Save Your Child from Six Killer Diseases

NATIONAL RURAL HEALTH MISSION

राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

TT Immunization for Pregnant women

IMMUNIZATION SCHEDULE

FOR THE PREGNANT WOMAN	
Early in pregnancy	T.T. - 1 (Injection)
One month after T.T.-1	T.T.-2 or T.T. Booster (injection)
FOR THE INFANT	
At 1½ months	B.C.G. (Injection)* D.P.T.-1 (Injection) and O.P.V.-1 (dose)
At 2½ months	D.P.T.-2 (Injection) and O.P.V.-2 (dose)
At 3½ months	D.P.T.-3 (Injection) and O.P.V.-3 (dose)
At 9 months	Measles (Injection)
At 16 to 24 months	D.P.T. Booster (Injection) and O.P.V. Booster (dose)

* If the infant has been delivered in a hospital/clinic, she/he should be given the B.C.G. injection at birth. Even if you are late for an injection / dose, you must still get it. Consult your health worker.

Tetanus

Polio

Measles

Diphtheria

Tuberculosis

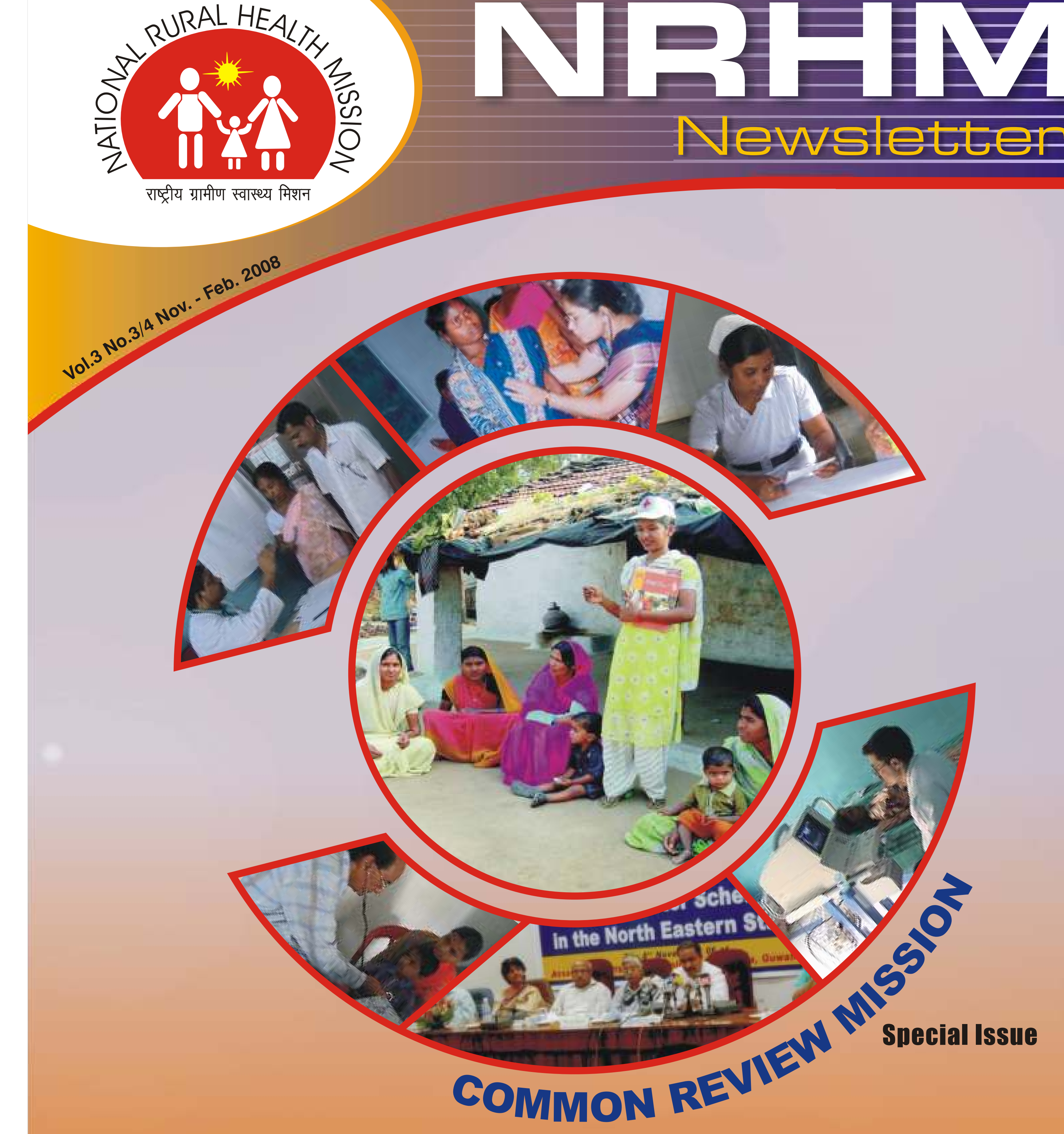
Whooping Cough

Immunize Your Child

Immunization facilities available at all Anganwadi Centres, Health Sub Centres, Primary Health Centres, Community Health Centres, District Hospitals and major hospitals.

AD Syringes are used now in Immunization for Injection Safety

Ministry of Health & Family Welfare, Government of India



TOLL FREE 1075

Call toll free number 1075 from any phone to alert for Disease outbreaks or epidemic. Report a patient of Cholera, Jaundice, Plague, Dengue, Meningitis, Encephalitis, Malaria, Chikungunya, Measles, Leptospirosis, Polio or any unknown disease. *Details on page no. 27*

Progress under NRHM

ASHAs

- Selection of 4,47,248 against Six lakh ASHAs during the Mission period (includes ASHAs for tribal areas and the Northeast).
- 3,34,664 ASHAs given orientation training and positioned in villages.

Link Workers

- The States of Gujarat, WB, Maharashtra, Andhra Pradesh and Haryana (non ASHA States) have selected, (apart from ASHAs for tribal areas) 96,067 link workers and trained and positioned them in villages.

Infrastructure

- All Subcentres in the country (1,46,000) provided with untied funds of Rs. 10,000 each. Over 1,11,979 sub centres have opened joint accounts of ANMs and Pradhans for utilization of annual untied funds of Rs.10,000/. 14440 subcentres have positioned a 2nd ANM.
- Out of 3910, 2870 CHCs have been identified for upgradation to IPHS and facility Survey completed in 2335.
- Rogi Kalyan Samitis
- Over 17,600 Rogi Kalyan Samitis set up in various facilities.

Manpower

- 6232 Doctors, 25,987 ANMs, 11,537 Staff nurses, 4380 paramedics have been appointed on contract by States to fill in critical gaps.

Management Support

- Over 1500 professionals (CA/MBA) have been appointed in the State and 506 District level Program Management Units (PMU) and 2432 blocks to support NRHM.

Mobile Medical Units

- Funds for one Mobile Medical Unit (MMU) per district released for 318 districts. The states have, till date have operationalised 188 Mobile Medical Units with their own funds.

Immunization

- Intense monitoring of Polio Progress Services of ASHA useful.
- JE vaccination completed in 11 districts in 4 states 93 lakh children immunized during 2006-07. JE vaccination is being implemented in 26 districts of 10 states in 2007. The 11 districts of 4 states where JE vaccination was carried out in 2006 have introduced JE vaccine in Routine Immunization to vaccinate new cohort between 1-2 years of age with booster dose of DPT.
- House tracking of polio cases and intense monitoring.
- Neonatal Tetanus declared eliminated from 7 states in the country.
- Full immunization coverage evaluated at 43.5% at the national level. (NFHS-III)
- Accelerated Immunization Programme taken up for EAG and NE State.

Institutional Delivery

- Janani Suraksha Yojana (JSY) operationalised in all the States 34.49 lakh women benefited so far in 2006-07 and 26.12 lakh in 2007-08.

Neo Natal Care

- Integrated Management of Neonatal and Childhood Illnesses (IMNCI) started in 145 districts this year.
- With the help of Neonatology Forum over 46,000 health care personnel trained in Newborn Care in the country.
- Module for Home based new born care developed in consultation with Dr. Abay Bhang. ASHAs to be trained in Home based new born care shortly especially in the States of UP, Bihar, Orissa, Rajasthan and Madhya Pradesh.

