MAPPING THE PROGRESS AND SHORTCOMINGS OF EMPOWERED ACTION GROUP STATES BASED ON COMMON REVIEW MISSION REPORTS

Dissertation report submitted in partial fulfilment of the requirements for the award of post graduate diploma

Submitted By

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POST GRADUATE DIPLOMA IN HOSPITAL & HEALTH MANAGEMENT: 2015 -17

(01Feb -30Apr 2017)

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ABSTRACT OF THE DISSERTATION

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2. NAME OF THE INSTITUTION	**: INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, DWARKA, NEW DELHI**
3. MANAGEMENT COURSE	**: POST GRADUATION DIPLOMA IN HOSPITAL & HEALTH MANAGEMENT**
4. STUDY DURATION	**: 01 FEBRUARY TO 30APRIL 2017**
5. TITLE OF THE TOPIC	**: MAPPING THE PROGRESS AND SHORTCOMINGS OF EAG STATES BASED ON CRM REPORTS**
6. DATE OF SUBMISSION	**: 01 MAY 2017**
7. APPROVED / NOT APPROVED	**APPROVED / NOT APPROVED**

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8. ABSTRACT OF THE INTENDED WORK:

INTRODUCTION

The National Rural Health Mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. Under the NRHM, difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed.

These initiatives are monitored and evaluated through several mechanisms on an ongoing basis both through internal and external agencies.. The **Common Review Mission** (CRM) has been set up as part of the **Mission Steering Group's** (MSG) mandate of review and concurrent evaluation.

After the launch of **National Urban Health Mission** (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other sub-mission of National Health Mission,

After the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other sub-mission of National Health Mission (NHM), 10 CRMs have been conducted so far.

The Empowered Action Group (EAG) set up to facilitate preparation of area-specific programmes in eight States, namely**, Bihar, Jharkhand, MP, Chhatisgarh, Orissa, Rajasthan, UP and Uttarakhand,** which have lagged behind the other states.

8.1 NEED FOR THE STUDY

The performance of EAG states needs to be monitored to affectively measure their progress. The yearly CRM G reports provide enough substance to validate the progress of these EAG states.

Hence there is an need to study these reports to validate progress and shortcomings

8.2 REVIEW OF LITERATURE

A review of literature is an essential aspect of any research. It helps the investigators to establish support for the need for the study, select research design, developing tools and data collection technique. This dissertation reviews literature relevant to the study. The literature encompasses both theoretical and empirical works that bears on the study and the variables are measured.

8.3 OBJECTIVES OF THE STUDY

1. To study the published CRM reports published by the ministry..

2. To study the state reports available in open domain

3. To identify progress and gaps in EAG states based on these reports.

4. To bring out suggestions based on the reports.

International Institute of Health Management Research New Delhi

The Certificate is awarded to

Lt Colonel Parag Mukherjee

in recognition of having successfully completed his Internship in the department of

NHSRC

and has successfully completed his Project on

Mapping the Progress and shortcomings of EAG states based on CRM reports

Date: 01MAY 2017

Organisation: ***NHSRC***

He comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

We wish him all the best for future endeavors

International Institute of Health Management Research New Delhi

TO WHOMSOEVER IT MAY CONCERN

This is to certify that ***Lt Col Parag Mukherjee*** student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at ***NHSRC*** *from* ***01 February 2017*** ***to*** ***30April2017*** ***.***

The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements. I wish him all success in all his future endeavors.

Dr. A.K. Agarwal
Dean, (Academics and Student Affairs)
IIHMR, New Delhi

Dr. A.K. Agarwal
Mentor
IIHMR, New Delhi

CERTIFICATE OF APPROVAL

The following dissertation titled ***"Mapping the* Progress and shortcomings of EAG states based on CRM reports"** is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of Post Graduate Diploma in Health and Hospital Management for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation.

Name	**Signature**
_____	_____
_____	_____
_____	_____

CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Lt Col Parag Mukherjee,** a graduate student of the Post- Graduate Diploma in Health and Hospital Management has worked under our guidance and supervision. He is submitting this dissertation titled ***"Mapping the* Progress and shortcomings of EAG states based on CRM reports"** in partial fulfillment of the requirements for the award of the Post- Graduate Diploma in Health and Hospital Management.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, or book.

Dr A.K. Agarwal
Institute Mentor
Dean, (Academics and Student Affairs)

Dr J N Srivastava
NHSRC

INTERNATIONAL INSTITUTE OF HEALTH MANAGEMENT RESEARCH, NEW DELHI

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled ***"Mapping the* Progress and shortcomings of EAG states based on CRM reports"** and submitted by ***Lt Col Parag Mukherjee*** Enrollment No. ***PGDHM/15-17/052*** under the supervision of ***Dr. AK Agarwal, IIHMR, Dwarka, New Delhi*** for award of Post-Graduate Diploma in Hospital and Health Management of the Institute carried out during the period from ***01 February 2017*** **to** ***30April 2017*** **embodies** my original work and has not formed the basis for the award of any degree, diploma associate-ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Lt Col Parag Mukherjee (PG/15-17/052)
On Study Leave (MOD/Indian Army)

FEEDBACK FORM

Name of the Student**:** **Lt Col Parag Mukherjee**

Dissertation**:** **NHSRC**
Organisation
Area of Dissertation**:** **"Mapping the Progress and shortcomings of EAG states based on CRM reports**

Attendance**:** **As required**
Objectives Achieved**:** **Fully**
Deliverables**:** **100%**
Strengths**:** **Sincere, Scientific and Analytical.**
Suggestions for**:** **Nil**
Improvement

Suggestions for Institute (course curriculum, industry interaction, placement, alumni)**: Nil**

Dr J N Srivastava
NHSRC
Date: May 2017
Place: New Delhi

ACKNOWLEDGEMENT

I express my gratitude and convey my sincere thanks to ***Dr Ashok Kumar Agarwal***, Professor and Dean (Academics) IIHMR, New Delhi for his valuable guidance and cooperation in my endeavour of my dissertation. I also express my sincere thanks to ***Mrs. Kirti Udayai*** Assistant Professor and Assistant Dean (Students Affairs) for her esteemed support and continued professional guidance.

I am thankful to **Shri Manoj Jhalani**, Joint Secretary NHM, MoHFW, New Delhi for providing me the opportunity to carry out my dissertation under their overall guidance..

I am deeply indebted to ***Dr J N Srivastava,*** NHSRC for his foresight and generous support without which it would not have been able to set the objectives for my dissertation. I would also like to express my gratitude to the functionaries and staff of NHSRC who were extremely helpful in elucidating in detail their task, duties and workload.

The planned schedule of activity, with in-built manageability helped me to understand the nuances of CRM reports with special emphasis on EAG states.

Lt Col Parag Mukherjee (PG/15-17/052)
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PART I

DISSERTATION & INTERNSHIP REPORT

(01February-30April2017)

Introduction

National Health Systems Resource Centre (NHSRC) has been set up under the National Rural Health Mission (NRHM) of Government of India to serve as an apex body for technical assistance.

Established in 2007, the National Health Systems Resource Centre's mandate is to assist in policy and strategy development in the provision and mobilisation of technical assistance to the states and in capacity building for the Ministry of Health and Family Welfare (MoHFW) at the centre and in the states. The goal of this institution is to improve health outcomes by facilitating governance reform, health systems innovations and improved information sharing among all stake holders at the national, state, district and sub-district levels through specific capacity development and convergence models.

It has a 21 member Governing body, chaired by the Secretary, MoHFW, Government of India with the Mission Director, NRHM as the Vice Chairperson of the board and the Chairperson of its Executive Committee. Of the 21 members, 11 are ex-officio senior health administrators, four from the states. Ten are public health experts from academics and civil society. The Executive Director, NHSRC is the Member Secretary of both the board and the Executive Committee. NHSRC's annual governing board meet sanctions its work agenda and its budget.

NHSRC is also a World Health Organisation Collaborating Centre for Priority Medical Devices & Health Technology Policy

The NHSRC currently consists of eight divisions – Community Processes, Public Health Planning, Human Resources for Health, Quality Improvement in Healthcare, Healthcare Financing, Healthcare Technology, Health Informatics and Public Health Administration.

The NHSRC has a regional office in the north-east region of India. The North East Regional Resource Centre (NE RRC) has functional autonomy and implements a similar range of activities.

Vision

They are committed to facilitate the attainment of universal access to equitable, affordable and quality healthcare, which is accountable and responsive to the needs of the people of India.

Mission

Technical support and capacity building for strengthening public health systems in India.

Policy Statement

NHSRC is committed to lead as professionally managed technical support organization to strengthen public health system and facilitate creative and innovative solutions to address the challenges that this task faces.

In the above process, we shall build extensive partnerships and network with all those organizations and individuals who share the common values of health equity, decentralization and quality of care to achieve its goals.

NHSRC is set to provide the knowledge-centred technical support by continually improving its processes, people and management practices.

PART 2

Common Review Mission

The National Rural Health Mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable and accountable quality health services to the poorest households in the remotest rural regions. Under the NRHM, difficult areas with unsatisfactory health indicators were classified as special focus States to ensure greatest attention where needed. The National Rural Health Mission (NRHM) aims to bring about the architectural correction of the public health system so as to make it "equitable, affordable and effective" with an enhanced capacity to absorb the increasing outlay on health. The hallmark of NRHM has been in establishing and strengthening state institutions in sustaining the continued inputs required in the health sector, improving accountability structures and fostering openness and transparency.

The thrust of the Mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectorial convergence at all levels, to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards (IPHS) for all health facilities. From narrowly defined schemes,

These initiatives are monitored and evaluated through several mechanisms on an ongoing basis both through internal and external agencies.. The **Common Review Mission** (CRM) has been set up as part of the **Mission Steering Group's** (MSG) mandate of review and concurrent evaluation. The review mission consists of Public Health Experts, Representatives of Development Partners, Civil Society Members, and GoI Officials. This is one of the important monitoring mechanisms to assess the progress of NRHM and it has been an annual exercise since 2007. After the launch of **National Urban Health Mission** (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other sub-mission of National Health Mission, The CRMs have been dealing with both these aspects.

The **findings** of the Review Mission emanate from the discussions with State Government officials, interaction with service providers, NGOs and also field visits to the States and Districts. The key findings are further discussed with the stakeholders in a participative manner and these then form the recommendations of the Review Mission. The Review Mission comprises

experts in the health sector from NGOs and Civil Society Organizations, donor partners in addition to the State and Central Government officials.

HIGHLIGHTS OF CRMs CONDUCTED SO FAR

After the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other sub-mission of National Health Mission (NHM), 10 CRMs have been conducted so far. The highlights of these missions are as under:-

1st Common Review Mission (2007)

This Common Review Mission (CRM) was set up as part of the Mission Steering Group's mandate of review and concurrent evaluation. It conducted its appraisal in November 2007, 16 months after NRHM got final cabinet approval in July 2006 and the actual processes started up. The terms of reference set out the task of
the 1st CRM to assess the progress of NRHM on **24 parameters**, which relate to the core strategies and the central areas of concern. Based on these, the CRM was mandated to identify the constraints being faced and to make recommendations on the areas that need strengthening and course correction.

The Review Mission was made up of 52 members- central and state health government officials and public health experts left for the selected states: Andhra Pradesh, Assam, Bihar, Chhattisgarh, Orissa, Madhya Pradesh, Gujarat, Jammu and Kashmir, Rajasthan, Tamil Nadu, Tripura, Uttar Pradesh and West Bengal.

2nd Common Review Mission (2008)

The Second Common Review Mission of the National Rural Health Mission was held in November- December of 2008, 43 months after the formal launch of the programme and 27 months after the Framework for Implementation was approved by the government. The Mission was divided into 13 teams and each team visited more than ten facilities in a minimum of two districts in a state. At each of these sites, the Mission interacted extensively with the community representatives, service providers, and officials. The Mission studied changes in **19 parameters**. This Common Review Mission, the second one, is an assessment of the progress during the last one year

The 2nd CRM selected the following thirteen states with a view to provide a representative picture of the progress made: Assam, Bihar, Chhattisgarh,

Orissa, Rajasthan, Tamil Nadu, Karnataka, Kerala, Madhya Pradesh, and Uttar Pradesh, Jharkhand, Maharashtra, Mizoram, The first ten of these states were also covered during the 1stCRM.

3rd Common Review Mission (2009)

The third CRM was organized in the first and second weeks of November 2009. This is 55 months after the formal launch of the NRHM and 39 months after its Framework for Implementation received cabinet approval-the date from which its implementation began. This CRM was undertaken in 14 states and 3 union territories—Bihar, Chhattisgarh, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand, Uttar Pradesh, Meghalaya, Sikkim, Jammu & Kashmir from the high focus states, and Andhra Pradesh, Gujarat, Haryana and West Bengal; Andaman and Nicobar Islands, Dadra and Nagar Haveli, Daman and Diu from the non-high focus states and UTs

The Terms of Reference of the Third CRM contained **22 parameters** for review. The findings against these parameters have been summarized in this report under five major headings. The first indicates the main output of the NRHM in terms of achievement of service guarantees. The others present the inputs and processes: human resources for health, efforts at decentralisation and community processes, programme performance, and management issues.

4th Common Review Mission (2010)

The Fourth Common Review Mission of the National Rural Health Mission was held from 15to 23 December, 2010. A total of 14 states and one union Territory was reviewed by 15 teams. The selection was intended to provide a representative picture of the progress made under NRHM. The states covered were Arunachal Pradesh, Nagaland and Assam from the North East, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttar Pradesh, and Uttarakhand from the high focus states, and Punjab, Tamil Nadu, Maharashtra and Kerala from non-high focus states and one union territory Chandigarh.

The Fourth CRM evaluated the existing health delivery system in each of the selected states through **11 parameters** which covered various aspects of the System.

5th Common Review Mission (2011)

With the NRHM into its seventh year, the CRM has become institutionalised as an annual event, undertaken in November each year. The series of CRM reports enable an understanding of the progress that states have made towards the NRHM objectives. In conjunction with other surveys they enable tracking of the achievement towards NRHM goals

A total of fifteen states were included in the fifth CRM. Eight of these were high focus states, two were from the North East, and the remaining five were non high focus states. Amongst the high focus states Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand were included. The non-high focus states were included were Andhra Pradesh, Goa, Gujarat, Haryana, and Karnataka. Himachal and Goa were included for the first time in the CRM. Chhattisgarh, Odisha, Rajasthan and Uttar Pradesh have been part of the last four CRMs. Bihar and Assam have been part of three CRMs, and Jharkhand, Gujarat, Andhra Pradesh and Uttarakhand of two CRMs. Haryana, Sikkim and Karnataka have been visited once before. **16 Terms of References** were covered in this CRM.

