
- Seven critical Care Blocks are sanctioned under ABHIM.
- State also received funds to developed critical care capacity in another 7 sites.
- In Bageshwar, the CCB is coming up at a distance from the district hospital, compromising functional linkages with other clinical departments.
- Under ECRP 2, a 32 bedded paediatric critical care unit is coming up in DH, Bageshwar.

WEST BENGAL

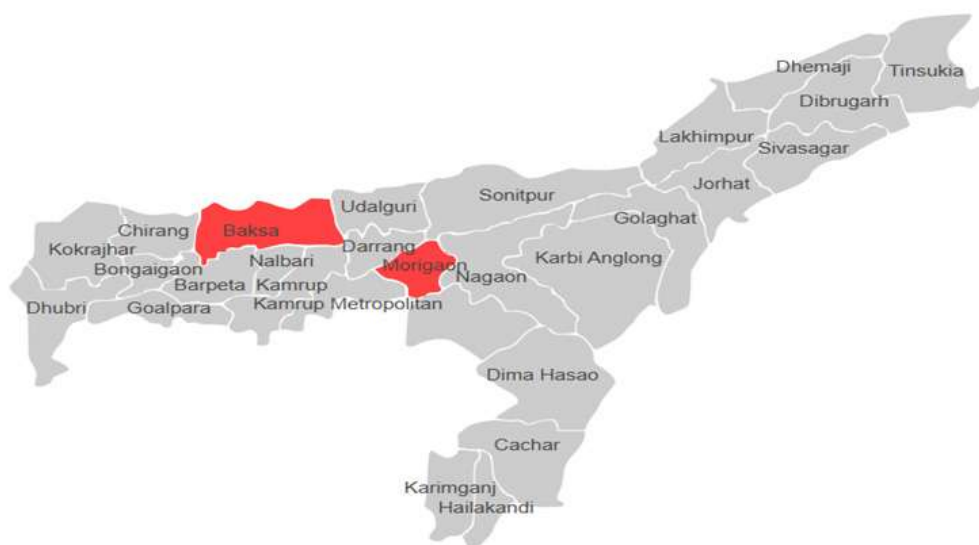
- In South 24 Parganas, it was observed that Block Public Health Unit (BPHU) was functional with dedicated epidemiologists in place.
- Lab linkages to facilities were found.
- Integrated Public Health Laboratory were functional, with automated entries from analyzers to the iHMS system and auto dispatch of reports to patients via SMS.

STATE TEAMS AND FACILITIES VISITED



ARUNACHAL PRADESH

Team Members	
Air Cmde (Dr) Ranjan Kumar Choudhury, Advisor, HCT, NHSRC- Team Leader	
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Sweta Roy, NHSRC	Dr. Sonali Sharma, (Dte.GHS)
Mahesh Jakati, SHSRC Karnataka	Prachi Singh, MoHFW
Simran Dahiya, MoHFW	Dr. Rajesh Kukade, MoHFW
Dr. Arvind Kumar, MoAYUSH	Abhishek Dadhich, MoHFW
Dr. Noorin Bux	Dr. Ajay Arya, RRC NE