Convergence

- Over 20 lakh Monthly Health and Nurtrition Days are being organized at the Anganwadi Centres in various states.
- Over 1,77,578 Village Health and Sanitation Committees have been constituted by the States. They are being involved in dealing with disease outbreak.
- Convergence with ICDS/Drinking Water/Sanitation/NACO/PRIs ground work completed.

- School health programmes initiated by Tamil Nadu, West Bengal, Karnataka, AP, NE States.

Health Action Plans

- State PIP received from 31 states during 2006-07 and 35 states PIP received during 2007-08. Project Implementation Plan (PIPs) of the States under NRHM have been appraised and funds released for the year 2006-07 & 07 - 08.
- Integrated District Health Action Plans (DHAP) have been prepared in 509 districts in various States.

Mainstreaming of AYUSH

- Mainstreaming of AYUSH taken up in the States. AYUSH practitioners co-located in 4919 PHCs. AYUSH part of State Health Mission/Society as members.

Trainings

- Trainings in critical areas including Anaesthesia, Skilled Birth Attendance (SBA) taken up for MOs/ANMs. Integrated Skill Development Training for ANMs/ LMV/MOs, Training on Emergency Obstetrics care and No Scalpel Vasectomy (NSV) for MOs, Professional Development Programme for CMOs are on full swing.
- ANM Schools being upgraded in all States.
- New Nursing schools taken up.

Mother NGOs

- 337 Mother NGOs appointed for 300 districts till date are fully involved in ASHA training and other activities.

Health Resource Centres

- National Health Systems Resource Centre (NHSRC) set up at the National level.
- Regional Resource Centre set up for NE.
- State Resource Centre being set up by States.

Monitoring and Evaluation

- Independent evaluation of ASHAs/JSY by UNFPA/UNICEF/GTZ in 8 States.
- Immunization coverage evaluated by UNICEF.
- Independent monitoring by identified institutions like Institute of Public Auditors of India.
- Ground work for community monitoring completed.

Surveys

- NFHS III and DLHS II completed.

Financial Management

- Financial Management Group set up under NRHM in the Ministry.
- During the FY 2005-06, out of total allocation of Rs. 6318.60 crore (R.E.) for the ministry, an amount of Rs. 5862.57 crore was released as part of NRHM.
- Against RE of Rs. 7951.08 crore for NRHM activities during 2006-07, Rs.7361.08 crore released (92.6%)
- Against BE of Rs. 11010 Crore for NRHM activities during 2007-08, amount of Rs. 4418 Crore released as on 31.12.07.

IEC

- IEC Multi-media campaign on health issues including immunization, Iodized Salt, Save the Girl Child
- Special issues of NRHM Newsletter.
- Health Melas organized in different States.
- Information booklets disseminated.
- Behaviour change workshops being organized for key stakeholders including state IEC representatives.

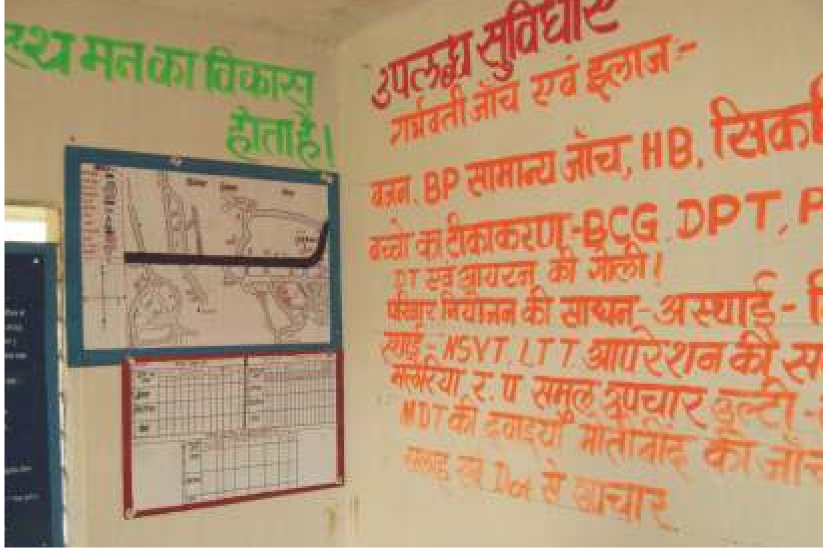
NRHM has boosted immunization coverage

COMMON REVIEW MISSION

CRM gears up state missions

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

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



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

NRHM has boosted immunization coverage

Key Findings

General Patterns

a. There is a general trend towards strengthening the services provided by the public health sector, with increasing access and improvements in quality, reflected in increasing utilization of the facilities. This increased utilization can be attributed to the overall increased attention and investment that the public health system is getting, the increase in institutional deliveries consequent to the Janani Suraksha Yojana, the filling up of vacancies, the untied funds being used to fill gaps in infrastructure and maintenance, and the improved availability of diagnostic services and drugs. However, there is still much to be done to call them 'fully functional' as per the Indian Public Health Standards(IPHS), and even these improvements are varied, with peripheral facilities receiving showing less changes while the district hospitals developed relatively more.

b. There is a varied performance of the NRHM across states. Different programme components have taken off at different rates. States that had better baselines and that had similar programmes in place have been quick to take off.

c. An increase in attention to the functioning of public health systems, the fact that the systems functionality in states and their bottlenecks are now receiving attention is a major contribution of the NRHM framework. A number of innovative strategies and measures are emerging locally in an effort by the state personnel to meet the overall objectives of NRHM.

d. An increase in public investment by the center has helped in many ways. However the system continues to lag behind in fund utilization and there are challenges in both programme management and governance to be overcome before the capacities to absorb more funds and deliver better services are in place.

e. As a rule the directions in which NRHM is proceeding as visible at the district level seem appropriate and welcome but the scale of roll out and the rate of roll out seem inadequate. Part of this is due to administrative constraints and perhaps issues of governance. Part of this is due to the time it takes to overcome inadequacies in human resources for health that results from a lack of planned growth in this sector. And part of it is due to the poor investment in public health services in the recent past. In many areas therefore the initiatives taken under NRHM would take time to manifest as improvements in service delivery and in health status.

Be wise. Immunize

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

Performance of NRHM Strategies

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

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

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

d. Hospital development societies (Rogan Kalyan Samitis- RKS) have been formed in most states and are with the provision of untied funds to them are acting as enablers of facility development. However, their role has been limited by the perception of RKS as an alternative financing device and the consequent emphasis on user fees as cost recovery. Composition of the RKS and processes of functioning are also not always conducive to community participation.

e. In most states panchayat standing committee members are involved in the District Health and Family Welfare Societies, Rogi Kalyan Samiti, the Village Health and Sanitation Committee (VHSC), and selection of ASHAs (as well as

Proactive Panchayat

Actual devolution of facilities to panchayats is a feature, only in West Bengal, Kerala and Nagaland. In states like Tripura and Tamil Nadu, the panchayat's role was found to be proactive and very valuable.

Timely vaccination saves life

certification of SC/ST/BPL families for JSY). Actual devolution of facilities to panchayats is a feature, only in West Bengal, Kerala and Nagaland. In states like Tripura and Tamil Nadu, the panchayat's role was found to be proactive and very valuable. Progress on VHSCs becoming functional has been slow, due to problems of states taking time to set up the enabling framework.

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

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

h. NRHM strategies and the IPHS have led to filling up of existing posts and the creation of new posts. However, shortages continue due to a lack of availability of sufficient nursing personnel and specialists. One priority is therefore the expansion of nursing and medical education in areas where human resource is scarce. In parallel multi-skilling of nurses as practitioners, and medical officers for specialist tasks is an additional strategy that some states have put in their PIPs but is yet to be operationalised. Poor performance due to lack of accountability was also noted.

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

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

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

Toll Free Telephone

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Multiple Reporting Still in Vogue

The Mission notes that the Integrated MIS Format for flow of physical performance data were found at all levels including the lowest (ANM). However multiple reporting is still in vogue, earlier forms are not yet abolished and there are many other constraints in data collection and flow.

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

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

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

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

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

Some Key Recommendations

The remaining 5 ½ year time frame of the NRHM gives us ample opportunity to strengthen its positive elements and make mid-course corrections.