6th Common Review Mission (2012)

6th CRM took place from 2nd Nov 2012 to 9th Nov 2012 and covered the following States: Bihar, Chhattisgarh, Madhya Pradesh, Rajasthan, Odisha, Uttar Pradesh, Uttarakhand, Assam, Manipur, Tripura, Kerala, Punjab, Tamil Nadu, West Bengal and Delhi.

The broad objective of the CRM was to review progress of the NRHM against expected outcomes and outputs defined in annual plans, with reference to the overall goals of the Mission. Seven of the states belonged to High Focus category; Bihar, Chhattisgarh, Madhya Pradesh, Odisha, Rajasthan, Uttarakhand, Uttar Pradesh; three were from the North Eastern States - Assam, Manipur, Tripura and five were the Non High focus states of Delhi, Kerala, Punjab, Tamilnadu and West Bengal. Of these states, Chhattisgarh, Odisha, Rajasthan and Uttar Pradesh have been visited in all six CRMs. Madhya Pradesh which was visited in all except the fifth. The states of Uttarakhand and Tamilnadu have been part of four CRMs, West Bengal and Kerala were visited thrice, and Tripura and Punjab in two CRMs. Delhi was included for the first time in a CRM.

Progress of NRHM was reviewed on ten broad parameters, each **with ten components**. This 10x10 matrix, or 100 process and output elements, captures essential dimensions of state government action and accountability for the necessary outcomes.

7th Common Review Mission (2013)

The seventh Common Review Mission (CRM) of the NRHM was held from November 8 to November 15, 2013 in 14 States / UT namely Bihar, Jharkhand, Odisha, Uttar Pradesh, Jammu & Kashmir, Himachal Pradesh, Arunachal Pradesh, Meghalaya, Nagaland, Andhra Pradesh, Haryana, Karnataka, Maharashtra, and Gujarat. The choice of states was partly by elimination. Six states were locked out by impending or on-going elections. Some states were facing special problems like Uttarakhand, which was recovering from a natural disaster, and the other southern states had been visited the previous year.

It was the first review mission of the National Health Mission (NHM), which comprises the existing National Rural Health Mission (NRHM) and the new National Urban Health Mission (NUHM) as its two sub-missions. A total of **10 Terms of Reference** were addressed in this CRM.

8th Common Review Mission (2014)

8th Common Review Mission (CRM) under National Health Mission was held from 7th November 2014 to 14th November 2014 in 15 States / UT namely Assam, Bihar, Chandigarh, Chhattishgarh, Kerala, Mizoram, Madhya Pradesh, Odisha, Punjab, Rajasthan, Tamil Nadu, Telangana, Uttar Pradesh, Uttarakhand, West Bengal.

This CRM addressed **11 objectives** .

9th Common Review Mission (2015)

9th Common Review Mission (CRM) under National Health Mission was held from 30th October 2015 to 6th November 2015 in 18 States / UT namely Andhra Pradesh, Assam, Chattishgarh, Delhi, Haryana, Himachal Pradesh, Jharkhand, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Meghalaya, Odisha, Punjab, Rajasthan, Uttar Pradesh, Uttarakhand, West Bengal.

The ninth Common Review Mission was undertaken when NRHM marked ten years of implementation and the NUHM just two years. The Ninth CRM ToR focused on assessing implementation status of new initiatives and guidelines issued by Ministry of Health and Family Welfare in terms of progress towards Kayakalp scheme for public health facilities, RKS guidelines, National Urban Health Mission, free drugs and diagnostic service initiative, operational guidelines for enhancing performance of multipurpose worker (female), Rashtriya Kishor Swasthya Karyakram (RKSK) and progress on Non Communicable Diseases (NCD) programme.

10th Common Review Mission (2016)

10th Common Review Mission (CRM) under National Health Mission was held from 7th November 2016 to 11th November 2016 in 16 States / UT namely Andhra Pradesh, Arunachal Pradesh, Bihar, Chandigarh, Delhi, Gujarat, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Kerala, Madhya Pradesh, Maharashtra, Nagaland, Tamil Nadu, Tripura, and Uttar Pradesh.

Eleven Terms of Reference (TOR) for 10th CRM were developed by the Ministry of Health and Family Welfare (MoHFW) involving different stakeholders and technical experts from the programme divisions and covered various dimensions of National Health Mission ranging from service delivery to governance issues. This year the CRM included eleven TORs, focused on multiple aspects of the health system.

MANDATE AND TERMS OF REFERENCE

On perusal of the CRM reports as brought out in the previous section, it's evident that the mandates of each CRM were drawn based on the current development goals and specific to the need of the hour. However the Terms Of reference have been varying i.e. 24 in the first and for the last six years settling to 10/12.

The reason was that when the CRM kick started every stakeholder wanted their perspective to be reviewed and thus the Terms Of Reference were too many, nonetheless with in the initial few reports it was realised that this yearly exercise has been reduced to mere filling up of checklists. Thus the revision of terms Of Reference was carried out to ensure better follow-up and credible action by the states.

EAG STATES

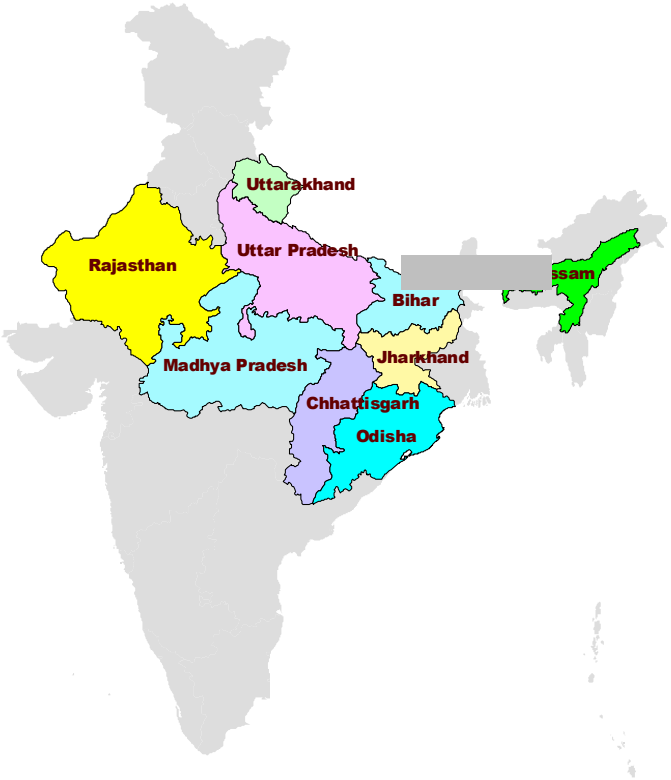
The Empowered Action Group (EAG) set up to facilitate preparation of area-specific programmes in eight States, namely**, Bihar, Jharkhand, MP, Chhatisgarh, Orissa, Rajasthan, UP and Uttarakhand,** which have lagged behind the other states. Detailed presentations were made by the member states reflecting upon the areas of concern, the measures taken by the State Governments to achieve systemic reforms and their expectations from the various Ministries of Government of India to emerge from the socio-demographic backwardness. It was agreed that the EAG needs to strengthen the systems of governance and monitoring. However, the greater need is to involve the community successfully through local empowerment and convergence. In a federal structure like India, there is need to strengthen the Centre-State coordination before direct interventions can be made at district levels

The EAG resolved to work with the participating States in formulating their action plan for improving service delivery. It was agreed that the plans will be prepared on the basis of the following guiding principles:

- It was noted that the problems in the EAG States are less to do with the availability of funds than the issue of governance. Therefore, proposals for resolving the systemic issues relating to key areas such as human resource management, logistics management, mainstreaming of the ISM practitioners, integration of numerous health societies at State and district levels, regular release of funds to operational levels, joint planning/training for the field staff of the cognate departments, greater autonomy to the districts and within districts, to hospitals and PRIs, will be integral parts of the plan.

- Within a State, incremental investments (that may be provided by the EAG) will be focussed at bridging the intra-state demographic divide. A key objective in this regard would be to ensure, through a systemic re-structuring of manpower in association with physical improvement, that the district and sub-divisional hospitals in the backward districts in a State provide the full range of RCH services including 24-hour availability of emergency obstetric services.

- The States of Chhatisgarh, Jharkhand and Uttaranchal -- may include in their plans, proposals for strengthening their planning and monitoring infrastructure.
- A major proportion of the funds available under the Rural Connectivity Scheme, Drinking Water Supply Scheme, the SJGSY Scheme and other Centrally Sponsored Schemes of the Department of Rural Development, will be directed to the backward districts. Proposals for utilisation of the Central assistance for these schemes will be integral to the State plan.



Profile of EAG States

Bihar

Bihar is located in the eastern part of the country. It is an entirely land–locked state, lies mid-way between the humid West Bengal in the east and the sub humid Uttar Pradesh in the west. It geographical location provides the state with a transitional position in respect of climate, economy and culture. It is bounded by Nepal in the north and by Jharkhand in the south. The Bihar plain

is divided into two unequal halves by the river Ganga which flows through the middle from west to east.

Chattisgarh

Chattisgarh, spread over 135,194 sq. km. is bordered by Madhya Pradesh on north, Maharashtra on west, Andhra Pradesh on south, Orissa on south-east and by Jharkhand on the north - east. It is predominantly forested region, known for the beauty of its naturally mixed forests, Mahanadi and Indravati Rivers. The state is rich in natural resources. It is also one of the most heavily affected states in India due to the left wing extremism.

Jharkhand

Jharkhand is a state in eastern India. It was carved out of the southern part of Bihar on 15 November 2000. Jharkhand shares its border with the states of Bihar to the north, Uttar Pradesh and Chhattisgarh to the west, Orissa to the south, and West Bengal to the east. The state has 24 districts, 251 blocks and over 32,615 villages in an area of 79,714 sq km 49,821 sq mi (129,040 km2). The industrial city of Ranchi is its capital and Dumka is sub capital while Jamshedpur is the largest city of the state.

Odisha

Odisha state has a population of 4,19,47,358 spread across 30 districts. It has 8 High Priority Districts (HPDs) harbouring over 15 percent (65,26,632) of the total population. The state has 118 tribal blocks as a whole, and 59 tribal blocks in the HPDs. The state has categorized all its facilities into V1, V2, V3 and V4 based on the degree of difficulty-to-access, with V3 and V4 being the most difficult and inaccessible facilities. There are 749 identified V3 and V4 facilities in the state, of which 560 are in HPDs alone.

Madhya Pradesh

The state of Madhya Pradesh has a population of 7.26 crores (Census 2011). There are 50 districts in the state. The State has population density of 236 per sq. km. (as against the national average of 312). The decadal growth rate of state is 24.3% (against 24.54% for the country) and the population of the state continues to grow at a much faster rate than the national rate.

Uttar Pradesh

Uttar Pradesh is the most populous state in the country with 19.96 crore inhabitants according to 2011 census. It covers an area of 2,40,928 Square km, equal to 6.88% of the total area of India making it the fifth largest Indian state by area. Hindi is the official and most widely spoken language in its 75 districts, 18 administrative divisions, 312 tehsils, 51914 Gram Panchayat, 822 development blocks and 107480 villages. The State is divided into four economic regions - Western Region, Central Region, Eastern Region and Budelkhand. The State has 44 high focus districts

Uttarakhand

Uttarakhand, the 27th State of the country was carved out of Uttar Pradesh on 9thNovember, 2000. The State is flanked by Himachal Pradesh in the north-west and Uttar Pradesh in the South and shares an international border with Nepal and China. The State, with its headquarters in Dehradun is spread over an area of 55,845 square km having 78 Tehsils, 95 blocks, 7227 Panchayats and 16,826 inhabited villages, 86 cities/towns. The State has 13 districts which are classified into two Divisions: six districts forming the Garhwal division and seven included in the Kumaun division.

Rajasthan

Rajasthan is largest State in India and is located in the northwest part of India. It has borders with Punjab in the north, Haryana and Uttar Pradesh in the northeast, Madhya Pradesh in the east and Gujarat in the south. On the western side, it shares a long stretch of international border with the neighbouring country Pakistan. Temperatures range around 40°C in summer and between 22°C and 8°C during winter. The climate is generally dry (except Aravali region) with scanty rainfall during July and September. The state has a population of 68.6 million and an area of 342,239 sq. km. It has 33 districts, 249 blocks and 44672 villages. The population density is 201 per sq. km. (as against the national average of 382 per sq. km).

Facts and Figures (data from RHS - 15, SRS-16, Census)

	Pop (Cr)	**MMR**	**IMR**	**ANM @SC/ PHC**	**Doc @ PHC**	**SC**	**PHC**	**CHC**	
Bihar	**10.4**	**208**	**42**	**19499**	**2521**	**9729**	**1883**	**70**	
Chattisgarh	**2.55**	**221**	**43**	**5703**	**368**	**5186**	**792**	**155**	
Jharkhand	**3.29**	**208**	**34**	**7170**	**372**	**3957**	**327**	**188**	
Odisha	**4.19**	**222**	**49**	**8225**	**1008**	**6688**	**1305**	**377**	
MP	**7.26**	**221**	**52**	**12412**	**999**	**9192**	**1171**	**334**	
Rajasthan	**6.85**	**244**	**46**	**15999**	**2412**	**14407**	**2083**	**568**	
Uttarakhand	**1.00**	**285**	**33**	**1828**	**160**	**1848**	**257**	**59**	
UP	**19.9**	**285**	**48**	**23731**	**2209**	**20521**	**3497**	**773**	

PROGRESS/SHORTCOMINGS OF EAG STATES BASED ON CRM REPORTS

For the purpose of assessment, the action/progress made by the states has been culled out from the CRM reports on a few common Terms of References.