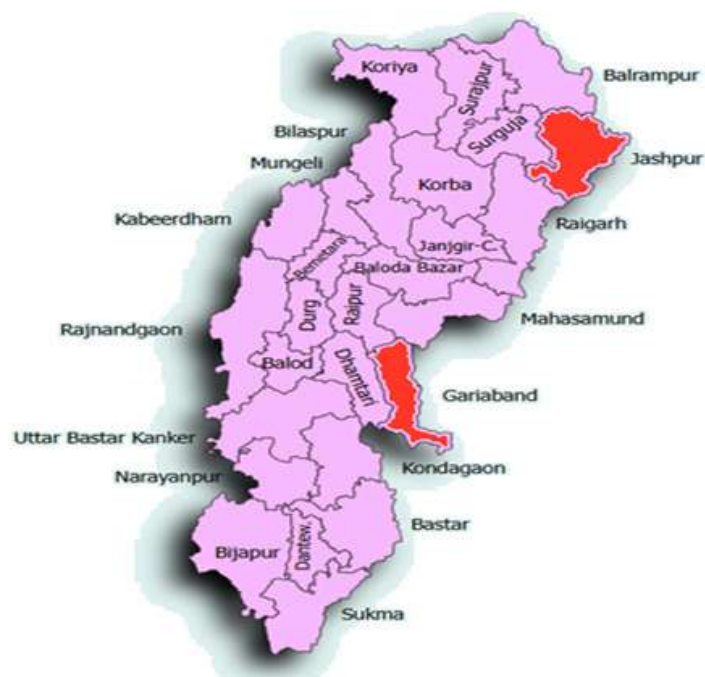
ASSAM

Team Members	
Dr. Pawan Kumar – Additional Commissioner, MoHFW, Team Leader	
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Dr. Sudipta Basa, MoHFW	Dr. Trideep Jyoti Deor, DGHS/MoHFW/RoHFW, Guwahati, Assam
Dr. Pankaj Thomas	Shri. Samsul Haque, MoHFW
Mr. Kannan P, NHSRC	Dr. Mridula Pandey, NHSRC
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Mr. Karuna Gogoi, PRC Guwahati	
Dr. Masram Pravin, MoAYUSH	
Mr. Arpit Singh, MoHFW	



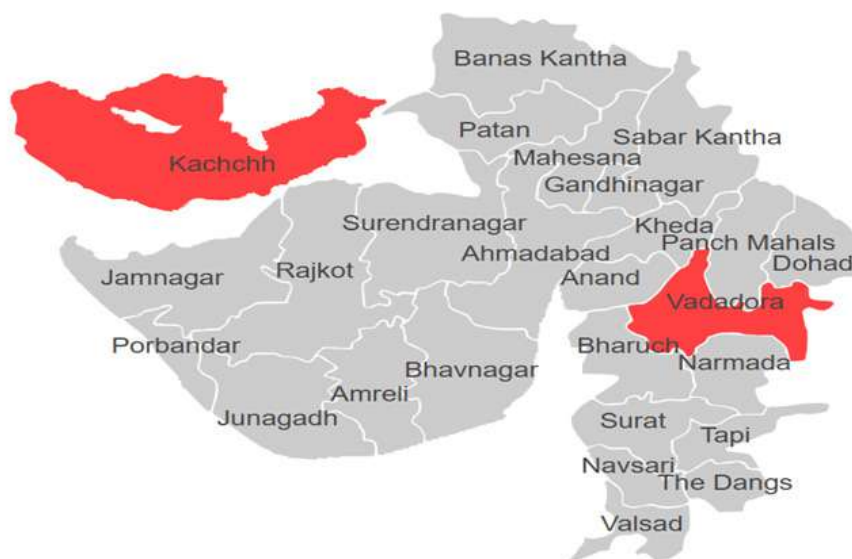
BIHAR

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Mr. Gyanish Kumar, MoHFW	Dr. Rutuja Kolhe, NHSRC
Dr. Monika Saini, NIHFW	Dr. Jitendra Kumar, PRC Patna
Ms. Ayushi Rai, NHSRC	Dr. Balaji Potbhare, MoAYUSH
Dr. Aditi Joshi, MoHFW	Mr. Shahid Ali Warsi, MoHFW
Mr. Manish Narayan, NITI Aayog	Mr. Nishant Sharma, MoHFW