At the Central Level

- Ensure timely release of funds to the states for various components of NRHM, especially Janani Suraksha Yojana.
- Work with states to evolve a common nomenclature for the facilities such as PHC and CHC as this influences much of the planning process and budgetary allocations.
- Build systems for actively promoting cross learning from the varied experiences of different states, and accelerating changes and innovations in poor performing states through appropriate facilitation, capacity building and technical assistance.

NEEDS A CLOSER LOOK

There need to be a systematic examination of the compensation packages and incentives being provided to the various health service cadre, and the opportunities for advancement in their careers along with a fair transfer and posting policy. These are some of the most sensitive indicators of good governance and a system of measuring and rewarding these needs to be built up.

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

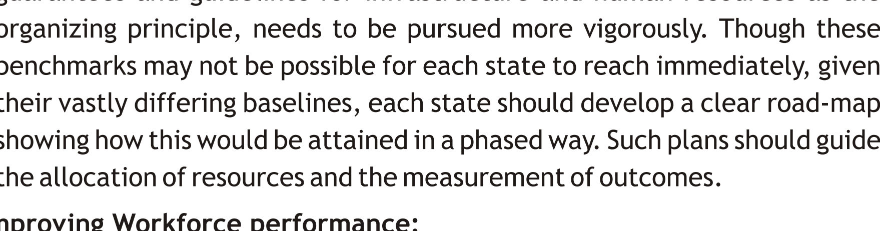
At State and District Levels

in programme management:

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

in attaining fully functional health facilities:

- Rational restructuring of the health services, with the IPHS service



guarantees and guidelines for infrastructure and human resources as the organizing principle, needs to be pursued more vigorously. Though these benchmarks may not be possible for each state to reach immediately, given their vastly differing baselines, each state should develop a clear road-map showing how this would be attained in a phased way. Such plans should guide the allocation of resources and the measurement of outcomes.

REVIVE TRAINING INSTITUTES

Pre-service training institutions for generating multipurpose workers, both male and female, and their supervisory staff, which have gone into dysfunction in the last decade, need to be revived, expanded and strengthened.

in Improving Workforce performance:

- Building a network of district, regional and state level training institutions led by the SIHFWs that ensures that the level of skills needed for service delivery at every facility and in every health programme are in place, is one of the most important areas of health sector reform that is urgently needed. Putting this in place at every level along with teams/centers for providing assistance and the institutional memory for district planning is another priority.
- Pre-service training institutions for generating multipurpose workers, both male and female, and their supervisory staff, which have gone into dysfunction in the last decade, need to be revived, expanded and strengthened.
- There need to be a systematic examination of the compensation packages and incentives being provided to the various health service cadre, and the opportunities for advancement in their careers along with a fair transfer and posting policy. These are some of the most sensitive indicators of good governance and a system of measuring and rewarding these needs to be built up.
- Multi-skilling of doctors and nurses and para-medicals is needed as a general strategy to provide the skill mix for reaching service guarantees under current human resource constraints.

Making available graded standard treatment guidelines and essential drug lists and formularies, which could guide the wide range of health care providers actually providing health care.

State-wise Performance on 24 Health Systems Development Parameters

ASSESSMENT OF CASE LOAD BEING HANDLED BY PUBLIC SYSTEMS AT ALL LEVELS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Increase in out patient cases and JSY deliveries; JSY deliveries in private clinics as well, even without formal accreditation.
2.	ASSAM	Increase in number of out patient and in patient cases due to JSY, better availability of doctors and medicines; higher increase where human resource gaps, especially Specialists, have been filled; not much change in case load at sub centre level as yet.
3.	BIHAR	Dramatic increase in case load at all Block PHCs, Sub District and District Hospitals; 24X7 Block PHCs offering out patient, emergency and institutional delivery services; substantial increase in institutional deliveries; doctors, drugs, diagnostics, uninterrupted power supply, infrastructure improvement, ambulance leading to improved public demand and expectation from public system.
4.	CHHATISGARH	Improvement in outpatient cases at the sub centre level. At PHC level the number has also increased but less. At CHC the picture was not very encouraging. Load at district hospitals is very heavy and Jeevan Deep Samiti has undertaken hospital improvement efforts. Shortage of specialist at CHC makes improvement of inpatient hospitalized care a little slow.
5.	GUJARAT	There has been an impressive increase in out patient and in patient cases for the State as a whole; often increase is related to the competence and commitment of the doctor posted at PHC which sets of a virtual cycle of all round PHC improvement and patient satisfaction; increase in a district often hides variation within.
6.	JAMMU &KASHMIR	Mixed reports of case load could be seen in all the districts visited; in patient load in CHC/DH/PHC is not commensurate with inputs of infrastructure and manpower; weak thrust on improving quality and range of service delivery.
7.	MADHYA PRADESH	Significant increase in institutional deliveries; insufficient increase in general utilization of services from health facilities; good gains in specially monitored and selected Dhanavantri Blocks.
8.	ORISSA	Overall increase in outpatient attendance; however, this increase is primarily in secondary care institutions and largely contributed to by institutional delivery increase; under utilization of services at primary care level often due to non-availability of services at those levels.

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S. No.	STATE	KEY FINDINGS
9.	RAJASTHAN	General increase in the use of government health facilities signals a positive change in people's perceptions; apart from institutional deliveries where increase is dramatic, there is increase in out-patient, in-patient, surgical procedures, diagnostics, lab investigations from public system; increasing trend in bed occupancy. National Health Programmes including RNTCP, blindness control, vector borne diseases and IMNCI are operated through the health facilities at all levels Sub Centres, PHC, CHC, and District Hospital; these facilities also offer the Indian System of Medicine, especially Ayurveda, to a limited scale.
10.	TAMIL NADU	Case load of patients treated, in patient and out patient, has increased considerably during the last one year in all primary healthcare centres, particularly CEmOCs and PHCs; drop in referrals from PHCs to higher level institutions; possible due to improvement of facilities through Patient Welfare Societies and close monitoring; clear shift in the case load towards public health facilities.
11.	TRIPURA	Most facilities showed an increasing trend in out patient load; institutional deliveries showed a significant increase; in in-patient cases the picture is mixed, varying from facility to facility.
12.	UTTAR PRADESH	Overall impression of a functional public health system which is delivering a considerable quality and quantity of services despite considerable constraints by which it is shackled; increase in institutional deliveries; high outpatients (not necessarily increase) due to improved availability of drugs.
13.	WEST BENGAL	Sustained efforts at strengthening the public system is leading to higher case load; sub-centres doing fixed day clinics and Gram Panchayats authorized to hire doctors for a few days in a week, facilitates higher utilization of services at the Sub Centre level; drug availability is satisfactory; institutional deliveries have gone up. BPHC and Rural Hospitals' up-gradation has also helped in meeting additional case load.