The terms of references identified are:-

- Service Delivery
- RMNCH+A
- Human Resource
- Community Process

SERVICE DELIVERY

Guiding Principles/Strategies of the NHM

- Build an integrated network of all primary, secondary and a substantial part of tertiary care, providing a continuum from community level to the district hospital, with robust referral linkages to tertiary care and a particular focus on strengthening the Primary Health Care System including outreach services in both rural areas and urban slums"

- Reduce out of pocket expenditure on health care, eliminate catastrophic health expenditures and provide social protection to the poor against the rising costs of health care, through cashless services delivered by public health care facilities, supplemented by contracted-in private sector facilities wherever necessary"
- Ensure that all public health care facilities or publicly financed private care facilities provide assured quality of health care services"
- Ensure increased access and utilization of quality health services to minimize disparity on account of gender, poverty, caste, other forms of social exclusion and geographical barriers"
- Promote partnerships with private, for profit, and not for profit agencies including civil society organizations to achieve health outcomes
- NHM will encourage the public sector to contract-in or out source those services which improve efficiency and quality of care in the public hospital

Bihar

- Infrastructure development plans are available at state and district levels, but there is no prioritization of construction of infrastructure based on un-served areas, backward areas, land availability and need especially for high caseload facility. Facility up gradation/construction is not as per IPHS. Quarters for staffs are highly inadequate across the state. The pace of construction is tardy and quality of construction variable.
- There is serious mismatch of infrastructure especially at the delivery points (except DH and SDH) which remain high case load facilities without adequate infrastructure, beds, seating arrangement, toilets, boundary walls etc. State has 496 functional Block PHCs working 24x7, each covering a population of approximately 1.5 to 2 lakhs but having very few beds. PHC K.Nagar in Purnea had only 9 beds and is conducting 15-20 deliveries per day. Due to lack of adequate beds newborns and women are kept out in the open verandah/corridors, due to less number of beds (i.e. only 6 bedded PHC) 48 hrs stay of the women after delivery is not being practiced.

- There is a 52% gap in existing functional HSCs and 51% gap in PHCs against sanctioned numbers in the state. There is a huge gap in sanctioned health infrastructure against IPHS norms with 12 medical colleges against 21 sanctioned, 126 FRUs against 208, 533 CHCs against 865, 2787 PHCs (APHC) against 3460 and 16623 in HSC against 20820.
- Infrastructure completion rate is around 29%. There is adequate supply of running water and electricity with power back-up in most of the facilities.
- In the State, most of the patients are coming for OPD, deliveries and emergency care. C-section rate is below 2% and utilization of public health institutions in general was found to be good only at District Hospital.
- State has implemented free Drug Policy. Bihar Medical Services and Infrastructure Corporation Limited (BMSICL) is central drug procurement agency. Three NABL accredited labs have been empanelled for quality testing of drugs. All the primary care hospitals in the district are not connected online for submitting online indent. Patient registration and medicine dispensing software is good initiative but actual use of software for planning is not happening. Drug supply system is inefficient at district level. Supply depends on availability of drugs in district ware house rather than demand base.
- Periodical Prescription Audits are not being conducted. State is in the process of developing a comprehensive Standard treatment guideline. EDL list is displayed at DH, CHC and SDH. Doctors prescribe branded medicine rather than generic prescription and as these medicines are not available in Pharmacy, patients have to go private medical stores to buy medicines which lead to huge out of Pocket expenditure.
- Free Diagnostic Services are being provided in the state since 2009 in all public health facilities and the facilities of advanced pathological and Radiological tests (except CT Scan and MRI) are being provided free to the patients at Medical Colleges & Hospitals. The reagents are being supplied to districts by the BMSICL. However, shortage of reagents is being observed at all levels except District hospital.
- Although state has sufficient number of Blood Bank but there is a shortage of Blood Storage Units. Blood banks visited in the facility are having necessary IT logistics and are well connected with internet.

Delay in receiving approval from State Drug Controller, Procurement of Equipment and Instruments, Lack of Human Resources (HR) as per norms, and lack of awareness amongst community for Blood Donation is an area of concern in the State.

- In the State there are total 69 Ayurvedic Dispensaries, 30 Unani Dispensaries, 28 Homeopathic Dispensaries (in rural areas), 26 Joint Dispensaries (Ayurvedic, Unani & Homeopathic) in 26 out of 38 districts. Further, 1348 AYUSH co-located facilities are available under NHM and 1060 AYUSH doctors are supported through NHM. However, in the visited facilities AYUSH MOs are not trained for National Programmes like SBA. Availability of AYUSH medicine is an issue in the state.
- In the State, 744 BLS ambulances are run by DHS, 10 (5 ALS + 5BLS) ambulances being run by Ziqitza Health Care Ltd. and 94 (44 ALS + 50 Mortuary Vans) are being run by Sammaan Foundation.
- The state has provision of outreach services through Mobile Medical Units. However, it is limited only in two districts. There are seven MMUs (National Mobile Medical Units) and 73 MMVs (National Mobile Medical Vans) supported by Government of India and 6 MMUs are also provided through MPLAD fund
- The state is in process of outsourcing the Maintenance of Bio Medical Equipment. The mapping has been completed at all facilities up to Additional Primary Health Centres level across the state.
- Quality assurance committee is functional at State, Regional and District levels; however meeting of district level QAC needs to be regular. No mechanism is in place to ensure adherence of Standard Treatment Protocol in both the districts.
- State has reported to have Grievance redressal system in which people can register their complaints through phone, on line or SMS, but Grievance redressal mechanism was not visible on ground.

TYPE	REQMT	SANCTIONED	AVL	GAPS
SC	20760	16623	10081	10679
PHC	3993	3312	1897	2076
CHC	865	469	70	795
SDH	63	55	38	25
DH	38	36	36	02

Chattisgarh

- State reports shortage in number of health facilities, particularly in Sub Health Centres. For instance, there is a shortage of 81 SHCs in tribal areas. Although support has been received under NHM for infrastructure up-gradation the progress has been sub-optimal.
- The institutional delivery has increased from 57.07% in 2011-12 to 73. 77% in 2014- 15 and, overall OPD and IPD attendance has increased in the state over the last few years.
- State has about 750 drugs in its EDL. However, supply of these drugs varies and most of the health facilities did not display the EDL
- State has STGs in place and training of the staff has also been conducted on the same. State is in process of revising the STGs currently. Prescription audits are conducted in the state. SHSRC is the audit agency. Prescription audits have shown that most practitioners are adhering to the recommendation of prescribing generic drugs.
- State level indenting of drugs is done through IT enabled inventory management system i.e. DVDMS. Drug Procurement is done through a central procurement agency, i.e. Chhattisgarh Medical Services Corporation (CGMSC). However, there is scope to upgrade on-line indenting system and percolate it down to PHC level in the first place and to the SC over a period of one to two years. Largely the supply of drugs has improved on account of online indenting. State has mechanisms to test quality of drugs.
- Diagnostic services were available at most of the facilities. Cost exemptions are provided for children below 18years, ANC cases, Malaria and for some vulnerable communities. State is yet to roll out free diagnostic services initiative of NHM
- Blood transfusion services need strengthening. One of the districts visited had no operational government blood bank or Blood Storage Unit but one functional private Blood Bank. The other district has one operational blood bank but a high user fee is charged along with replacement of one blood unit.
- The mapping exercise of all biomedical equipment in the state has been undertaken by HLFPPT and the report is yet to be shared with the districts. The policy and procedures for condemnation are yet to be clearly communicated.

- All the ambulances have GPS fitted in them and these are as per national guidelines. Functional call centre present. A prudent mix of 108 and 102 ambulances were seen in the blocks visited; strategically positioned at the DH and CHCs to cater to the call on priority. At present the state does not provide services through MMUs but has conceptualized to provide mobile medical services through the 108 vehicles which are unutilized.
- PPP arrangements are made for outsourcing HR through private agencies in districts where the posts are vacant since a long time. Apart from this, Bio-Medical Equipment Management and ancillary services such as diet facility has been out sourced. Specific MoUs have been signed for conducting cataract surgeries.

Jharkhand

- State needs to address the challenge of inadequate distribution of health facilities in tribal areas Vis a Vis non-tribal areas.
- The OPD and IPD services in state are improving gradually; however, due to geographic constraints the utilization of outdoor and indoor facilities is poor at most of the health facilities State has recently launched the free drugs policy. State budget also supports free medicines for IPD and OPD patients but the range of drugs provided free of cost is very limited.
- National List of Essential Medicines of India 2011 has been adopted by the state and it has 181 drugs in its EDL. STGs are yet to be formulated by the state. Prescription audits not yet initiated in the state.
- Jharkhand Medical and Health Infrastructure Development and Procurement Corporation have been set up as Central procurement agency. However, it is still in nascent phase and procurements at district level are essentially done by a committee (of MO, DPM and Finance manager).
- Quality assurance system of drugs found to be weak in the state. For Drugs procured at state level, random sampling is done by Drug Inspectors and tested in State Drug Laboratory.
- State has recently notified Free Diagnostics Scheme. As of now good range of diagnostic services is available in the state in public facilities. All tests are free for BPL populations. State has also entered in

collaborations with private providers to provide enhanced range of lab services at district hospitals.

- Due to non-availability of blood transfusion facilities at many FRU's, cases have to be referred causing unnecessary trouble and expenditure.
- M/S HLL Ltd. NIT has completed mapping work and the state is under process of developing a Comprehensive Annual Maintenance Contact. Uninstalled equipment's were spotted in a few facilities.
- Largely AYUSH systems have not been co-located within PHCs/CHCs and District Hospital level facilities. Most AYUSH dispensaries are non-functional. Poor availability of AYUSH drugs was observed.
- Ambulances are not GPS fitted and there is limited monitoring of inter-facility transfer and drop back services. However, the MMUs are well equipped with staff and conduct 25 camps per month on an average.
- It is not clear how system of Quality Assurance for the supplies delivered at the health facilities is ensured. There is no mechanism in place to manage expired drugs, reagents and vaccine across the facilities in the district.

- Diagnostic services are free to the patients and are being outsourced to SRL at DH and all other facilities are doing diagnostic facilities by their own and are free of cost.
- Dialysis services are not available at the DH, Dialysis services have not being rolled out in the State.

- National ambulance services are not being rolled out in the State; State is in the process of taking up the services. Ambulance vehicles have been purchased and infrastructure procurement is under process.

- State has 94 MMUs operational across the state covers all 24 districts. There are three mobile medical units in each of the districts and managed under Public Private Partnership mode. The monitoring mechanism of the MMU services is in place. MMUs provide the services of OPD, drug dispensing and basic laboratory services only. The micro-plan and tour plan of MMUs are being maintained.

- The state has not initiated the Biomedical Maintenance Programme so far. Junk materials occupy many service areas affecting the health services.

- The State entered into partnership with different agencies for diagnostic services, managing MMU services, and maintaining cleaning and security services at District hospitals.

Madhya Pradesh

- 83% completion of infrastructure at State and district level. Water and electricity connections were available in DH, CH, CHC and PHC. Majority of Sub-centres were well equipped and functional with all required logistic.

- Facilities are distributed as per geographical needs however its functionality and coverage by assured transport is an issue for time to care approach.

- Sardar Vallbhai Patel Aushadhi Yojana has ensured the availability of essential drugs. State has its own Essential drug list 2016-17 with 436 drugs approved under it. However, number of drugs are made available at various levels vary.

- Standard treatment guidelines were developed but they are yet to be disseminated. There is an IT enable inventory system present till CHC for management of drugs and logistics. However, indenting is done by own analysis, software should forecast depending upon consumption**.**

- Drug testing is done in 11 empanelled laboratories which are NABL accredited. Drugs are directly received from the manufacturer and quarantined till in house testing report comes. All drug ware houses and stores have IT enable inventory management system present – called E- Aushadhi.

- All the essential diagnostic services being provided at free of cost in all facilities. In interaction with the beneficiary at different centres there was no out of pocket expenses incurred on diagnosis at any facility at any level.

- Both districts have dialysis units. Utilization is better in Ratlam. The services are provided at free of cost to BPL patient whereas Rs. 800

charged to patient in APL category. AV fistula as well as Central line insertion is not performed at district hospital which costs about Rs. 18000 to the patient.

- State has not proposed any district under DH strengthening however DNB courses have been sanctioned at one district hospital JP Hospital Bhopal and bridge courses for nursing staff at Gwalior district hospital.
- The State has 135 licensed blood banks (Govt. blood banks 60, IRCS/Charitable 06, Pvt 69 & 71 BSC). It was found that the medical officer and technician were not aware about SoP as well as discard process for unused or waste blood unit at Ratlam. The blood collection was mostly done by replacement. The blood bank services are provided free for maternity cases and BPL families and processing charge of Rs. 600 is taken from others.
- The AYUSH doctors and other Staff are not under the administrative control of District CMHO.
- The operationalization of MMUs services in state varies from district to district due to lack of staff and poor IEC activities about MMU in community.
- The feedback received from the beneficiaries revealed that both during the call and arrival of ambulances the call centres asks too many questions which leads in long waiting time
- The state has initiated the process of mapping of biomedical equipment recently. No AMC has been done for maintenance of equipment.
- The State of Madhya Pradesh has empanelled 11 agencies for quality testing. All empanelled agencies are NABL (National Accreditation Board for Testing and Calibration Laboratories) accredited. It includes the drug testing also. The state has outsourced the Ambulance services, technicians and in-house nurse for running the Dialysis unit. The poor quality of services and lack of supervision were observed by the CRM team
- Stare has 1773 standalone Government Ayurveda Hospitals. In addition there are 110 facilities (CHCs and PHCs) which are functional with AYUSH doctors but no MBBS doctors. AYUSH facilities are not

co-located at most of the places. AYUSH MOs are provided training in the implementation of national programs (including disease control programs like malaria and leprosy), family planning, nutrition and maternal and child health (e.g. ante-natal care and immunization) by the CMHO. Female AYUSH MOs are provided training in SBA. RBSK program has involved AYUSH doctors in community based screening. A shortage of supply of medicines, equipment and storage space was noted.

- Various ancillary services such as Security, Laundry, Hospital cleaning, have been out sourced, with outsourcing contracts being done at District level. However, the quality of services is poor and monitoring is weak

Uttar Pradesh

- It is observed that adequate physical health care infrastructure exists in the state at different levels except for CHCs which are less in number.
- There is a substantial increase in number of OPD and IPD cases from 2013-14 to 2015- 16. However, lack of services at sub-district level substantial number of referrals are being made to District Hospitals

- State has implemented "Free Drugs initiative". EDL drugs list are available at almost all facilities visited and list of available drugs is displayed publically.