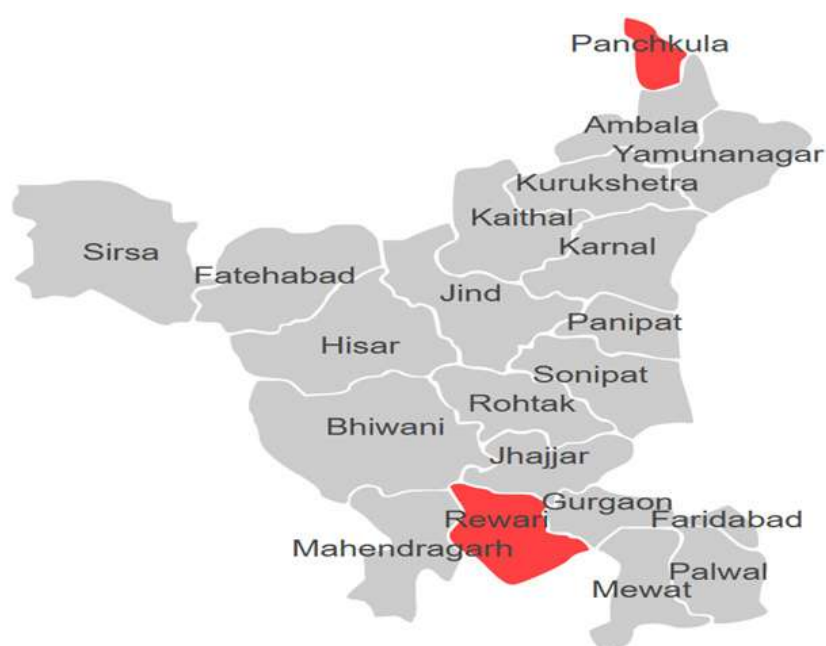
CHHATTISGARH

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Mr. Ashutosh Agarwal, MoHFW	Dr. Yankee Dahiya, NHSRC
Mrs. Jhuma Manna, MoHFW	Dr. Rajkumar Arya, RRC NE
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Dr. Trilochan Bhoi, MoHFW	Dr. Mannu Apurab
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GUJARAT

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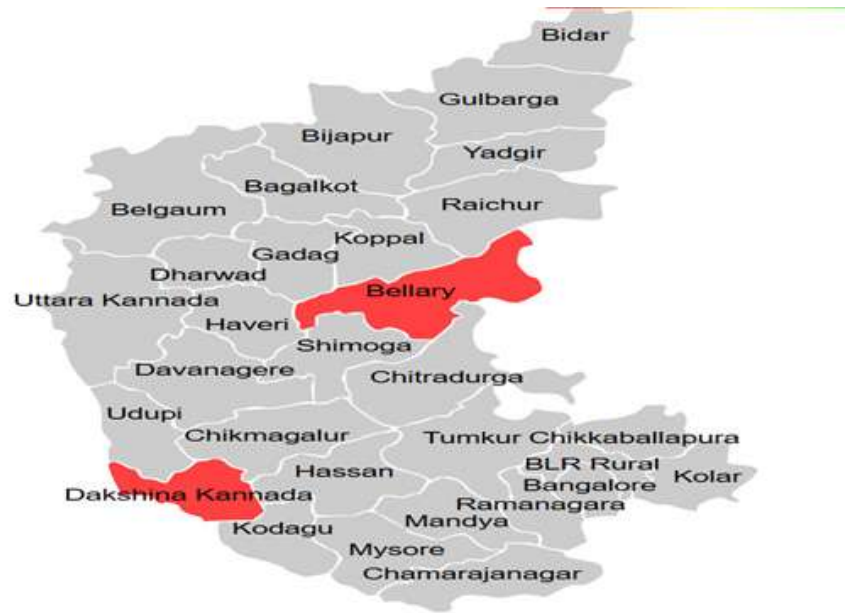
JAMMU AND KASHMIR

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JHARKHAND

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Mr. Devindra, PRC, ISEC, Bangalore	



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Dr. Srishti Gulati, NHSRC	Ms. Priti Singh, MoHFW
Ms. Ritu Malik, NHSRC	Dr. Bhavya Fernandez, SHSRC, Kerala
Dr. Akshat Purohit, MoHFW	