daughter is precious

Sex determination of unborn baby is illegal

Care for her Education & Health

Designed by IEC, Ministry of Health & Family Welfare, Govt. Of India

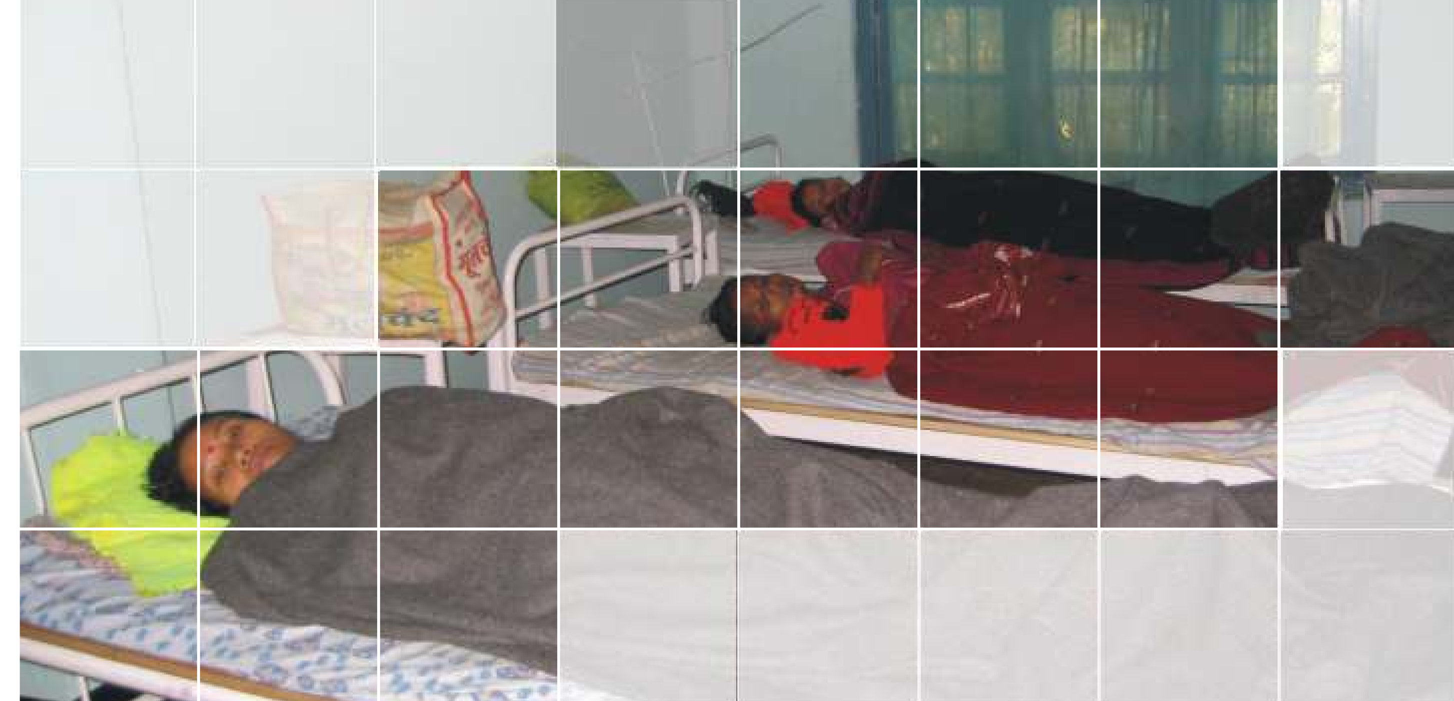
Inform about defaulting doctors/ technicians to Appropriate Authority in your district

Timely vaccination saves life

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

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Lab facilities adequate at PHC/CHC levels; improvement in infrastructure; blood storage units coming up; need for adequate staffing at selected CHCs/PHCs; case for Mandal level pooling of in-patient services; private practice of doctors interferes with higher utilization of hospitalized services from public facilities; government doctor is also the private practitioner.
2.	ASSAM	While bed occupancy and emergency care is steadily improving, availability of nurses and doctors is still a pressing issue; District Hospitals still catering to main in patient load; deliveries are now happening at many more places as is surgical procedures; constraint of Specialists is the major issue.
3.	BIHAR	Human resources, especially nurses, is a constraint; physical infrastructure is improving steadily; Operation Labour Room to improve services at Block PHCs; Rs. 23 lakhs worth of repair and new buildings in all Block PHCs from Finance Commission funds is nearing completion; PPP for 24X7 power supply by generator and ambulance is working well; PPP for cleanliness needs to be decentralized to facility level from the district level.
4.	CHHATISGARH	While physical infrastructure improvement has taken place, provision of adequate doctors and nurses need to be emphasized. Blood storage at CHC also needs to be prioritized. Up-gradation of CHCs behind schedule.
5.	GUJARAT	Significant improvement in infrastructure; commensurate addition of Staff Nurses must be a priority for sustained improvement in utilization of facilities; wherever qualified medical officers and related facilities exist, the bed occupancy seems to be better; availability of drugs was found to be uniformly satisfactory everywhere.
6.	JAMMU &KASHMIR	Infrastructure and manpower is adequate in many places; in spite of it, service guarantees are few, especially for hospitalized treatment and surgeries; need to provide more service guarantees; no CS in many places despite appropriate specialists posted there.
7.	MADHYA PRADESH	The improvement in facilities for in patient care is not commensurate with the increased load due to JSY; needs priority attention; need to streamline systems of diagnostics and availability of medicines;
8.	ORISSA	Nomenclature differences of PHC/CHC; there is progress in facilities though yet to reach Indian Public health Standards; staff shortages and non-availability of staff during odd hours present a major constraint; diagnostic facilities and logistics of drugs and consumables need improvement.

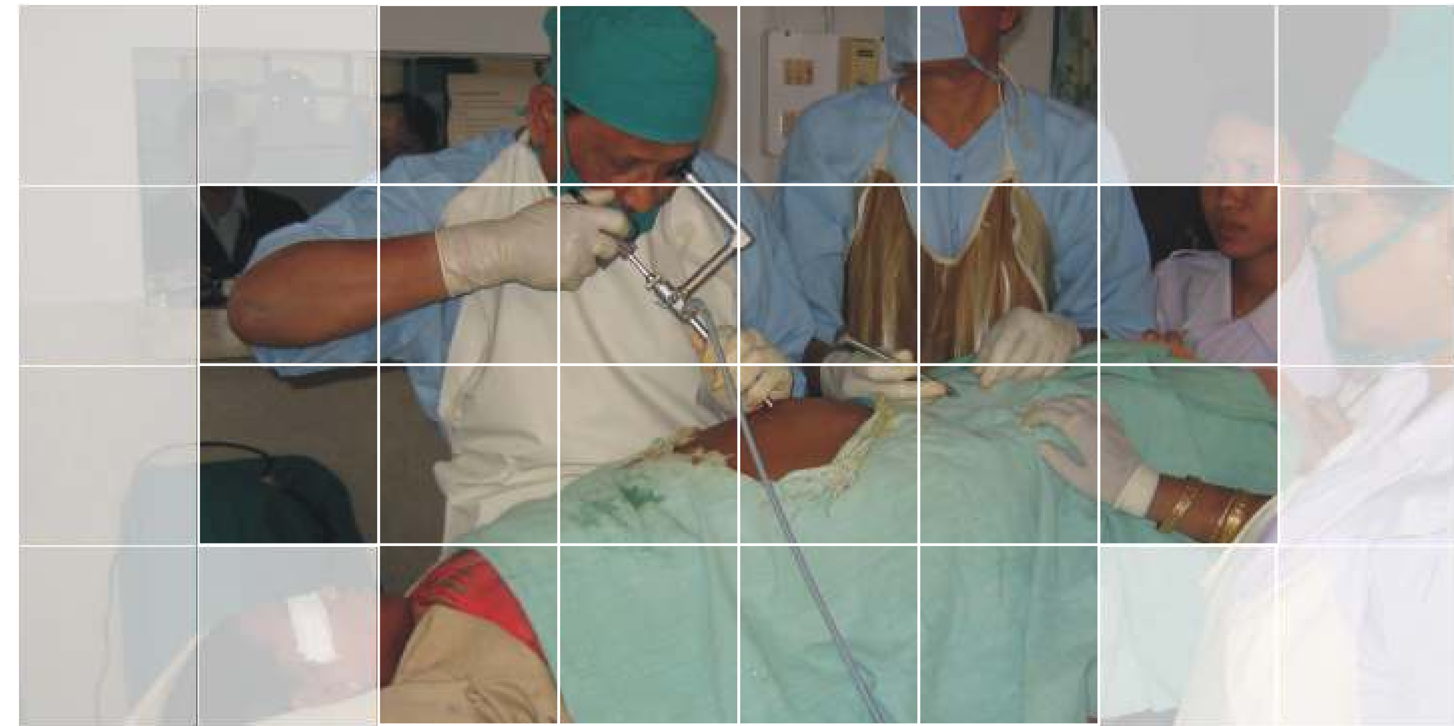
S. No.	STATE	KEY FINDINGS
9.	RAJASTHAN	Increasing utilization of services putting pressures for better preparedness; infrastructure is much better at many places because of conjunctive use of NRHM and RHSDP funds; but still needs more inputs and a better hygiene and sanitation, upgraded institutions with human resources doing much better.
10.	TAMIL NADU	Available bed strength being utilized quite satisfactorily; facility improvement is under way.
11.	TRIPURA	Health functionaries are a very committed team, but shortages of trained professionals like specialists, doctors, para medics, Nurses and Lab Technicians; Improvement of physical infrastructure also needs to be on a faster track as PWD is not able to cope with the additional load; availability of drugs is satisfactory; TB and Malaria tests are in public facility; lot of other tests are from private providers.
12.	UTTAR PRADESH	Nursing staff is a major constraint; shortage of specialists also a constraint, good level of improvement in hospital cleanliness and demand for services; untied funds and RKS helping tide over problems.
13.	WEST BENGAL	128 PHCs and 93 Block PHCs have been upgraded; another 82 BPHCs being up graded; Doctors, Specialists and Nurses have been appointed; Lab Technician appointments are held up due to a court case; PPP for diagnostic services have been started in some BPHCs and Rural Hospitals; there is a demand for more such facilities.