- Online Drug Procurement and Inventory Contract System (DPICS) have been functional up to district level and are being used for indenting and distribution. All the District Hospitals are separately connected through software for submitting online indent while below DH level facilities submit their indents manually to District Drug store. At district level, drug samples are being collected by Drug Inspector and tested. During exit interviews with patients and community interactions as well, it was found that beneficiaries were not incurring any OOPE on drugs while availing the public health services.

- Majority of Essential diagnostic tests as per free diagnostics initiative, are being provided in the laboratory of the District hospital/ CHC. During exit interviews with patients and community interactions as

well, it was found that beneficiaries were not incurring any OOPE on diagnostics while availing the public health services.

- Many Blood banks are functioning without License which is an area of concern.
- 108 and 102 Ambulance services are working well with sufficient utilization.
- The Comprehensive Bio –Medical Equipment Maintenance Programme need to initiated across state up to District and below facilities level
- AYUSH facilities were found to be co-located and functional at District Hospitals. The average AYUSH OPD is about 150-200 patients per day. AYUSH doctors also informed that they are taking part in different health programs but they have not received any training since last one year. There is acute shortage of AYUSH medicines. Ayurveda and Homeopathic medicines were supplied in 2015 after a gap of two years. Unani medicines have been supplied for the first time in 2015

Uttarakhand

- While the state has adequate number of facilities given the population norm; it still needs more facilities with respect to 'time to care approach'. The general up keep of the health facilities is good.
- There is significant increase in service utilization in terms of outpatient, inpatient and surgeries over the last three years. The regional and district hospital are overburdened, while service utilization at CHC, PHC and sub-center varied from facility to facility. The dependence on public health institutions is higher as there are no significant private health services available.
- State has put a revised drug policy in 2015 which mentions the provision of generic drugs for free. However, shortages/stock outs of essential commodities was seen across many of the facilities leading to out of pocket expenditure. State has about 575 drugs in its EDL and these are made according to the level of facility. However, at most health facilities the EDL was not displayed and no mechanism for prescription audit is in place.

- For procurement the state is using e-procurement mechanism through state e-tender portal. State has mechanisms to test quality of drugs. Currently diagnostic services are provided with minimum user charges to the APL category of patients while the BPL patients are provided these services for free of cost.
- The state does meet the requirement of having a blood bank in each district. Out of total functional blood banks, only 4 blood banks are 24X7 (Doon Hospital Dehradun, Base Hospital Srinagar, Base Hospital Haldwani, Sushila Tiwari Govt. Hospital Haldwani); other blood banks work only for 16 hours (two shifts) and during night, if required, service is provided on call. None of the blood storage centres are functional 24X7. User fee is charged by the blood bank except for Pregnancies and sick infants (JSSK), thalassaemia, haemophilia and BPL.
- A large number of equipment's were found to be dysfunctional. Biomedical Equipment Mapping and segregation of usable/non-usable equipment at facilities has been completed. Based on this report, the State is preparing to issue an RFP by mid November 2015. Modus operandi for unused equipment and maintenance of all bio medical equipment yet to be worked out.
- Many hospitals at district/sub district level have AYUSH services co-located. However, there is variability in infrastructure for AYUSH services. For instance, Doon hospital 9th common review mission | report 2015 54 has got a very good AYUSH infrastructure (even attracting many VIPs for treatment) but in Kalsi CHC, a security watchman's cubicle is allotted for one Ayurveda and another Homeopathy doctor.
- The patient load in all AYUSH sections visited was low because the alternative system has not become popular and wherever AYUSH services are initiated, the full complement of physician, drugs and therapies are not available.
- Fitting of GPS in vehicles is underway and already most of the vehicles are covered. State has one centralized call centre. 108 ambulances are performing well in the state with an addition of providing referral services under school health programs and Khusiyon Ki Sawari. MMUs are operating in the state in partnership with NGOs.

- The State of Uttarakhand entered into partnership with GVK-EMRI for 108 Ambulance and Emergency services and with Rajbhara Medicare Private Limited for managing the health facilities (Community Health Centres and Urban Primary Health Centers).

Odisha

- Out of 8429 Health facilities 600 (7.1%) are functioning as Delivery Points. Out of 64 FRUs (CHCs and other FRUs excluding DHs) only 33 FRUs are conducting C-section. Improvements are observed, but in practice service delivery did not match the designation of the facility.
- There is an increase in IPD by 186% from 2008-09 to 2014-15 and OPD by 247% from 2008-09 to 2014-15. Nirmaya scheme, an initiative to provide free medicine to the people by the Odisha Government, increased the utilization of services at district and sub district level.
- Nirmaya Scheme is an initiative to provide free medicines to all by Odisha government. E-Aushadhi is only fully functional till district level.
- Benefit of free diagnostic services not extended to all categories of beneficiaries accessing public health facilities. Diagnostics under JSSK are free however, OOPE have been reported on account of lack of USG services in public facilities.
- Free drug services have been launched by the Chief Minister for health facilities in State upto SDH level since April 2015.150 drug distribution stores have been functional against 725 sanctioned in State.
- 108 and 102 are functional but have remained underutilized due to inadequate awareness amongst beneficiaries about these services.
- Blood services need to be improved. 52 BBs have a valid license and 36 out of 43 sanctioned BSUs are currently functional.
- State has several PPP initiatives; for e.g. sub centre in tribal areas with support from NGOs to provide primary services, ASHA Griha etc. and state has lined up external evaluations for those completed few years.
- Utilization of AYUSH services has been innovatively built into the existing system where in AYUSH doctors are involved in ANC, delivery, child care, capacity building of ASHAs, and sector level meetings, epidemic management, etc.

- Functional Maternity Waiting Rooms (MAA Gruha) were found. Pregnant Women were found to be motivated by ASHAs to stay in MAA Gruha especially from hard to reach areas.
- Quality of ANC care needs to be improved as only HB estimation and weight was taken up in an ANC check-up at field level.
- Mixed scenario was found in terms of administering zero/birth dose of Hepatitis B and OPV and Vitamin K injection as few facilities were found to be given while few facilities staff was not adhering to the protocol.
- Good practices in terms of community growth chart being plotted and maintained at the Anganwadi center, properly documented VHND micro-plans for every ASHA, ANM and AWW were observed.
- NRCs (Nutrition Rehabilitation Center) was providing wage loss payments to the mothers/care-givers as per the GoI guidelines. However, wage loss payments was being given at time of 2nd Follow – up which appears to be an effective local solution to promote mothers to stay till recovery and attend at-least 2 follow ups. There is need for strengthening the referral linkage between the facility (NRCs & NBSUs) and community.
- Fixed day FP services are provided on Monday but family planning services are largely focused on terminal methods. The scheme of Home Delivery of Contraceptives by ASHAs has taken off well however, IUCD and PPIUCD services are offered only at facilities above PCH level.
- State has separated the VHND from the Immunization Day. This de-linking has shown effective delivery of services. Odisha is the only state to initiate 'WIFS junior' – Weekly IFA tablets to primary school children.

Rajasthan

- The number of facilities providing Level 2 and Level 3 delivery care were less as per the population norm. Further, state has a shortfall for 50 L facilities.
- Due to referral of pregnant women, the utilization of services has increased at the district hospitals/medical college. One of the reasons for the referral is the non –availability of adequate Human Resources (Medical officers and Specialists) at peripheral facilities. Very few

functionaries have been trained on SBA, RI, IMNCI and PPIUCD. There is no adequate training provided for skill upgradation of both regular and contractual staff.

- State has a free drug initiative in place and it is being implemented satisfactorily. The state reported satisfactory level of availability of drugs and interactions with the beneficiary indicated that free drugs initiative is largely successful.
- Rajasthan Medical Services Corporation is the central procurement agency responsible for procurement of generic medicines, surgical and diagnostic equipment for all healthcare institutions of the State. Local purchase was made for those medicines which were not available through the central purchase.
- Inventory management is being done through the e-Aushadhi and efficient use of this application was observed in the state for generating on-line demand, on-line purchase order generation, stock ledgers, expiry drug details, transfer of drugs from one District Drug Warehouse to another District Drug Warehouses.
- State has mechanisms to test quality of drugs.
- State has launched the scheme of free essential diagnostic tests in government hospitals across the state called Mukhyamantri Nishulk Janch Yojna (MNJY). Under the scheme, patients can undergo 57 free diagnostic tests at government hospitals linked to medical colleges.
- As on December 2015, out of total 85 Blood Storage centre (71 licensed + 14 applied) 57 were functional. At present, 107 Blood Storage centres are licensed and 87 are functional. Despite this improvement, a large number of designated FRUs still don't have a functional Blood Storage Unit. Non availability of trained staff and dysfunctional equipment hamper service delivery severely.
- E-Upkaran, a comprehensive software to improve the inventory management and maintenance services of equipment in hospitals is in place. This covers all the 2,500 facilities of Rajasthan, including medical colleges and hospitals across all districts. Mapping has been completed in the state.
- The state has 1013 sanctioned AYUSH co-located facilities. Reported average OPD of AYUSH for the year 2014-15 was 1660 per PHC/CHC. AYUSH Medical officers are also engaged in RBSK, vaccination, pulse polio, Family planning, RNTCP and vector born

disease prevention activities and conducting institutional deliveries, supportive supervision and health education. Procurement of AYUSH medicines is not streamlined and it was observed that (in the facilities visited), there hasn't been any AYUSH supply from last 3 years. In absence of the AYUSH medicines, these doctors provide OPD services using allopathic medicines.

- The ambulances are equipped according to guidelines. 104 ambulances are being managed at district level and at facility level. It is mostly utilized for drop back. 9th common review mission | report 2015 52 services. It was found that women and communities were mostly utilizing private vehicles to reach to the facilities for which they were being reimbursed.
- All districts of Rajasthan are equipped with Mobile Medical Units and Mobile Medical Vans providing a range of services including immunization, ANC services and screening for malaria, leprosy and blindness. In addition to difficult to reach villages, PHCs without MOs and SCs without ANMs are also targeted. State has implemented centralized GPS Monitoring for all the MMUs/MMVs in the State.
- Ambulance services except Janani express are being managed under Public Private Partnership Mode. The State entered in partnership with GVK for 108 ambulance services.
- State has constituted 64 Mobile Health teams of RBSK at Zonal Headquarters by utilizing the existing staff. Field level implementation is planned and mapping of schools and AWC is in process.
- IEC material was not displayed sufficiently in focal points.
- Lack of role clarity in ASHA support structures

RMNCH+A

Objectives

- To assess the planning of RMNCH+A, alignment with RMNCH+A 5x5 Matrix based upon gap analysis and prioritization for continuum of care based upon utilization and delivery points.
- To review delivery and quality of PPIUD services, JSY & JSSK entitlements, establishment and functioning of SNCUs, NBSUs,

NBCCs, NRCs, RBSK screening, immunization, Alternate Vaccine Delivery arrangements, Maternal and Child Death Review, organization of AFHS .

- To oversee community level care arrangements for Home based new born care, safe delivery at home through SBA, advance distribution of Misoprostol, Iron Supplementations, Adolescent Health Days, Peer Educator and AH counseling etc.
- To review the preparedness for implementation of Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

Bihar

- Number of functional delivery points and FRUs was insufficient. In Madhubani, out of 7 designated FRUs only DH was fully functional. SDH, Jhajarpur was functional as FRU but currently BSU is non-functional since 6months because of staff being on long leave.
- Labor rooms at DH and SDH were as per guidelines but at peripheral facilities like BPHC, CHC, and MCH center, poor maintenance and lack of basic hygiene was found. Shortage of beds in the maternity ward led to sharing of beds when case load is high.
- ANC services need to be strengthened in a big way. Tests for Hb, Blood Sugar, urine are neither available nor ANMs were skilled to perform these tests. IFA tablets and Nischay kits were not available since many months.
- Irrational use of drugs such as Misoprostol and Oxytocin to induce labour was noted at facilities,
- Shortage of Oral pills, condoms, emergency pills and Nischay pregnancy testing kits was reported as these have not been available since 4 to 6 months.
- Female sterilization are conducted at all health facilities either through camp, daily operation or as a fixed day service. About 10% of women delivering at DH received PPIUD. Several ANMs posted in labour rooms were not trained to insert IUDs while in few facilities PPIUCD services were not provided despite the presence of trained service provider.
- A large number of doctors were trained in first trimester MTP through an IPAS supported programme but Medical and surgical abortion have been combined in a nonstandard way. Medical abortion was not available in both the district.

- SNCUs have been established in 18 out of 36 District Hospitals. Sub optimal utilization of equipment at SNCU at Madhubani DH was noted. Phototherapy units in SNCUs/NBSUs are not being used. Quality of reporting at these facilities also needs to be reviewed.
- State has reported 496 functional NBCCs at Delivery Points, yet many more delivery points need to be covered.
- Issues of absence of HBNC kits with ASHAs and irregular supply of equipment/drugs was seen. The supervisory and handholding support by ASHA facilitators was found to be very weak.
- NRCs are run on a PPP model throughout the State. NGO/Agencies have been provided ward, kitchen and office space and a budget provision Rs 3,60,000 of which fifty percent is paid upfront and balance payment is based on admissions. NRC Model appears encouraging but its effectiveness depends on close monitoring and needs to be evaluated.
- JSY payments were done before discharge through account payee cheque but due to lack of funds, payments have not been done since July'2014. OOP on transport was common as obstetric and pediatric staff was found to be unaware about their responsibility in arranging transport.
- Huge mismatch in demand and supply of vaccines led to shortage of measles vaccine was observed at almost all facility levels. VHND Sessions were being organized in very cramped spaces, due lists were available only at some places with ASHAs.
- Maternal Death and child death review are not being conducted in both districts. RBSK scheme is yet to be launched in the state. State is planning to constitute 1068 teams in 534 blocks and DEIC have been planned at nine Divisional Head Quarters. State has 123 operational AFHC clinics but menstrual hygiene scheme and WIFS are non-existent.
- Weak follow up & data of IUCD expulsion not captured. PPIUCD training even though has been completed, 30% of them are trained but still unable to utilize the technique.
- Blue IFA tablets under WIFS program has never been procured at the state as yet. Bihar Medical Service and Infrastructure Corporation (BMSIC) are responsible for the procurement of all the drugs at the state. It was given to understand that by December 2016 the procedure of procurement of IFA tablet at the state will be completed.
- District has integrated the six services like Family Planning, ANC, PNC, Immunization, Nutrition and Counseling with VHND. ANM, ASHA and

Helper are supposed to provide services: BP & Hb. estimation, Urine albumin, vaccination, issue of MCP Cards & Safe motherhood booklet, FP spacing methods, general drugs etc.