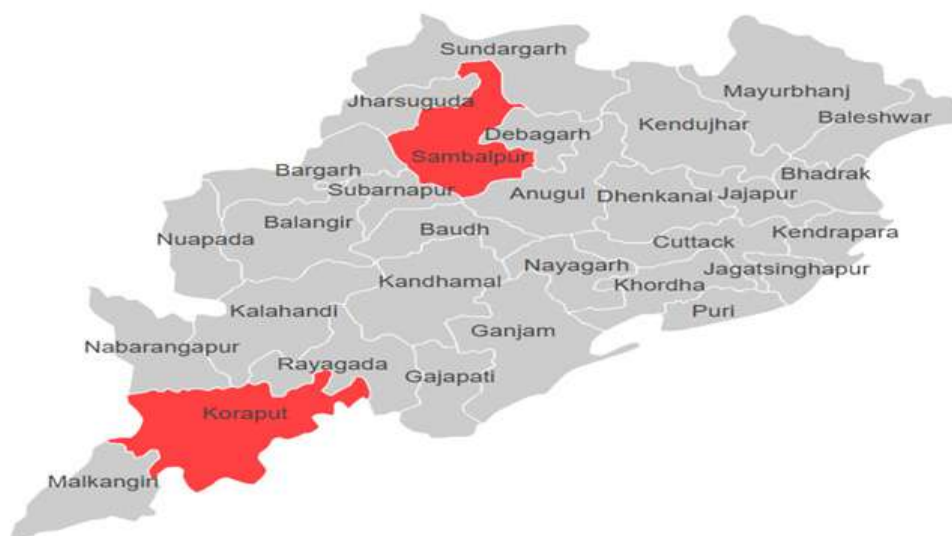
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Dr. Pradeesh CB, Ministry of Tribal Affairs Mizoram	



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Mr. Shatrughan Thakur, RCH	
Mr. Diwakar Sharma, AYUSH	



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Ms. Divya Devi, Ministry of Tribal Affairs	Ms. Vertika Agarwal, NHSRC
Dr. V.K Chaudhuri, CIP, Ranchi	Mr. Dhruv Kumar, MoHFW
Amitava Acharyya, MoHFW	
Mr. Pawan Luniwal, MoWCD	



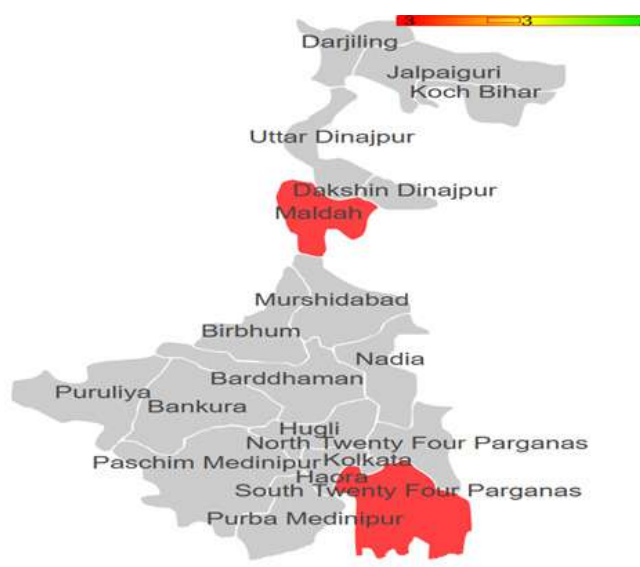
UTTAR PRADESH

Team Members	
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Dr. Ravi Kumar, MWCD	Khushbu Chauhan, MoHFW
Dr. Supriya Bhandari, MoHFW	Dr. Neelam Kumari Singh, MoAYUSH
Ms. Rachana Kumari, NHSRC	Dr. Vijay Yadav, PRC Lucknow
Ms. Daisy A. John, NHSRC	Dr. Richa Sharma, NHSRC
	Ms. Bhavna Nahata, NHSRC



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Team Members	
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Dr. Devajit Bora, RRC NE	Mr. Prasanth K S, NHSRC
Dr. Neha Satoiya, MoHFW	Dr. Ashish Kumar, MoHFW
Dr. Kapil Joshi , MoHFW	Dr. Betsy Varghese, DGHS
Dr. Santosh Kumar, AIIMS Rishikesh	Dr. Athira Satisan, MoHFW
Dr. Tarun Kumar, MoAYUSH	Dr. Manju Madhavan , SHSRC Kerala
Mr. Amit Gupta, MOWCD	Mr. Hemant Pandey, BMHRC, Bhopal



WEST BENGAL

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Mr. Ankur Sharma, MoHFW	Dr. Rahul Pandey, MoHFW
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GOVERNMENT OF INDIA