QUALITY OF SERVICES PROVIDED FOR INSTITUTIONAL DELIVERIES

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Institutional deliveries in public and private facilities; BPL paid on the basis of certificate; 26 percent institutional deliveries in public sector in the districts visited.
2.	ASSAM	Mixed picture, depending on human resource availability; signs of improvement in CHCs/ FRUs in many places; need to improve cleanliness and waste disposal; community perceives improvement in services due to improved infrastructure and availability of drugs, doctors, nurses and para-medics at health facilities.
3.	BIHAR	Quality of services compromised due to large scale shortage of Nurses; State is recruiting 8000 ANMs/Nurses; need to focus on cleanliness, waste disposal, etc.
4.	CHHATISGARH	While JSY coverage has increased, payments are not timely. More attention needs to be paid to quality of service.
5.	GUJARAT	Qualified medical officers for conducting deliveries was found in most of the institutions; in particular, district and sub district hospitals showed brisk activity and interest from doctors to patient needs; RKS filling gaps in infrastructure; problem of shortages of doctors and specialists and staff nurses remains everywhere and more glaringly so in un served and under served areas specially in the tribal tracts; there are no short term solutions for such shortage except to increase intake in Nursing Schools.
6.	JAMMU & KASHMIR	Very poor condition of labour rooms and lack of privacy in many places; inadequate new born care; improvement in institutional deliveries after JSY recorded in all institutions but quality of care needs to improve.
7.	MADHYA PRADESH	Quality of services needs improvement; RKS must have greater patient welfare focus; early discharge after deliveries is a problem; need to prepare facilities for in patient care; cases of misuse of JSY as well.
8.	ORISSA	Quantum increase in institutional deliveries putting further load on secondary care institutions Block PHC, CHC, Sub District and District Hospitals; very few deliveries at Sub Centre / Mini PHC level.
9.	RAJASTHAN	Sharp increase in institutional deliveries; 62 percent jump over 2006; quality of care improving; hospital stay needs to be longer; need for more cleanliness in some institutions; improved performance and maintenance due to RMRS and untied funds in many institutions.
10	TAMIL NADU	Availability of medical and para medical and nursing personnel in the Block PHCs and other PHCs was found to be satisfactory; infection management and cleanliness found to be satisfactory; patients satisfied with the quality of services.

S. No.	STATE	KEY FINDINGS
11.	TRIPURA	Increase in institutional deliveries is noticeable; still a large number of home deliveries due to distance factor from facilities; preparedness for complicated deliveries compromised with shortage of trained professionals; One New Medical College through PPP and Nursing College through PPP recently set up may ease situation in a few years.
12.	UTTAR PRADESH	Gaps in quality of care at all levels; Sub Centre deliveries suffer in the absence of physical infrastructure and referral transport linkages; women returning after 3-4 hours after delivery from facilities is a problem; delivery cases have tripled at District Hospital level. Insistence on replacement donors even in case of life saving transfusion under JSY is a problem.
13.	WEST BENGAL	Institutional deliveries have increased; Many Sub Centres are far better equipped now with untied funds to carry out deliveries; Up gradation of PHCs and BPHCs along with the untied funds have also helped in improving the infrastructure; Panchayats are fully involved in this process of improving quality of services.



SYSTEMS IN PLACE FOR IMMUNIZATION AND CHANGES IN THE FIELD

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Performance of the State is satisfactory.
2.	ASSAM	Impressive progress in immunization coverage; increased awareness is palpably visible at all facilities; cold chain and vaccine availability well maintained; major role of ASHAs and ANMs in enhancing awareness and in organizing immunization rounds; improved monitoring of performance at State level.
3.	BIHAR	Cold chain well maintained; Facility improvement of Block PHCs and PPP for Generators at Block PHCs helps; alternate delivery of vaccines is working well; polio rounds taking too much time, adversely impacting on other health programmes.
4.	CHHATISGARH	Mitanins has completed list of hamlets where children were not immunized. List has been acted upon by district authority enhancing immunization coverage.
5.	GUJARAT	Following measures for effective immunization initiated mapping of poor performing Blocks followed by area specific strategies; immunization through mobile unit in difficult and remote areas; monitoring through RIMS; appointment of State Routine Immunization Monitors; measles surveillance.
6.	JAMMU & KASHMIR	System of routine immunization at facilities on fixed date and out reach in villages could be recorded; increase in coverage and usage of AD Syringes; regular immunization sessions being held at village level and in Sub Centres as per records. System of waste disposal needs to be put in place.
7.	MADHYA PRADESH	Report has not commented on immunization separately; more improvements in the selected Dhanavantri Blocks that re being monitored closely; some thrust on maternal and child health, including immunization.
8.	ORISSA	No confirmation of increase in immunization coverage; even where institutional deliveries have significantly increased, there is no matching increase in immunization coverage,
9.	RAJASTHAN	Very good progress in covering under one age children for full immunization; strong monitoring; functional sub centres improves outreach.
10.	TAMIL NADU	State has adopted 'fixed day fixed place system for immunization; every Wednesday, 8683 Village Health Nurses visit villages and around 1500 workers in urban areas to carry out immunization activities; has ensured timely immunization and quality coverage.
11.	TRIPURA	Immunization coverage is high; Village Health Days are popular; system of following up on immunization of children; helicopter used for health camps in remote areas.
12.	UTTAR PRADESH	Alternate vaccine delivery and untied funds to Sub Centres has helped in improving the sessions for immunization.
13.	WEST BENGAL	Some stock outs for OPV and hepatitis B vaccine has been reported; otherwise immunization levels in West Bengal continue to be satisfactory.

Be wise. Immunize

DIAGNOSTIC FACILITIES AT HEALTH CENTRES AND THEIR EFFECTIVENESS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory quality of diagnostic facilities available at all levels.
2.	ASSAM	Lab Technicians have been deployed PHC onwards; further vacancies being filled up; ANM providing basic services; need to multi skill and break separate vertical systems for diagnostics; gaps in equipment and maintenance in some places; new equipment are with three year AMC.
3.	BIHAR	Diagnostic services up to Block PHCs through PPP working very well; basic services available at reasonable cost; x-rays in 136 institutions by outsourcing.
4.	CHHATISGARH	Not commented upon.
5.	GUJARAT	Satisfactory availability of diagnostic facilities and their utilization at all levels.
6.	JAMMU & KASHMIR	Diagnostic facilities of x-ray,, ultra sound, ECG, lab , were available in all Sub Divisional Hospitals and one PHC visited; facilities being poorly utilized in many places.
7.	MADHYA PRADESH	Improvements in a few places; key Lab Technician shortages hamper diagnostic services;
8.	ORISSA	Diagnostic facilities weak; compartmentalized system of TB and Malaria needs to move towards multi-skilling; happening in a few places.
9.	RAJASTHAN	Basic diagnostic facility available every where; free for BPL, pensioner, and senior citizen; user charges for others through RMRSs (equivalent of RKS).
10.	TAMIL NADU	All PHCs are provided with lab providing basic facilities; special services like ECG, X Ray in upgraded PHCs; semi-auto analyzers in Block PHCs; District Hospitals have ECG, X-Ray, Ultra sound with CT Scan.
11.	TRIPURA	TB and Malaria diagnostic facilities in PHCs; other tests in private in many places; need for integration and multi-skilling of Lab Technicians and other para-medics to improve availability of diagnostic services.
12.	UTTAR PRADESH	Though under staffed, basic diagnostic facilities were available at most places; staff shortages are a key issue. Multi-skilling offers potential for closing gaps.
13.	WEST BENGAL	PPP for diagnostics seem to be working well in Bengal as well; Lab Technician for TB and Malaria are there but they do not seem to be doing TLC/DLC/ etc. The inability to fill up vacancies of Lab Technicians due to court cases is also posing problems; there is demand for PPP for diagnostics.