- High rate of home delivery: There has been an increase of 4% points in full immunization coverage of the state (65.6% in AHS 11-12 to 69.9% in AHS 12-13). IFA was not given due to non-availability. OOPE informed on transportation, diet by the beneficiaries during the sequence of their delivery at health institution.
- Routine lab tests and USG are currently being done in private facilities and the community felt that if that these facilities are made available at no cost, this would ensure more mothers to come to the facility
- Most JSSK benefits are not being provided to mothers and they are incurring OOP.

Jharkhand

- Facility based family planning services like female sterilization, interval IUCD and PPIUCD services were provided mainly through district hospitals and very few CHCs.

- Spacing methods like the CC, OCP and ECs were mainly distributed by the Sahiyas (ASHAs). Spacing methods like condom and OCPs were not adequately available across all the facilities. Pregnancy testing kits (Nichchay kits) were available at all facilities including the VHND sites.

- AFHCs in both the districts were available at the district hospital and CHCs. It was observed that the clinics at the DH were functioning well as compared to the clinics at the CHCs. The footfalls at the clinics in the health facilities visited were below satisfactory. No proper records and registers on service delivery at the AFHC were maintained at the clinic.

- Coverage under the WIFS program is 21% of the target population. Average in school coverage is 24% and out of school coverage is 18% of the total beneficiaries. Last procurement of IFA tablets was done in May 2015. Emergency response system is in place. 100% reporting isn't in place due to lack of support from the education and WCD department.

- Most of the Staff (ANM and SN) conducting deliveries were trained in SBA and NSSK and have the knowledge and skill in different procedures.

- Some issues related to quality of service were observed e.g., properly filling up of the partogram, infection prevention and disinfection practices by the providers. Partogram was not done for all the cases and in many cases it was not done properly.

- Basic lab investigations for ANC were available at DH and CHC level, however the laboratory services were not available at the below CHC level facilities.

- Post-partum stay at hospitals ranges from 24 hours to 48 hrs depending on the case load and the bed availability in that particular facility. The post-partum and the ante natal mothers stay together in the maternity ward. The necessary laboratory investigations and drugs are provided to the mothers free of cost.

- Free entitlements under JSSK were being provided to the pregnant women and sick infants in both the districts visited. Free entitlements under JSSK was largely being free drugs, diagnostics, diet during delivery and home to facility transport, provided to the mothers.

- Janani Suraksha Yojana (JSY) payments being made timely through DBT in the health facilities visited.

- The maternal death reviews are done by the field staff through verbal autopsy, however its review is not held at the district level by the district level committee. The reporting and review of maternal death reviews need to be strengthened

- Blood Bank/BSU was not available at few DH

- No SNCU has been established in many districts. It was learnt that complicated cases from CHCs and PHCs are referred to the DH hospital. At DH, no SNCU or NBSU is available and the referred cases are managed in the general ward.

- NRCs are established within the hospital, adjacent to the patient wards. The NRCs are managed by the ANMs, who are trained in cooking, food preparation and counselling the mothers on diet. Proper diet was given to mother and children admitted in the MTC.

- In RBSK, the services for identification and referral of cases (0-18yrs) for 4 D's were not properly in place in the state. In both the districts visited, DEICs were not established. There is an urgent need to establish the DEICs for management of the referred children having 4 D's.

- Cold chain and alternate vaccine delivery system are established and maintained effectively. Cold chain equipment's such as ILR, deep freezer etc. were well maintained with functional temperature charts and updated records. There is a effective system in place for storage and transport of vaccines from the regional vaccine store to district vaccine store to ILR points to session sites.

- Birth doses of OPV and Hep-B are being given to neonates before their discharge, BCG is mostly given DH and high case load CHCs to avoid wastage of vaccine.

- Due list is being maintained by ASHAs and ANMs to track pregnant women for ANC and for immunization at VHNDs. ASHAs mobilizes the beneficiaries to the VHND sites. Incentives for ASHAs for full immunization were found to be up-to date. It was observed that ANMs had good knowledge and skill on immunization. Moreover, 4 key messages were given to all the mothers after immunization.

- It was found that none of MCP cards had mention of findings from antenatal and postnatal examination

Madhya Pradesh

- Inadequate knowledge and skill of staff nurses in IUCD insertion, limited follow up and counselling done, with beneficiaries reporting side effects, acute shortage of HR trained in Non-Scalpel Vasectomy and LTT.

- The average client load of the AFHCs in visited district was found to be satisfactory. AH counsellors at the AFHC were providing counselling services to the visiting adolescent clients. However, few of the counsellors at AFHCs were not trained to provide counselling services.

- State reported 100% coverage of schools and AWCs under WIFS program in FY 2015-16. State reported 53% coverage of total beneficiaries of which 43% were in school and 29% were reported to be out of school.

ERS is in place. Emergency response team has been formed and trained at the block level in all the districts.

- For planning the facilities, maternal health norm for delivery points has been taken but its operationalization is not improving due to lack of adequate Human Resources.
- Maternal death review is limited to clinical cause and systemic gaps are not being identified.
- Well functional SNCUs, NBCC and NRCs are available but bed occupancy rate varies from low to over crowding
- Child death review has been done for few cases (only SNCU deaths),this is not systematically as per guidelines and findings are limited to clinical causes.
- The RBSK teams are incomplete and needs strengthening.
- Mahila Swasthay Shivir (MSS) is functional but it is a duplication with NCD intiaitve and PMSMA.
- In both the visited districts, due lists were not available at most of the VHND sites visited. Mobilization of the beneficiaries at the VHND site was found to be weak.
- Involvement of ANMs for making micro-plans was sub-optimal, village wise RCH registers are yet to be used and active verification for missed out and left out cases is not being done. It was felt that the ANMs needs to be trained in identification, management & reporting of AEFI.
- full immunization coverage has shown significant decline in few district from 68.6% in 2012-13 (AHS 2012-13) to 49.4% in 2015-16 (NFHS 4)

Uttar Pradesh

- Home Delivery of Contraceptives was well implemented in the district. ASHA supplied with OCP, ECP, condoms and pregnancy testing kits.
- Interval IUCD service uptake is very poor in the district. Counselling over family planning method found to be poor during ANC and PNC periods.

Availability of FP commodities sufficient at all level of facilities. ANM/SN demonstrated skills in insertion of IUCD at all facility.

- The AFHCs are functional at the level of DH and CHCs. There is a dedicated AH counsellor posted at the AFHCs in the DH. The client registration record showed that most of the adolescents visiting the AFHC are married. The service delivery register at the clinic showed that most of the adolescent visited the clinic with complaints related to skin and learning problems.

- The state reported 16% total coverage of beneficiaries of which 22% was in school and 12 % were out of school. Procurement of IFA tablets is done at the district level according to rate contract.

- State has MHS program under state budget in the name of "Kishori Suraksha Yojana". Where in free distribution of sanitary napkins are being done in schools for adolescent girls in 50 districts.

- MCP cards not completely filled, it mainly focuses on key things like BP, Hb, TT, Weight, and IFA. Identification of High risk pregnancies is very low, Line listing of high risk pregnant not maintained. The record maintenance quality is poor at the level of facility or with ANM at Firozabad.

- District data reveal that 68% of the deliveries are conducted at institutional level and 32% are home delivery. Most of the home deliveries go unattended as district doesn't have any specific strategy for it.

- Payments under JSY are happening through Direct Benefit Transfer (DBT). There is delay in the payment as some of the beneficiaries still do not have bank account.

- The utilization of transport services was more in the rural areas and where ASHAs are active. Majority of the normal deliveries have stayed less than 24 hours regardless of being proper counseling by the health staff and provision of JSSK services.

- Comprehensive abortion Care provided at District hospital, Both MVA & EVA methods used for abortion. Firozabad reported good number (2050) of spontaneous abortions while only 303 reported from Gonda.

- 88 Maternal deaths (25% of target) have been reported from April to October 16. The major reasons for the deaths reported are Hemorrhage (49%) and Sepsis (15%). The district has a mechanism for MDR. 78/88 deaths have been reviewed in the district, 6 deaths reviewed by District Magistrate.

- Home Based New Born Care kit available with all ASHA met. Their knowledge regarding the danger signs identification in new-born and mothers was good.

- National Iron Plus Initiative is not implemented in the districts, Iron Syrup not available with ASHA/beneficiaries, 6-10 age group is missed out in the program.

- No referrals from Field level (ANM/ASHA/AWW), SAM cases identified in the OPD of District Hospitals are only admitted in the NRC. Admission criteria not followed in many cases as NRC meant for sick SAM children. Basic equipment not in place (weighing Machine). Low cure rate, investigation and clinical supervision followed after admission for sick children

- RBSK initiated in both the districts. Screening at School and AWC is going on. Most of the RBSK teams are not complete. The district does not have DEICs. Around 47% schools and AWC have been visited by RBSK teams and 27% children have been screened against target till October 2016.

- Micro plan for immunization needs to be updated and should also incorporate plan to cover the sub-centers with no ANMs in place.

- EVIN is being extensively used and there is no mismatch in stock reported.

- Cold chain is maintained at all the levels and all vaccines were found to be available at cold chain points with functional temperature charts.

- Though birth dose vaccination is being given every day, there is no SOPs to ensure every child is vaccinated before discharge as the vaccination is at fix time once a day whereas post natal stay is only for about 6 hours

Chhattisgarh

- There are 75 designated FRUs in the state, of which 48 are providing C-section facilities. The number of functional FRUs has increased from 28 (2014-15) to 48 (2015-16).
- Line listing and tracking of severely anemic mothers is not followed in Balrampur. HIV, VDRL, HBsAg, CBC, RPR, PVC tests are not being done during ANCs in the District.
- 7 Private Hospitals have been accredited for JSY Services in Rajnandgaon. Their contribution has been 790 Institutional Deliveries out of a total of 10037 in the district till September 2015.
- Utilization of 102 Mahtari Express for the transportation of Sick New-borns is still suboptimal in the state.
- Trained providers are conducting PPIUCD insertions in the state but the number is considerably lower than the number of deliveries reported. 9th common review mission | report 2015 69
- Most of the ANMs in both the districts were trained in IUCD insertion and performing the procedures in peripheral facilities as well. However records of follow-up & cases of removal are not maintained.
- Condoms and OCPs are available with Mitanins and they possessed adequate knowledge of modern contraceptives &Pregnancy Testing Kits. However emergency contraceptive pills were not available in most of the facilities. Laparoscopy, Tubectomy, NSV not being performed in district.
- Huge shortage of FBNC services throughout State. There are 16 Sick New Born Care Units (SNCUs) sanctioned in the state, of which 13 are functional. Essential medicines such as Syrup Salbutamol, Nebulizer, and Pulse Oxymeter were not available in few facilities
- AFHCs were not functional in the visited districts. No information was available about the client load as no records are maintained by the counsellor.
- Operationalization of the existing AFHC to be done as per RKSK guidelines. Under WIFS program, IFA tablets were available in schools and AWCs visited in both the districts. Students and teachers were aware of the benefits of consuming IFA tablets.

Madhya Pradesh

- In both districts the institutional delivery rate has increased significantly, however, Caesarean-section facilities with blood bank (CEmONC) were available only at District Hospital.
- There is perceptible improvement in quality of Antenatal Care (ANC) services being provided at all levels from sub-center upwards upto district hospital.
- Provision of Anemia Management Card with details of doses of Iron Sucrose introduced by States was found to be used in across all facilities. The consumption of IF A was found to be good.
- ASHAs were accompanying the pregnant women for delivery in many cases and many mothers had used Janani Express for coming to the facility, but there is need for improving transport facility (home to institutional) by Janani Express.
- In both district, JSY payments were made within the stipulated time of discharge through direct bank transfers.
- PPIUCD has gained momentum as the main method of spacing and gradually replacing Interval IUCD services. Mechanism of follow up after PPIUCD is to be streamlined in both districts visited.
- NSV rate has shown a very sharp decline in last three years. Strategy to increase male involvement in FP services is to be developed.
- Comprehensive Abortion Care services (CAC) are being provided only at district hospital level in both districts.
- Both districts had well-functioning SNCUs at respective District Hospital and reporting online.
- Cure rate from NRCs remains comparatively low at around 50-60 percent. Vitamin K prophylaxis at birth was being provided at all facilities visited in both the districts with some exceptions due to unavailability.
- The utilization of services in the AFHCs that were visited was low, especially where there is no female counsellor. Adolescent Helpline and career counselling centre is functional in Bhopal and offers counselling facilities on the telephone and in person.
- All govt. and govt. aided schools and AWCs are covered under WIFS. No stock outs have been reported in the last 3 months.
- MHS is currently implemented in 8 districts and 19.2 lakh sanitary napkins have been provided through social marketing to adolescent girls.

Production and supply of sanitary napkins by self-help group, at Jamgod (Dewas), is a good initiative that can be scaled up across the districts and state in a phased manner.

Odisha

- In general, awareness on the RMNCH+A 5x5 matrix among the health care providers at facilities and Block Programme staff was good. IEC material on RMNCH+A was prominently displayed including list of essential drugs in most of the facilities visited.
- Basic lab investigations for ANC were not being done at PHC level. Some PHCs were found to prescribe the investigation and these were done from private facilities leading to increased OOPE.
- No line listing of severely anaemic women and identification of high-risk pregnancies being done at SHC/PHCs.
- Prescription audits were done at the DH and few CHCs and it was seen that third generation antibiotics were routinely used post delivery.
- IV Iron Sucrose for severely anaemic mothers was not available in most of the FRU visited.
- Out-of-pocket expenses reported by beneficiaries on diagnostics including USG and transportation.
- Maternal Death Review committee is functional and regular meeting minutes were recorded. However, infant and child death review committee are not functional and no review is taking place.
- Fixed day family planning services and PPIUCD services were provided through district hospitals and very few CHCs, with fairly good quality of care.
- Pregnancy testing kits (Nichchay kits) are available at all facilities except in few sub centres. Emergency contraceptive pills were not available at most of the facility and also the knowledge of EC was poor among the staff.
- Although FBNC services are commendable at all levels, rampant use of Anti-biotic was noticed
- Under RBSK the record keeping was found to be good in the schools visited. However, absence of tertiary linkages and referral facilities leave outcome to be desired.

- WIFS program was implemented in schools and for out-of-school girls. In Nabrangpur district, stock of IFA tablets was seen at the school but on interaction, many girls reported that they never consumed the tablets.
- Peer education programme is in the nascent stage and no program activity was observed at the field level.

Uttarakhand

- Poor display and low Awareness on RMNCH+A 5x5 matrix was evident among the service providers and programme management staff in both Dehradun and Nainital which are non-High Priority Districts.
- Shortages / stock outs of RMNCH+A essential commodities such as IFA, Mg So4, Vitamin A, Pregnancy testing kits, Condoms, Medical Methods of Abortion drugs (MMA drugs), RTI /STI colour-coded syndrome drug kits, etc. were seen in many of the facilities visited in both the districts.
- Privacy in labour rooms was compromised in Nainital district and the facilities reported poor supply of essential commodities listed in 5X5 Matrix. Sub-centre Palio in Dehradun which is conducting >10 deliveries a month had no running water supply and no pits for disposal of biomedical waste.
- Delivery records as well as immunization records were missing in most of the facilities visited as no ANMs were posted at facilities.
- Safe motherhood booklet was not available at facilities and thus was not given to pregnant women at the time of registration.
- In Nainital District Women Hospital, high OOPE was reported by outdoor ANC cases on account of purchase of certain drugs, which were unavailable in the hospital.
- Partographs were not routinely maintained in the facilities visited, post-delivery stay at institution was frequently noted to be less than 48 hours.
- Though villages reporting high number of home deliveries have been identified, their plan for advance distribution of Misoprostol was not in place in both the districts. RMNCH+A counsellors were in place at the CHCs and higher centres in the facilities visited.
- Quality Assurance Committee for family planning at district level was found to be weaker on their role.
- Readymade milk substitutes (Lactogen) was purchased after being prescribed for all C-section cases.

- Oral Rehydration Salt and Zinc tablets were available in both the districts for the management of diarrhoea, but prescribing ORS& Zinc was not in practice.
- Alternative vaccine delivery is not operational in hilly terrain and remote areas eg. Chakrata and Kalsi blocks and also in some of the areas under Sehaspur block.
- WIFS programme is not being properly implemented in both districts. It was observed that there was no supply of blue IFA tablets at the schools and AWCs visited. Poor awareness of the WIFS program was observed among the functionaries.
- Menstrual Hygiene scheme is not operational in the districts visited.
- Peer education programme is in the nascent stage and selection of peer educators has been initiated.

Rajasthan

- Designated First Referral Units (FRUs) were found to be non functional as per norms due to unavailability of required trained HR and blood storage units in both districts.
- About 400 essential medicines are supplied by the Rajasthan Medical Services Corporation (RMSC) in all public health facilities. It has assured adequate and timely supply of generic medicines.
- Functional newborn corners are available in all delivery points; however, they were under-utilized
- State has constituted 64 Mobile Health teams of RBSK at Zonal Headquarters by utilizing the existing staff. Field level implementation is planned and mapping of schools and AWC is in process.
- Adolescent friendly health clinics are functional with dedicated counsellors. WIFS and School Health Program have been rolled out with good coverage. No demand of sanitary napkin from community was reported because of poor quality, though they are available at the warehouse.
- All PHCs and CHCs are providing fixed day services for sterilization., PPIUCD services are mostly limited to the district hospital because of availability of trained manpower
- Facility level MDR review has been operationalized but community level MDR is yet to be operationalized.

- Adequate number of VHNDs/vaccination sessions are being planned throughout the two districts. Microplan for immunization of drop-outs and missing children from unreached areas were available.
- The first trimester registration for ANC is low in Dholpur district when compared to state average. District hospitals are taking maximum load for delivery services. There is only one functional CEMONC centre in each of the two districts.
- Some of the essential drugs as per 5*5 matrix were in shortage like Misoprostol, Nifedipine, Mifepristone, Labetalol, RTI/STI drugs etc. Folic acid is available in 5mmg form instead of 400mcg
- To ensure early initiation of breast feeding and immunization of newborn and postnatal counseling of mothers at facilities, Yashodas are deployed in DH and CHC. However, role of these volunteers is still very limited, as seen in Bikaner district.
- Only 1 sonography machine available in each of the districts (at DH) resulting in long waiting period and in many cases the OOP expenses for USG at the private facilities turned out to be high.
- State has established a functional grievance redressal system for JSSK-Rajasthan Sampark, however awareness among community regarding this system was found to be poor in Bikaner district.
- RMNCH+A counsellors are in position at DH & Medical College but their training is yet to be completed. 9th common review mission | report 2015 79
- RBSK has not implemented in Dholpur & Bikaner district; teams formed in previous year dissolved; nodal persons for RBSK (AYUSH doctors) not in position.
- High cases of birth asphyxia reported from DH DHolpur, indicating poor implementation of labour room protocols. It indicates the need for more skilled staff in the labour room and management of high risk cases by Gynaecologist.
- The AFHCs (known as ‘Ujala’ clinics) had a separate room but had low footfalls.
- The ANMs were not trained in RKSK. Launch of helpline for adolescent - 104 as 24X7, and development of the protocols for the helpline is underway.

Human Resource

Guiding Principles/Strategies of the NHM

- NHM shall focus on creating/strengthening institutions for building capacity at state and sub-state and regional levels. States will be supported to develop strong HR Management systems with improved practices for decentralized recruitment, fair and transparent systems of postings, timely promotions, financial and non-financial incentives for performance and service in underserved areas, measures to reduce professional isolation by provisioning access to continuing medical education and skill up gradation programs, provide career opportunities for frontline workers, and utilize the enormous flexibility available under the Mission
- NHM will support development of a course for B.Sc in Community Health for mid-level clinical care provider
- Nurses will serve as the backbone of clinical facilities and NHM will support the expansion of their role as clinical care providers

Since its inception a decade ago, the NHM has made a significant contribution towards addressing the shortage of the health workforce in the public health system. It has also helped to strengthen administration and management of the health system through the provision of programme management units at state, district and block levels. An estimated two lakh additional medical, nursing and para-medical personnel have been added on a contractual basis through the NHM. This has helped to address shortages in some areas, but significant gaps remain in others, e.g. a lack of specialists (84% vacancies) in secondary public health facilities observed in Bihar.

Strengthening the human resource element of public health systems requires a focus not only on the quantity, but also on the quality and competence of the employed functionaries. Initiatives such as the empanelment of external HR agencies to support States with large scale recruitments will help address the quantity gap whereas the introduction of competency based skill tests will help to ensure that the competence of the inducted health professionals is of a standard to ensure high quality health service delivery through our public health facilities. Bihar has already included skill based competency assessment as part of recruitment of skill care providers while Madhya

Pradesh and Uttar Pradesh are using Competency assessment tests for identifying skill gaps of the existing staff

Bihar

Availability of HR

- State has appointed AYUSH doctors at 1384 Additional PHCs under mainstreaming of AYUSH who also provide primary health care at facilities in absence of allopathic doctors.
- As a retention strategy, state has reserved 50 % of the PG diploma seats for in-service doctors.
- Despite of shortage of Psychiatrists, the state has been able to run Mental Health Programme through roping in Psychiatrists from Medical colleges and other places in districts.
- There is huge shortage of Specialists - 84% of regular posts and all contractual posts of Specialists (Gynecologists, Pediatricians, Anesthetists) are lying vacant in the state.
- Unavailability of Human Resources has become major hurdle in implementation of various programmes in state. All posts of Epidemiologist, State/District Programme Coordinator are vacant under NPDCDCS in state. NPHCE (Elderly care), NTCP (Tobacco control), IDSP and RNTCP also facing similar shortages in programme specific HR.
- State has been unable to fill all approved posts of RMNCHA counselors and therefore as an interim measure, ANMs are being trained in Family Planning counseling for providing counseling.
- Although the state has upgraded various medical colleges and increased MBBS and PG seats, but still the generation capacity is far from the required.
- In spite of the efforts to increase the seats in medical and paramedical courses the number of seats and availability of quality trained HR remains a problem for Bihar especially for Specialists, MBBS doctors,

staff nurses and ANMs. The doctor-population ratio in the state is 1:3500 compared to the national average of 1:1700

- To strengthen the pre- service education of the nursing midwifery cadre the state has established a State Nodal Centre (SNC) at IGIMS, Patna. This will support to increase the quality of educational and clinical processes & practices at the 21 ANMTCs and 7 GNM schools of Bihar.
- The state has also made efforts to develop the nursing cadre. A separate nursing cell and directorate is being established to ensure focused leadership and regulation for better development of nursing midwifery cadre
- The Human Resource Information System (HRIS) in the state is utilized for quantifying human resource at all levels, postings and deployment and vacancy identification.
- State has taken steps to ensure rational deployment of specialist and multi-skilled MOs at functional facilities. Officials from regular cadre are being selected on deputation to hold critical management posts.
- Differential remuneration based on geographical distribution, difficult and high focus areas have been implemented.
- Performance appraisal system has been put in place for NHM staff. However, its purpose seems to be only punitive with no rewards and benefits to better performing functionaries leading to lack of motivation.

Training & Capacity Building

- ANMTCs were found lacking in basic amenities such as bedding, ventilation and food facility. Overcrowded hostel with compromised and unhygienic living conditions were leading to skin ailments among the residents.
- Doctors trained in CEmOC and LSAS are posted in non-FRUs which has been leading to non-utilization of skills imparted.
- There is felt need for training Service Delivery staff on waste management, infection control protocols, etc.

Workforce Management

- Competency based skill assessment tests are used for recruitment of skill care providers but the same is not yet used for skill gap assessment of in-service staff for deciding on corrective trainings.
- Services of LTs were seen integrated across programmes beyond the programme under which they were hired. LTs under RNTCP were seen doing routine tests other than the tests under RNTCP.
- Web based HRIS is in place for informing decision-makers for HR planning, training need assessment, postings and transfers in the state. However, HRIS is not yet integrated with TMIS in state.
- Decentralized recruitment of MOs and SNs through weekly-held walk-in interviews is discontinued in some districts owing to limited capacity of district health administration for handling extra administrative burden. Recruitments conducted at state level are time-consuming because of delayed roster clearance exercise at district level.
- District Health Officials don't have authority to depute staff within the district based on needs. This is resulting in various specialists irrationally placed at higher care centers rendering them non-functional.
- There is no performance assessment mechanism followed in state.

Jharkhand

Availability of HR

- Significant vacancies of regular and contractual staff including technical and nontechnical staff exist in the state.
- Shortage of MOs is affecting the functionality of PHCs in the state,, leading to high patient load at the FRUs/CHCs.
- The absence of regular recruitment procedures for MPW (Male) has resulted in a scarcity of these functionaries in the state. The numbers of LHV posts are also limited.
- The recent appointment of MPWs have improved the healthcare services uptake especially communicable diseases

- There are long standing vacancies of regular and contractual staff which have led to improper management and thus underutilization of health services.
- Deployment of the staff for optimizing healthcare delivery is another challenge
- Due to shortage of HR the doctors serve 2-3 institutions in a week hence due to non-availability of doctors, patients are often turned down

Training and Capacity Building

- Sahiyas are being regularly trained on various modules, but for other cadres all capacity building programmes are lagging behind except Kayakalp Training.
- The skill labs are in the process of being established.
- Newly appointed health care personnel do not undergo any induction training which would orient them towards national health programs

Workforce Management

- The state has to formulate an HR policy backed by a robust HRMIS to effectively manage Human Resources for health
- There is no transparent system of postings and transfers.
- The state has formulated HR norms for recruitment, remuneration, promotions & postings; these have been in place since 2011.
- Performance appraisal system has been developed recently but its application is limited.
- There is no mechanism for performance monitoring and associated disbursement of performance-based incentives.
- An HR Cell is in place for management of contractual workforce in the state. Competency based skill tests of paramedical staff, programme management units, administrative and nursing staff are being conducted for recruitment.

Madhya Pradesh

Availability of HR

- Considerable shortage of doctors in the state - over two-fifth posts of regular doctors and over two-third posts of specialists lying vacant in state.
- State has recently reduced retirement age of ANMs from 65 to 60 years, which has impacted on their availability in public health facilities.

Training and Capacity Building

- Training Centres for MPW have been shut down in the state.

Workforce Management

- HRMIS is established in the state and HR information entries made but the database is not updated for the last 3-4 months.
- Competency assessment tests are being held in the state but there is lack of information if the same is being utilized for taking corrective trainings and for selection of skilled staff.
- The state has defined criteria for posting through its recently introduced transfer policy. The state has also developed a proposal for career progression of NHM staff as well.
- The state has initiated rationalization of Accountants and LTs and their deployment is being carried out across various programmes.
- Further efforts need to be made for the rational deployment and utilization of LSAS and EmOC doctors.
- Performance based incentives to the staff have been helpful in expanding the reach of Maternal and Child health services to distant facilities.
- Performance appraisal system is in place but not being utilized for determining salary increments of the NHM staff.
- Skill based competency assessment tests to be adopted for future recruitment of Nurses and ANMs.
- There is a HR cell at state level to look after HR functions in the state.
- The state has constituted a technical resource group to establish a Public Health cadre in the state.

Uttar Pradesh

Availability of HR

- For postings and transfers of regular staff, the criteria are annual appraisal and seniority. Promotions are displayed on state government website except for ANMs and Group D staff.
- There is a shortage of human resources - Medical Officers, Group D staff hence affecting the quality of services being rendered at health facilities

Training & Capacity Building

- TMIS (Training Management Information System) is being used by state and districts as well.
- Training of contractual staff is regularly being conducted by NHM.
- Trainings/refresher trainings may be planned and conducted regularly

Workforce Management

- Human Resources Information System (HRIS) has been developed and being used effectively
- Contract renewal is subject to skill evaluation where qualifying criteria is 50% and below which contracts are not renewed
- Performance based incentives are being provided to frontline health workers e.g. SBA staff nurse is given Rs.400 per delivery beyond 25 cases per month
- HR policy for contractual staff under NHM is yet to be implemented in the state
- False reporting was observed in many registers being filled by ASHA/ANM/Staff nurse

Chhattisgarh

Availability and Adequacy

- The lengthy processes of recruitment, poor perception of salaries and compromised management environments have been a deterrent to MOs and Specialists towards joining the service.
- To address the shortage of MOs, AYUSH Medical Officers and Rural Medical Assistants (RMA) are deployed at PHCs by the state. The creation and regularization of RMA positions has been very helpful in augmenting human resources for health in the state. However, shortages of skilled care providers especially specialists and general doctors still exists in the state.
- Outsourcing of staff has been put in place and has shown reasonable success evidenced by the recruitment of nearly 440 tribal-reserved posts of nurses and doctors, which were earlier vacant due to the low turnout of tribal candidates. This has specially been the case at the Sick Neonatal Care Units (SNCUs)

Training and Capacity Building

- SIHFW faces acute shortage of staff with 21 of 27 posts lying vacant.
- Lack of adequate mobility support for the District Training Coordinator and concerned staff have resulted in difficulty in undertaking monitoring of trainings.
- No systematic training calendar or database developed in the state.
- Very limited RMNCH+A training has been provided in the last year against the targets set.
- Over 500 Mitanins have been trained in ANM courses through special provisions for Mitanins introduced by the state so far but their deployment in the system needs to be scaled up.
- As the existing gaps in ANM vacancies have been filled, the state is in the process of phasing out ANMTCs and orders have been issued to shut down all 75 Private ANMTCs in the state.