Timely vaccination saves life

VI MANPOWER POSITION IN HEALTH CENTRES

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	There are manpower mismatches; need to focus on a few institutions rather than all institutions at the same time, for in patient, hospitalized treatment; satisfactory Lab Facilities; satisfactory position of Nurses; over 2500 2nd ANM already appointed.
2.	ASSAM	NRHM has increased/improved availability of MBBS Doctors, AYUSH Doctors, Nurses, ANMs; Lab Technicians and Pharmacists being recruited; ASHAs are very enthusiastic and are helping in putting community pressure on public facilities.
3.	BIHAR	Improving, but not fast enough; Sub Centres and Additional PHCs to be fully operational shortly; present focus on Block PHCs; Appointments of ANMs, Nurses, Lab Technicians, OT Assistants near completion; need to plan for additional manpower more effectively, especially nurses.
4.	CHHATISGARH	There are shortages of staff at various levels. State needs to plan nursing and doctor needs more effectively. Quality of ANMs is reasonably good. Mitanin programme very strong, is more than 60000 Mitanins creating an environment for state health institutions to provide services. Mitanins very effective in the field. They have drug kits as well.
5.	GUJARAT	Major shortages in most cadres, AYUSH doctors being posted to fill vacancies of medical officers in PHCs; lack of specialists; urgent need for nursing staff to provide actual 24X7 services; ANM deputation reduces availability of ANMs where they are needed; Lab Technicians have been provided in most of the PHCs.
6	JAMMU & KASHMIR	Good availability of Specialists and other professionals; Specialist services during day time; need to provide more quarters for staff to enable resident health workers; need for rationalization and clear service guarantees from professionals.
7.	MADHYA PRADESH	Large scale shortages at all levels including specialists, PHC doctors, MPW (Male), Pharmacists and Lab technicians. Employment of doctors is only on contract basis since several years. Some manpower shortages being met in innovative ways; PPP training sponsorship for nurses from vulnerable social groups and remote areas; large scale shortages.
8	ORISSA	Shortage of 700 Medical Officers; need for manpower needs assessment and long term planning; shortage of Nurses and ANMs; State has taken many steps additional incentives for KBK area, appointment of contractual specialists, increase in MBBS seats, doubling Diploma in Lab Technology seats, 33% increase in intake of ANM Training schools, starting B.Sc. and M. Sc. Nursing courses, short term course on Anaesthesia and Emergency Obstetric Care, and posting of 1500 additional staff nurses in the peripheral institutions.

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S. No.	STATE	KEY FINDINGS
9.	RAJASTHAN	Shortage of Specialists, especially Gynaecologists, Anaesthetists, and in public health; MPW(M) not filled up and training institution languishing; ASHA Sahyogini doing TB, Malaria, JSY and immunization work, besides coordination with ICDS.
10.	TAMIL NADU	3 years compulsory rural service helps in filling vacancies; 740 VHN posts and 2400 Medical Officer posts filled up; 2258 Nurses recruited under NRHM to provide 24 hour service at PHCs. Second ANM not being considered as PHCs are able to close the gap.
11.	TRIPURA	Doctors' Association playing very important role in reducing absenteeism by promoting rotational posting for remote areas; there is a shortage of adequate number of trained and skilled doctors, nurses and para medics. Need for more ANM Schools as well as two districts do not have any institution.
12.	UTTAR PRADESH	Human resource is the challenge in UP; large unmet need for nurses, doctors and para-medics; need for more rational deployment as well; Key Specialist shortages alongside incidence of irrational deployment as well. AYUSH doctor being added at PHCs. 2nd ANM not in place. Large gap in male workers.
13.	WEST BENGAL	West Bengal has taken major steps to meet its need for ANMs; training capacity has been raised from 600 to 3500 by involving higher order Nursing Institutions in ANM Training and by involving Non Governmental organizations; difficulties in getting Specialists; strong Nursing cadre and Directorate is helpful in further strengthening the system.

Make the Mother
& Baby Safe

Register pregnancy
At least 3 Checkups
Take TT Immunization,
Iron & Folic Acid tablets
2 check-ups after delivery
Ensure Routine Immunization for children
Promote Breast Feeding
Opt for delivery only at hospital
Or by a skilled birth attendant
Benefits for hospital delivery to poor families under Janani Suraksha Yojana
Ministry of Health & Family Welfare, Government of India

Timely vaccination saves life

VII UTILIZATION OF ROGI KALYAN SAMITIS AND UNTIED FUNDS AT VARIOUS LEVELS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Large scale use of untied funds at all levels; VH&SC, Sub Centres, Hospital Development Societies have received funds and utilized it; Sub Centre needs not taken care of as resources are given village wise; sanitation and cleanliness is the focus; wider public health activity likely to be taken up
2.	ASSAM	RKS and untied funds have worked as enablers at all the places visited; used for improvement of amenities; elected representatives involved; funds being used for emergency referrals as well.
3.	BIHAR	Funds have reached and utilization has just started up to Block PHCs; need to speed up utilization to improve cleanliness and basic standards; need for stepping up of activity at Sub Centre and Additional PHC level; RKS guidelines prepared and disseminated; institutions need confidence to spend; electricity, ambulance, diet, and cleanliness through PPP.
4.	CHHATISGARH	Untied funds utilized at all levels from sub centre, PHC, CHC etc. Jeevan Deep Societies playing positive role in hospital improvement need to give more confidence to these Societies for utilizing untied funds.
5.	GUJARAT	RKS at the level of hospitals and sub hospitals are well set; RKS at CHC level is one year old and teething problems are over; RKS at PHC not registered as yet in many places; funds used for face lift of facilities; need to do more patient oriented services as well.
6.	JAMMU & KASHMIR	Hospital Development Boards from before, charging user fees; RKS formed at PHCs and funds received; process being completed in CHCs and District Hospitals; few facilities were yet to receive funds.
7.	MADHYA PRADESH	RKS are fully functional; evidence of substitution of State Government resources by RKS resources; needs immediate rectification; user fee collections form large part of RKS Budget; infrastructure maintenance, salary and medicine purchase are few items of expenditure; need to provision medicines from general hospital budgets; need to ensure that poor are not denied health care because of user charge.
8.	ORISSA	RKS set up everywhere but not effective everywhere as yet; works taken up to improve facilities; needs to make RKS realize their role and function.
9.	RAJASTHAN	RMRSs established everywhere up to PHCs; raising revenues and also receiving untied grants; reasonable sums of discretionary funds are now available at institutions; while some have made good use, fear of incurring expenditure in others; Sub Centres have improved with untied funds; cashless hospitalization of BPL a focus in RMRSs.

S. No.	STATE	KEY FINDINGS
10.	TAMIL NADU	Patient Welfare Society funds has led to marked improvement in the facility appearance and has considerably improved the look of the facility; development of gardens, gas stove connections, reapir, RO system for drinking water, inverter in labour room etc. done with untied funds.
11.	TRIPURA	RKS funds and untied funds very well utilized with complete involvement of Panchayati Raj Institutions.
12.	UTTAR PRADESH	Untied funds well utilized at Sub Centre level, improving the performance of the institution; RKS set up and beginning to use resources. Delayed utilization of RKS/untied funds due to delays in guidelines. State already had system of user charges which has been modified; need to ensure that resources remain with the institution.
13.	WEST BENGAL	RKS formed in each and every institution up to PHC level; Panchayats fully involved; untied funds used very effectively to improve the quality of services; physical infrastructure handed over to Panchayats for maintenance; Panchayat Samiti involved in decision making;