Workforce Management

- The financial and non-financial incentives introduced through the CRMC incentives scheme has been helpful in the improving the retention of health workers, including those of specialists, general

MOs, EmOC and LSAS trained MOs, nurses, ANMs and RMAs in the difficult, most difficult and inaccessible areas as defined by the state.

- Skill based competency assessments have been adopted for the recruitment of doctors, nurses and allied health professionals.
- There is a dedicated HR cell at the state level – this is under the charge of a specific Deputy Director.
- The HRMIS framework has been set up but its functionality is currently limited and it has no linkage to postings and transfers or to training.
- Promotion rules for staff have not been revised for a while and need updating.
- Various clinical/leadership positions such as Block Medical Officers are currently operational on an ad-hoc basis; these need to be regularized.
- The state health department doesn't have any specified policy for recruitment and performance monitoring of professionals working in public health sector.
- Significant vacancies exist for Specialists (82 per cent), Staff Nurses (52 per cent), Lab. Technicians (52 per cent) and LHVs (43 per cent). In the LWE affected Bastar region, 255 out of 277 sanctioned posts of Specialists are lying vacant.
- The Chhattisgarh Rural Medical Corps (CRMC) is an attempt to address the critical gap in human resources in the state by offering a bouquet of incentives as part of rural retention strategies. The scheme aims to increase availability of medical services in difficult and remote, rural areas of the state.
- Currently there is no dedicated staff to coordinate and monitor training programmes under NHM.
- The state is in the process of establishing Skill Labs.

Odisha

Availability and Adequacy

- In spite of initiatives taken by the state such as decentralization of recruitments at the district level, over one-third vacancies exist for Medical Officers and Staff Nurses posts.

- There is also significant shortfall of Gynaecologists, Anaesthetists and Paediatricians in FRUs.
- The State does not have a specialist cadre - Medical Officers and Specialists join services at the same level as Assistant Surgeon. There is irrational postings for specialists leading to their underutilization
- Although there has been an increase in sanctioned posts of human resources, the state still faces shortage of specialists at the District Hospitals.
- In absence of MOs, AYUSH MOs and Pharmacists are managing various PHCs in the state.
- Seat intake in the existing 3 Government Medical Colleges has been increased by over 40 percent in the current year

Training & Capacity Building

- AYUSH MOs have been trained in SBA, NSSK, and Routine Immunization etc. to assist in implementation of National Health Programmes
- State plans to establish training information/archive centre and repository at state and district level as State Training and Education Centre (STEC) and DTEC respectively. Online Training Management Information system (TMIS) has been developed in 2013 and is being utilized for planning of trainings in the state.
- With the support of NHM, the state has launched a web-enabled facility for application to nursing courses in state government nursing institutes with the help of manpower from NHM programme management units.
- In order to encourage students from vulnerable communities to undertake nursing courses, the state offers scholarship facility to candidates from Scheduled Caste and tribal populations.

Workforce Management

- Deployment of the newly appointed staff under NHM is being done at high caseload facilities in remote districts on a priority basis.
- Multiskilling of the LTs have been done and the trained LTs have now been placed at labs offering integrated lab services in various District, Sub-District Hospitals and CHCs.

- Decentralized recruitment procedures, conditional promotions subject to completion of minimum service tenures, hard area allowances and relaxation of maximum eligible age are some of the strategies adopted to increase HR availability in the state particularly at the difficult areas.
- Despite the constitution of a dedicated 'transfers committee' for rationalizing postings of EmOC and LSAS providers, more than half of the trained EmOC and LSAS providers yet to be placed at designated FRUs.
- The proposal for introduction of a Public Health cadre is awaiting cabinet approval.
- State uses a detailed performance assessment system with predefined performance based key deliverables. The system is being further revised.
- Temporary skill stations have been setup at District Hospitals and assessors trained to undertake skill assessment based recruitment of the ANMs and Staff Nurses. In addition, competency assessment of existing ANMs has been completed and those identified with skill gaps provided mentoring support through the trained AYUSH MOs or LHVs.
- The state has recently replaced several absconding doctors with the adhoc appointment of other doctors.

- There are no differential pay structures devised for the Nursing and Paramedical staff working in the notified hard-to-reach areas. But Performance Based Incentives (PBIs) have been started for AYUSH doctors, nursing and paramedical staff, SNCU staff and for the paramedics serving at V3/V4 institutions.
- The State has developed IT based HR-MIS software for the contractual employees working under NHM, which helps in managing the contract terms and salary payments.
- State Institute of Health and Family Welfare (SIHFW) has been designated as a nodal institute for coordination and monitoring of the RCH/NRHM training and communication for development activities in the state. Training Management Information System (TMIS) has also been developed in collaboration with NIHFW and MoHFW.

Rajasthan

Availability and Adequacy

- Significant vacancies of Specialists, Nursing and Paramedical staff– 66 % vacancies of Specialists, 48 % vacancies of pharmacists, 44 %vacancies of LTs, 31 % vacancies of Nurses exist in the state currently. (RHS 2015) There are large number of vacancies (around 38% in Dholpur and 29% in Bikaner) in various posts.
- Even with increased capacity through recruitment of contractual staff under NHM, the state is unable to meet the requirements of health providers, especially in the hilly, tribal and desert areas
- Despite the efforts made by state such as revision in salaries, there is huge shortage of specialists and Staff Nurses with more than half of the regular posts vacant.

Training & Capacity Building

- Adhering to the timelines in the training calendar has been a challenge. There is a need to train more care-providers in SBA, RI, IMNCI and PPIUCD.
- Skill assessment of nursing staff in High Priority Districts has been conducted on a pilot basis and the state intends to link this with the Training Management Information System (TMIS).
- There is no performance assessment/review mechanism for identifying individual training needs and planning need-based training for various functionaries.

Workforce Management

- Hard area allowances and performance-based incentives are provided in the state, but there is limited awareness about this among staff.
- There is no HR Cell in the state. However, nodal officials have been assigned to handle HR functions at state and district level.
- There is no definite policy for transfers and rational deployment of personnel.
- There is no specific Public Health Cadre in the state

Uttarakhand

Availability and Adequacy

- Since the inception of NRHM, sanctioned posts have increased for specialists – maximum for Physicians (44 per cent) and Pediatricians (33 per cent) at CHCs. But the number of in-position Specialists has declined by 38 percent. Maximum vacancies were seen for MOs (MBBS) at 76 per cent and Specialists, in particular for Gynecologists (63 per cent), Anesthetists (65 per cent) and Pediatricians (40 per cent).
- More than half of the sanctioned posts of specialists and doctors are vacant in the state.
- Many of the CHC-FRUs were not functional because of lack of Gynecologists (or EmOC trained MOs) and Anesthetists (or LSAS trained MOs).
- Unequal distribution of LTs was observed across facilities - some had only one LT while others have multiple LTs - each working under different programmes.

Training & Capacity Building

- The state has two functional Regional Training Institutes (Haldwani & Dehradun) and the Institute at Haldwani is being upgraded as a SIHFW.

Workforce Management

- In order to retain doctors in rural areas, the state offers differential salary packages and reservation in PG courses for doctors serving in rural areas.
- The Department has recently setup an HR Cell for workforce management. Implementation of HRMIS in underway in the state and the HR data is being captured in a phase-wise manner.

Community Processes and Convergence

Objectives:

- To review the present status of ASHA program with reference to progress and the quality of training, analysis of ASHA drop-outs, promptness in selecting new ASHA, monthly incentive amounts, payment mechanisms (PFMS and Aadhar linked) and regularity of payments, non-monetary incentives, periodicity of replenishment of Drug Kits, adequacy of equipment kits, quality of home visits and community interaction, with a focus on the marginalized.
- To document the key challenges and constraints faced by the ASHA
- To appraise the progress made under NUHM – with regards to (a) Mapping of vulnerable population; (b) Mapping of slums in target setting for ASHA and MAS and adequacy of targets of ASHA and MAS: (c) Status of ASHA selection and training; (d) Constitution and training of MAS; (e) Level of integration of support mechanisms available under NRHM with NUHM for CP interventions viz- staff, grievance redressal mechanisms, payment process, performance monitoring etc; (f) Assess the challenges faced by the state in implementation of community processes interventions in urban areas.
- To assess the extent of integration and effectiveness of support structures at various levels for VHSNC, ASHA and Community Action for Health (CAH), periodicity of review meetings, mechanism of performance monitoring of ASHA, status and effectiveness of ASHA software for payment or other ICT platforms to improve payments,
- To appraise the constitution/reconstitution and quality of meetings of VHSNC and RKS, and the extent and quality of convergence with PRI, ICDS, Departments of Education, Water & Sanitation and Rural Development. Status of fund flow and utilization of untied funds.
- To analyze the preparedness of ASHA and VHSNC to undertake tasks related to rolling out comprehensive primary health care

Bihar

- State has 91% of ASHAs selected against the target of 93,867 under NRHM, and 66% selection of Urban ASHAs against the target of 391.
- Since last one year, no trainings have been conducted for ASHAs under NRHM. Under NUHM, training of state trainers has been done, but there is a slow pace of mapping of slums seen in urban areas.
- State shows a slow progress in terms of training of ASHAs, 91% ASHAs are trained it Round 1, 78% in Round 2, 65% in Round 3 and only 8 % in Round 4. In last one year, no training have been conducted.
- Training of ASHAs was managed by NGOs at state and district level. At state level, MOUs were signed with four agencies (PHRN, Janani, Caritas India and PFI), out of which PFI opted out in April 2014 and MOUs are not renewed for the other three agencies as well. Payments for all agencies are still pending and needs attention.
- At district level, the state's MoUs with 14 NGOs to serve as district training agency has expired and no new MoU have been signed.
- 98% of ASHAs in state have bank accounts and payment is now done through PFMS.
- State has not implemented routine and recurrent incentives for all components yet. For JSY payments, part of incentive is also linked with IFA consumption during ANC period, but IFA is not available in state for last two years.
- Some of the ASHAs reported getting lump sum amount of Rs. 500-700 in last month. ASHAs are acting as DOTS provider but did not receive any payment since 2014.
- Replenishment of drugs is irregular in both the districts. In state, only 89% ASHAs have received HBNC kits. Availability of HBNC kit varies amongst ASHAs; few ASHAs have purchased thermometers on their own.
- State has set up support structures at all four levels. However, there are large number of vacancies and this affect the quality of handholding support to ASHA. Supportive supervision visits are not being done due to

insufficient mobility support. High attrition rate among the support staff is seen in the state.

- 87% of ASHA facilitators have been selected in state against the target of 4,964. Clarity on performance monitoring system and supervisory roles of AF is poor in districts.
- Grievance redressal mechanism is not functional in state.
- State has 100 % formation of VHSNCs at Gram panchayat level with bank accounts. There is no progress in VHSNC training since July 2014. Functionality of VHSNC is reported low in Siwan district. Involvement of PRI is poor in VHSNC and RKS. RKS funds are utilized for purchasing CCTV cameras and other expenses.
- ASHA has good knowledge on maternal health and family planning, but training needs to be improved substantially for child health and new born care. Slow pace of training and lack of refresher training is leading to skill attrition of ASHA.
- In West Champaran, some ASHAs are covering population more than 2,500.

Jharkhand

- Sahiyas are knowledgeable and committed to their work and form an effective link between the health system and the community.
- State needs to revise the target for sahiya's selection, as current target is based on Census-2001, thus leaving 10-15% villages/hamlets uncovered by any Sahiya.
- 94% of total sahiyas are trained up to Round three and Round four still being underway. Meanwhile state has conducted refresher training for its 80% Sahiyas and 2779 ANMs.
- Sahiyas are measuring BP and HB as a part of ANC care during VHND. They have not received a formal training for this but have learnt these skills on the job by the ANM.

- The performance monitoring is done on a regular basis; however, the feedback mechanism is not satisfactory. Sahiya Sathi have a poor understanding of the monitoring indicators.
- Sahiyas from Mahagama block of Godda district heave not received any Routine and Recurring incentive till date.
- Integration within the support structures of NRHM and NUHM with respect to Community Processes is reported good in the state.
- Mechanism of replenishment of drugs is not appropriate and uniform.
- State has made it mandatory for Sahiyas to escort pregnant women to institution for JSY incentive.
- Sahiya Sathis continue to function as Sahiyas for their allocated population impeding their role of a facilitator.
- Grievance redressal system is functional only in 14 districts of the state.
- Sahiya Help Desks are functional in all 24 districts of the state.
- Sahiya rest rooms are available in 24 districts at DH level and in few FRUs/CHCs of the state.
- State has created a corpus fund which provides an accidental cover to Sahiyas and assist them financially in case of disability and death in an accident.
- VHSNCs have been reconstituted in the state but training is yet to be conducted. About 50% of VHSNCs have a woman elected member of GP as its member and chairperson. Members are not participating in VHND, VHP and community participations as of now.
- VHSNC Fund utilization is not as per the guidelines and needs more clarity.
- RKS is being reconstituted across the state. State has involved PRI representatives in RKS and DHS.
- Health promotion through Participatory Learning and Action has been implemented in 6 blocks in state.

- Community Based Monitoring activities are undertaken in all the 24 districts with coverage of 137 blocks (6 blocks in each district) and 6850 villages (50 villages in block).
- Convergence at the village level is effective; however, it needs strengthening at the block level.

Madhya Pradesh

- ASHA selection in state is 94% against the target of 62,853 under NRHM, and 98% against the target of 4,200 under NUHM
- Dropout seen at state level is minimal i.e. 2%, with the main reasons being career progression, non-functionality and migration.
- ASHA software is functional in state and a database of all ASHAs is created at district and state level. The software is linked with PFMS for payments of ASHA incentive.
- Average incentive earned by ASHAs observed during field visit ranges from Rs 1,500 to Rs 2,500 per month.
- Training of ASHAs shows a slow progress and only 24% ASHAs are trained at state level in all rounds of module 6 & 7. In Ratlam district, only 8% ASHAs are trained in all rounds. Also in the same district, 42 newly recruited ASHAs are working without any formal training.
- State has also trained ANMs and LHVs in module 6 & 7 to provide support to ASHA.
- State has good ASHA support system. There is 1 ASHA Sahyogini (AS) for 16 ASHAs in field, and around 95% ASHA sahyoginis are in place.
- Monitoring and supportive supervisory mechanism needs strengthening.
- Non-monetary incentives are provided to ASHAs for motivation. ASHA awards are given twice a year. ASHA is also covered under insurance scheme where 81% of ASHAs and 99% of AS are enrolled.
- Gram Arogya Kendra (GAK) is established at all AWC in the state. There are 48,957 GAKs in the state.

- Formation of MAS is not complete in Ratlam, and accounts are not yet opened across the district.
- Regular replenishment of drug kit and supply is done by AS, however the quality of equipment is a matter of concern, for eg. Weighing machines are not functional
- Grievance redressal mechanism is functional at district and block level and MGCA committees are established at various levels.
- There are 45 rest rooms for ASHA in state, and they are only at district level. However, temporary rest rooms were available in two blocks of Dindroi district. In Ratlam, ASHA rest room is being used as a part of maternity ward due to space constraints as a part of building collapsed.
- Intensive CAH in started in seven districts of the state.
- VHSNCs are reconstituted in the state as per the guidelines. Minutes for all meetings are recorded and available with ASHA. All members are not trained yet and the pace of training is also slow. In current year, VHSNCs have not received the funds, due to underutilization and non-submission of UC for last year.
- Functionality of RKS is compromised in the districts.
- Convergence within the departments is seen but it is not utilized adequately by the department of health.
- District level focus on review of ASHA, VHSNC and RKS is poor

Uttar Pradesh

- Shortfall of ASHAs was noted in the state, as only 85% in rural and 72% in urban have been selected against the targets.
- State needs a systematic process of mapping all villages/areas where ASHAs are yet to be selected. Many ASHAs reported of covering over 2000 of population.
- Most ASHAs met during field visit reported covering over 2000 population. The districts have not yet done any systematic process for

identification of areas uncovered by any ASHA. The average gap from the time of drop-out of ASHAs to the new selection was more than one year in Firozabad.

- State has made substantial progress in ASHA trainings in last 2-3 years. Presently, it has completed training of 65.3%, 64.8% and 0.9% ASHAs in Round 1,2 and 3 respectively. However, delay was noted in starting induction training after selection of new ASHAs.

- HBNC kit was available with ASHAs but thermometers were not functional.

- ASHA payment systems have been linked with PFMS. In district Firozabad, on the initiative of District Magistrate, an innovative system of Drop-box has been introduced and ASHAs can deposit their payment vouchers in this drop-box anytime and the payment was done on a weekly basis.

- The state has a robust support structure presently. Support and review meetings are held and capacity building workshops are planned for ASHA support cadre at every level

- State has started the process of segregating the role of ASHA and ASHA facilitator since March 2016. Majority of ASHA facilitators have opted to continue working as ASHA facilitator's role, leading to a dropout of ASHAs

- Grievance Redressal Systemis in place at all levels with regular monthly meetings. However, in Firozabad, there was no documentation observed.

- State has provided mobile phones to all ASHAs in FY 2015-16, and funds have been approved this year for giving bi-cycle to ASHA sanginis

- Mobile kunji and Mobile Academy applications have been implemented in the state, however it could not be observed in the field as the call could not be connected with "Dr. Anita".

- The state has introduced an insurance scheme which provides an accidental cover to ASHAs and ASHA sanginis, with a financial assistance of Rs. 2 lakh in case of accidental death and permanent disability.

- Reconstitution of VHSNCs as per the guidelines and formation of MAS is yet to be done in the state.

Uttarakhand

- 15,431 VHSNCs have been established, with ASHA as the member secretary. Meetings are not regular and capacity building of PRI members is necessary. ASHAs in Uttarakhand are a very visible face of the programme, and the state has achieved its selection target.
- Training pace is good with trainings being organized in residential mode. The programme is supported by NGOS in each district acting as DARC. ASHA have been trained in topics such as disaster management, ARSH, RSBY, Maternal Death audits, and WIFS.
- The average monthly incentives amount to Rs.1500-2000. ASHA payments are through e-transfers, but there are long delays reported. Recall of key messages by ASHA is an issue indicating the need for additional refresher training.
- The ASHAs are required to maintain a diary and to fill in several formats but little monitoring or feedback of this is visible.
- Drug kit replenishment is a challenge.
- ASHA grievance redressal systems at district and block level appear to be limited to delay of payment, but the monthly meeting also serves as a forum.
- Well-equipped rest rooms for ASHAs have been set up at all District hospitals Monthly meetings for ASHAs are held at the Sub-centres and PHCs with 80-90% of ASHAs attending the meetings.

Chhattisgarh

- Most Mitanins met, were found to be motivated, well informed and capable of counselling women/mothers. They were viewed by community as a critical link with the health system.
- Attrition rate is low - around 1.3% and the major causes included selection in ANM course or promotion into Mitanin Facilitator role or death/ migration and family pressure.

- State has strong support structures for Mitanins, at all levels – sub block, block, district and state. Excellent integration of AWW and Mitanins was also evident at field level.
- Most Mitanins are conducting Rapid Diagnostic tests and HBNC visits. Mitanins are involved in village level planning and also facilitate the Fulwari scheme (on child nutrition and health in tribal blocks)
- Mitanins have been provided a communication kit including a flipbook designed for home visits Findings regarding availability of drugs were mixed, as some Mitanins had all drugs while few Mitanins had expired medicines.
- The state has introduced various measures to support mitanins –Mitanin Samman Diwas by PRIs to honor Mitanins at village level, 40% reservation for Mitanins in Govt ANM schools since 2011 (about 1700 Mitanins are enrolled), social security scheme through Mitanin "Kalyan Kosh".
- Mitanins payments are irregular as most Mitanins interviewed have not received incentives for more than a year. These delays are mainly due to payment procedure routed through PRI members. To address this, District Collector of Rajinandgaon has reversed the decision to route funds through PRIs.
- Mitaninis member secretary/convener of VHSNCand handholding of the committees is through the Mitanin Support Structure.
- On an average, 80% of VHSNCs are conducting monthly meeting in any given month and around 71% of VHSNCs are preparing village plans. VHSNCs also record and discuss deaths in the village along with the community reported causes of deaths.
- Community Based Monitoring activities are undertaken in all 146 blocks and VHSNCs monitor 27 indicators on health, nutrition and sanitation and record it in their Monitoring registers monthly.
- Inter sectoral convergence was found poor even on VHND days.

Odisha

- State has selected 95.4% ASHAs but a gap of 12 % was reported in High Priority Districts. Dropout rate was only 0.9%, with major reasons being selection in other jobs and death.

- In addition to training modules provided from MoHFW, state specific trainings are also carried out as refreshers training on different thematic areas. Skills of trainers were found to be excellent.
- Knowledge of ASHAs on ANC, Institutional delivery, HBNC, Immunization and Family Planning is good but skills of using HBNC equipment ARI timer, thermometer and weighing scales needs improvement.
- Drugs and HBNC kit were available with all ASHAs. Medicines are replenished during monthly sector meeting but HBNC equipment is given once. ASHAs were well versed with the use of medicines.
- Average incentive earned by ASHA is Rs. 2099/- (April 2015 to Sept 2015). Payment is made online through PFMS but incentives for activities under the RNTCP were reported to be delayed
- Awareness among ASHAs about all incentives especially family planning programme was low. Though state has vouchers for ASHA payments but ASHAs lacked clarity about the claim process for incentives specifically under disease control programs.
- State has created support structures at all levels except at block where existing block level functionaries - Block MOIC and the BPM are responsible for CP activities.
- ASHA Sathis are selected from the existing ASHAs and continue to work as ASHAs also. Despite the high work load ASHA Sathis are doing commendable work in supporting ASHAs. They receive a monthly honorarium of Rs. 2000/- along with performance based incentives.
- One of the criterions for Sathi selection is the incentives earned, this in practice excludes ASHAs covering small population and earning low amounts of incentives.
- CUG has been given to ASHAs with monthly Rs. 100/- for mobile phone recharge.
- ASHA Gruha are available at DH and high delivery load CHCs, which were found in good condition.
- Bi- cycles have been issued to ASHAs and ASHA Sathis and are seen as a medium of empowerment.
- Working area of ASHA is not coterminous with Anganwadi. Thus some Anganwadis have 3-4 ASHAs who have to share the incentive for VHND and immunization services.

- ASHAs are involved in awareness generation on Household toilets under Swaccha Bharat Abhiyan. She is also involved in Shakti Barta-Counseling on MCH under WCD.
- RKS are formed as per guidelines but regularity of meetings varied across state. RKS funds are used for hiring Specialist and services such as housekeeping, security, etc. RKS has large unspent balance.
- Quarterly GP level meeting is conducted with involvement of PRI, ICDS & Health Dept under the chairpersonship of GP Sarpanch to review and regular support Gaon Kalyan Samitis. State has provided printed registers to all GKS. United fund is utilized as per the need and approved village health plan. Funds are received by the VHSNCs in two instalments during the year.
- State Advisory Group for Community Action was constituted in 2012 and 19 meetings has been held. No meeting was reported since last one year. Community Action for Health is being scaled up to 13 districts. Capacity building have been organized for ex officio members of VHSNC but training of members other than the office bearers is missing

Rajasthan

- Overall state has 94 % ASHA selection but major gaps were observed in Bikaner with 74 % selection.
- Launch of ASHA Soft has made payments of most incentives regular except for malaria programme.
- Replenishment of drugs for ASHAs is adhoc in various districts.
- ASHAs functionality as mobilizer was found to be good but skills of ASHA in providing HBNC was found to be limited due to unavailability of equipment kit and lack of mentoring support.
- State has not invested in training of support staff of ASHA programme. Lack of routine monitoring of training and poor post training support emerged as major gaps in ASHA programme. Lack of clarity about roles of ASHA support structure was observed in both districts.
- Large number of vacancies exist at all level starting from district to sector level; District ASHA Coordinator post has been vacant in many districts
- State does not have dedicated Grievance redressal mechanism for ASHA. State has “Rajasthan Sampark“ for anyone to lodge a complaint but awareness regarding this was negligible among ASHAs.

- State has initiated a process of enrolling ASHAs for 10th and 12th std. through NIOS and so far 30 ASHAs have been nominated from all districts.
- Services provided during Village Health and Nutrition Day was more focused on clinical part of ANC and immunization. Counselling on Family planning and nutrition was not being done.
- Out of 43,440 VHSNCs, 2742 villages are having less than 100 population therefore untied funds are being transferred to 40698 VHSNCs. 36000 VHSNCs (88%) have opened account. Reconstitution of VHSNC committees has been done in both the districts but training of VHSNC members has not been initiated
- Though six districts were identified for CAH and constitution of state planning and monitoring committee is underway but there is no awareness about the process at the state level. State received approval of Rs. 30 L in ROP 2014-15 for CAH, which was utilized, on printing of RMRS (RKS) guidelines, VHSNC monthly calendar and printing of booklet for PRI members
- Rajasthan Medical Relief Society (RKS) has been constituted in most of the health facilities. However reconstitution as per new guidelines is yet to begin. Irregularity of meetings was observed in all facilities. There is a lack of knowledge among members about the process of using RMRS untied fund in Bikaner district. RMRS money is utilized for purchasing computer and other office expenses
- No convergence mechanism at District Health Society (for planning, monitoring and inclusion of left outs and drop outs) at ward level amongst ICDS, Health & FW, PHED, and Education.

RECCOMENDATIONS & OUTCOME

1. Given the above scenario EAG States now needs to concentrate on much faster up gradation of infrastructure, increase bed capacity, ensure optimal utilization of available HR, take steps to make monitoring effective and develop a robust system for capacity building. The areas of priority action may include:

- Differential facility/block/district plan and its speedy execution especially infrastructure at SC/PHC/CHC level
- Strong and responsive capacity building system which can take care of the dynamic requirements of the health system, reviving SIHFW, exploring PPP in training
- Empowerment of staff for effective monitoring and supervision and ensuring follow up action
- Long term systemic changes in terms of comprehensive HR policy which explores absorption of contractual staff and building up a public health cadre

2. Past CRMs have highlighted similar issues however pace of implementation in the States seems to be slow. Most of the studies/plan and decisions recommended in past years are still under consideration by the States.

3. The very ethos of Common Review Mission is to take corrective and mid-course action at the State level and states are also required to include these recommendations in their PIP. On review of all CRM reports it has come to fore that the structure of reporting doesn't include a section for the action taken by the States on the Recommendations by previous CRM reports. A section to include the actions taken on previous CRM reports would ensure better action by the states.

4. In spite of the gaps, the performance/achievement of the EAG States in terms of goals and outcomes in the last five years in some areas has been impressive.

5. The achievements have primarily been possible for the high commitment of the numerous people working at various levels within the health system to improve the health situation. However the pace needs to be

much faster so that in the coming years the momentum itself can sustain the rate of progress.

6. Time to care approach is yet to be institutionalized in most Uttaranchal, largely due to poor road connectivity and challenges related to inclement weather conditions in such remote areas. This needs immediate attention.

7. Under the Pradhan Mantri National Dialysis Programme, BPL populations have been exempted from user charges for availing dialysis services across all States. While most EAG States have reported availability of dialysis services in varying degree; Jharkhand is yet to operationalize dialysis services at district level through PPP mode. Whereas Bihar (17 centres) has made substantial progress.

References

1. CRM reports available with the NHSRC
2. State reports available in the open Domain
3. SRS, Census Documents, RHS