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

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	PRIs involved in VH&SC, Sub Centre level activities; as members of Hospital Development Societies.
2.	ASSAM	VH&SC not set up as yet as fresh PRI election is to be held; willingness to involve PRIs, village opinion leaders, local NGOs and Mahila Samitis; PRIs participating in RKSs and at Sub Centre level.
3.	BIHAR	VH&SC to be set up under the umbrella of PRI very soon; Panchayats involved in RKS; need to orient PRIs for better management of health institutions and for inter sectoral convergence.
4.	CHHATISGARH	Mitanin programme works very closely with Panchayati Raj Institutions. Innovative Swasthya Panchayat Yojana in Chhattisgarh. Indicators have been developed for measuring health status and delivery of health services at the village level. Panchayat fully involved in this exercise. State is now setting up VH&SC under umbrella of PRI.
5.	GUJARAT	Need to involve PRIs more directly; DHS meets but the District Health Mission under the Zila Parishad Adhyaksha does not meet often; VH&SC accounts managed by ANM and teacher and not by PRI representative; need for capacity building in PRI members for better management of the health system.
6.	JAMMU & KASHMIR	No PRI in J&K; however, community members are fully involved.
7.	MADHYA PRADESH	Not commented upon separately; need to step up involvement of Panchayati Raj Institutions; joint accounts have been opened;
8.	ORISSA	PRI role limited to attending meetings and management of untied funds; VH&SC not in place as yet; ASHA has been positioned; Village Health Days are being conducted.
9.	RAJASTHAN	Panchayats involved in the health system; partnership at Sub Centre level is working well; Village Health Committee meeting regular; Viilage Health Committee and water and sanitation committee to merge under the umbrella of Panchayati Raj.
10.	TAMIL NADU	12619 Village Health and Sanitation Committees are fully functional; untied grants used for cleanliness; has helped in community involvement; involvement of PRI at village and Sub Centre level is very good; Panchayats providing free meals for patients in a few places.
11.	TRIPURA	Very high and effective involvement of Panchayati Raj Institutions in health institutions; very active in Rogi Kalyan Samitis and Sub Centre Committees; Village Health Committees being constituted along with water and sanitation committees;
12.	UTTAR PRADESH	PRIs are involved in the Village Health and Sanitation Committees and the Sub Centre level Committee, as also the RKS; need to enhance their involvement in the management of the health system.
13.	WEST BENGAL	Panchayats are actively involved in the management of the health system; RKS and united funds available with them; Gram Unnayan Samitis working as VH&SCs;

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

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	District Plans prepared in 2007-08. District Teams are involved; involvement will increase with earmarked DPMUs and SPMU for the purpose, which is in the process of being set up.
2.	ASSAM	24 districts prepared plans in 07-08; regular district level review meetings; review by CM/Minister regularly improves performance; need to improve record keeping of District Health Mission meetings.
3.	BIHAR	District Plans by unicef in 2 districts; rest of the district through technical consultants; data collected but matter went into litigation; still being resolved; low local involvement.
4.	CHHATISGARH	All districts have prepared their plans in the previous year. Need for more intensive discussion on the district plans. Need to link it up with Swasthya Panchayat programmes.
5.	GUJARAT	Plans prepared for all the districts; approved by the Executive Committee; need to seek approval of the District Health Mission.
6.	JAMMU & KASHMIR	District Plans nearing completion; done by contracting out; while planning is participatory, district level health functionaries needed to be more fully involved in the process; District Health Society meetings being held; need more focus on NRHM.
7.	MADHYA PRADESH	Good system of District Health Action Plans and their appraisal; District Plans as basis for monitoring and review as well; village plans being developed. Need more participatory processes at community level.
8.	ORISSA	District Health Action Plans prepared for 2007-08; being prepared for 2008-09; District Health Mission involved but process needs more decentralization to be able to capture needs.
9.	RAJASTHAN	26 of the 32 districts have prepared integrated plans; 23 plans already appraised; remaining plans being prepared; District Missions active.
10.	TAMIL NADU	2007-08 plans complete; Plans for 2008-09 are under way; will be completed by January 2008; Facility Surveys nearing completion for PHCs and Sub-Centres; Household surveys are in progress.
11.	TRIPURA	Village Plans are prepared based on household health data and with involvement of PRIs; facility surveys were conducted but without involvement of community/PRI; Planning and Monitoring Committees have to be established; District Plans prepared for all the four districts.
12.	UTTAR PRADESH	District Health Action Plans have been prepared but the involvement of district teams is weak; need to improve involvement of local stakeholders.
13.	WEST BENGAL	2007-08 Plans made by all 23 districts; process for 2008-09 under way; likely to be completed in January 2008; Panchayats fully involved at each level; Chairman of Zila Parishad heads the District Health Mission that meets regularly;

SYSTEMS OF FINANCIAL MANAGEMENT

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Quality of accounts in Area Hospitals and project Hospitals is satisfactory; need for improvement in untied fund accounts at PHC/CHC/Sub Centre and VH&SC level; need for more capacity building.
2.	ASSAM	Very good accounting system with proper account books, payment and receipt records, referral details, etc. being maintained; well performing system for flow of funds.
3.	BIHAR	SPMU, DPMU, Block Managers are all in place; SPMU needs to improve supervision; Monthly district audit proposed;
4.	CHHATISGARH	SPMU and DPMU have been set up. Need to improve their acceptance within main stream health system. Clarity of role required.
5.	GUJARAT	The overall financial management system seemed to be properly streamlined; District Accounts Managers managing accounts at the district level; delegation of administrative and financial powers needed.
6.	JAMMU & KASHMIR	Need to improve financial management system; SPMU/DPMU in place since April 2007; need for orientation ad training of functionaries; need to follow financial procedures as laid down in NRHM system; need to ensure timeliness of fund releases.
7.	MADHYA PRADESH	Excellent system of monthly district audit; SPMU/DPMU fully functional; timely audit of accounts; governance issues regarding procurement need attention.
8.	ORISSA	Need for dedicated accounting personnel at Block level; SPMU and DPMU is in place; no delay in release of funds to districts.
9.	RAJASTHAN	Societies have merged; SPMU/DPMU are functional; Block Management structure being put in place; fund flow is smooth; very good use and accounting of untied funds.
10.	TAMIL NADU	System of record keeping right from the village and sub health centre levels to PHC/Taluk hospitals and District Societies is extremely good; system of financial reporting is very good.
11.	TRIPURA	Untied funds have increased the need for better financial management as there are many more details needed; strengthening of the system is going on; needs some more attention.
12.	UTTAR PRADESH	SPMU/DPMU not set up as yet; however systems; mainstream health functionaries are satisfactorily managing the financial system including of JSY.
13.	WEST BENGAL	Accounts Managers provided in Districts and Blocks; Financial management system is very effective; PRIs involved in decision making at all levels;

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HEALTH MANAGEMENT INFORMATION SYSTEM AND ITS EFFECTIVENESS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Effective reporting system for surveillance; ANMs reporting weekly; data being acted upon.
2.	ASSAM	The availability of information and its use at the State level is very good; district level needs to do more data analysis rather than mere mechanical data collection.
3.	BIHAR	Data Centre at State level collecting Block PHC data regularly; data being used for effective monitoring; district level needs to be activated;
4.	CHHATISGARH	System of reported through sub-centres. Needs further strengthening.
5.	GUJARAT	Useful institution specific data being generated and regularly monitored; helps in focusing on under performing institutions;
6.	JAMMU & KASHMIR	HMIS being collected by facilities and submitted to district/State; however, analysis of data collected not happening at facility and district level; need for facility specific monitoring to ensure full utilization of professionals at institutions.
7.	MADHYA PRADESH	Useful MIS work; reporting systems getting streamlined;
8.	ORISSA	A weak area in the State; Monthly Sub Centre reports submitted to PHC; needs more local level analysis. State is proposing training of staff for better data management.
9.	RAJASTHAN	Report has not commented on HMIS.
10.	TAMIL NADU	Excellent reporting system is in place; All districts are reporting on the new MIES format on time.
11.	TRIPURA	Integrated MIES data formats found at lowest levels; Multiple reporting still in vogue; contractual staff reporting on NRHM; needs more support of regular staff; community monitoring is not in place as yet but PRIs are involved in sanction and expenditure of untied funds across all facilities.
12.	UTTAR PRADESH	Need to improve system of HMIS and quality of data. Facility specific data has been devised for monitoring service guarantees. More effective use of the data is possible for district planning.
13.	WEST BENGAL	Not commented upon in the CRM Report; Good data collected as part of planning for Health System Reform in West Bengal; need for integrating data sets effectively.

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RATIONAL USE OF MANPOWER AT VARIOUS LEVELS TO ENSURE APPROPRIATE SKILLS FOR BETTER OUTCOME ?

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Rationalization calls for pooling of hospitalized, in patient services; Sub Centre, PHC, CHC Nursing needs provided for; shortage of Specialist; need to ensure assured services.
2.	ASSAM	Though manpower is being used optimally, there is room for some further rationalization; shortage of Specialists; under utilization of 2nd ANM due to non residence need for corrective action; ASHAs helping put pressure on public system.
3.	BIHAR	Serious efforts at rationalization by Block pooling of doctors at Block PHC, Sub Divisional and District Hospital; more service guarantees, especially with regard to surgery and in patient care possible with this rationalization, but not happening as yet; shortage of nurses/ANMs.
4.	CHHATISGARH	Governance reforms needed to ensure rationale deployment of specialists, doctors and nurses. System of incentives introduced to encourage doctors and nurses to work in remote areas. Better governance and cadre management needed.
5.	GUJARAT	Since large vacancies will continue to occur at all staff and professional levels, the skill mix would have to be constantly evolving and shortages will have to be met by trying many innovations; one third of the PHCs in a district had staff shortages.
6.	JAMMU & KASHMIR	Need for rationalization from large pool of manpower available to the State to guarantee services; need to carefully look at facility and service mix; need for orientation and training of staff nurses.
7.	MADHYA PRADESH	Report has not commented on this separately; while staff availability has improved, more work needed to ensure better rationalization of services in remote areas; need for improved promotional avenues and regularised (not contractual) employment for PHC and CHC doctors to attract more medical human-power to the rural public health system.
8.	ORISSA	Lack of rational use of manpower is an area of concern; Specialists posted in PHC is wasting of skill; need for system of posting and transfers. State has engaged 259 AYUSH doctors.
9.	RAJASTHAN	Deployment is rational but shortages persist, especially for Specialists; GNMs being appointed as ANM but MPW (M) vacant.
' 10.	TAMIL NADU	Counselling' an integral part of the posting system; Human resource shortages made up by hiring of services whenever required.

Be wise. Immunize

RATIONAL USE OF MANPOWER AT VARIOUS LEVELS TO ENSURE APPROPRIATE SKILLS FOR BETTER OUTCOMES

S. No.	STATE	KEY FINDINGS
11.	TRIPURA	State is rationally using manpower; ANMs from outside the district poses problems in remote areas, of non residence since malaria is a problem, State has filled up posts of MPW (Male) on contract.
12.	UTTAR PRADESH	Lot more rationalization needed in the management of cadre of Specialists and Doctors; need for rational use of Nurses, Paramedics as well, based on case load.
13.	WEST BENGAL	Efforts have been made to rationalize manpower and make the system efficient and effective; few key vacancies (Specialists, Lab Technicians) posing problems; decentralization of contractual recruitments at local level, even by Gram Panchayats for fixed day services;

24x7 Call Centre Established to receive Outbreak Alert from across the country by a toll free phone

A call centre has been established under the Integrated Disease Surveillance Project (IDSP) to receive alert/information for Outbreaks and Epidemic Diseases.

You may call the toll free number1075 from anywhere in the country using either fixed phone or cell phone of any service provider (GSM or CDMA) free and inform regarding:

- **An outbreak or incidence of disease in large number in any localities.**
- **Incidence of an unknown disease in your family/ area/ workplace**
- **Report a patient of Cholera, Jaundice, Plague, Dengue, Meningitis, Encephalitis, Malaria, Chikungunya, Measles, Leptospirosis, Polio or any unknown disease**

Calls can be made by Health Workers, Health Care Personnel, Members of public/community, Private Practioner, Panchayat Members, community leaders and all such persons aware of any occurrence of disease that is likely to spread.

Presently the call centre is being opened to the calls from health personnel only at this stage.

The call centre is operational 24 hours a day, 365 days a year. So you can make a call any time of the day or night absolutely free.

Call from anywhere in the country

1075 TOLL FREE

You may also send the same information by e-mail to dmit_idsp@rediffmail.com

Ministry of Health & Family Welfare
(Integrated Disease Surveillance Project)

Timely vaccination saves life

XIII THRUST ON DIFFICULT AREAS AND VULNERABLE SOCIAL GROUPS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	More in patient treatment in public facilities will improve access of vulnerable groups; out patient facilities and availability of drugs is useful.
2.	ASSAM	District PIPs reflect special thrust on SC/ST, and minorities; separate record of OPD cases of SC/ST/Minorities, available for inspection; coverage of Char areas by camps; demand for health services in Char areas.
3.	BIHAR	Poor flocking government hospitals for drugs, doctors and diagnostics; operationalizing Sub Centres and Additional PHCs will further help in attending to needs of vulnerable groups.
4.	CHHATISGARH	Mitanian programme very pro poor. Provides communities an opportunity to seek health services. Need to improve health services faster.
5.	GUJARAT	Data on SC/ST being generated by HMIS; closer monitoring of data driven monitoring required;
6.	JAMMU & KASHMIR	Special action on remote areas through RCH camps/sessions.
7.	MADHYA PRADESH	Mobile units for remote areas; more camps needed in remote areas. In tribal areas ASHAs are required at hamlet or cluster of hamlets level (may be below 1000 population) to ensure adequate coverage of remote and far-flung households.
8.	ORISSA	State has initiated a large number of activities for tribal areas; Swasthya Melas, incentives for posting in difficult areas, etc.
9.	RAJASTHAN	Clear BPL focus in RMRSs for cashless hospitalized treatment of BPL; provision for generic drugs for poor.
10.	TAMIL NADU	Ambulance services and RCH camps take care of many needs; Specialist camps are also being organized; thrust is on vulnerable groups.
11.	TRIPURA	Helicopter service health camps in remote, inaccessible tribal villages; State needs to analyze disaggregated data on health parameters.
12.	UTTAR PRADESH	Activation of Sub Centres though untied grants and presence of ASHAs helps households to connect with health facilities; almost two third of deliveries at the PHC/CHC were of SC and OBC, but coverage still low; need to further increase focus on marginal groups.
13.	WEST BENGAL	Vulnerable groups are a focus; ASHA only for tribal areas and minority concentration areas with unsatisfactory indicators; ANMs from difficult areas from such communities;

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

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	ASHAS selected and completing 23 day training; very high quality of training by NGOs; likely to make a difference in the demand for public services.
2.	ASSAM	ASHA enthusiastic and enjoys confidence of community; ASHAs given radios; ASHA radio programme well received; 2nd training going on; Non resident 2nd ANM is a concern; ASHAs demanding services for communities.
3.	BIHAR	ASHAs are local and very enthusiastic; well trained for basic activities; handling JSY, Immunization, DOTS; playing social mobilization role; very active; payments not timely; need for facilitation and resource support.
4.	CHHATISGARH	Mitanins are an outstanding success. ANMs in the field working very well. More Lab Technician, Doctors, Specialists required with better governance and incentive system.
5.	GUJARAT	ASHA/Gram Arogya Sathi selected; first round training nearing completion; drug kit must be provided to ASHAs immediately on completion of training.
6.	JAMMU & KASHMIR	ASHA selection completed; first round training complete; second round in a few districts; ASHAs found to be quite knowledgeable; non payment against activities is an issue. Need to record output of all functionaries in institutions.
7.	MADHYA PRADESH	Most ASHAs selected and first round training completed; lack of role clarity between ASHAs and AWWs/ TBAs; creating conflicts regarding compensation money.
8.	ORISSA	ASHAs are visible everywhere; selection complete; 36% have advanced training and 88% had done induction training; Trained ASHAs have badges; induction training has been found to be very helpful. .Performance of ANM is not satisfactory; delay in release of ANM salaries; shortage ofpara medical staff; performance of doctors not satisfactory at PHC/CHC level; overburden on doctors at Sub Divisional and District Hospital level.
9.	RAJASTHAN	ASHA Sahayoginis are doing very well; handling malaria, TB, immunization, JSY and family planning; well integrated with ICDS; blended payment of stipend and performance based payment is a good model; ANMs are doing well.
10.	TAMIL NADU	The patients, the community, and all stake holders have a very high opinion of health personnel in the State; known for their devotion to work; ASHAs not provided for Tamil Nadu.
11.	TRIPURA	Health staff are generally motivated, committed and enthusiastic; ASHAs selected by transparent process involving the PRIs; trained in first module and provided drug kits; training included training on use of Rapid Diagnostic Kits for malaria; bright red coats and blue kit bags have given a unique sense of pride and

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

S. No.	STATE	KEY FINDINGS
		identity to the ASHAs; ASHAs working as drug dispensers and JSY motivators. Doctors playing important role in remote areas;
12.	UTTAR PRADESH	ASHAS have had one round of training; there is drop out especially of those who were looking for government employment; immunization, JSY work focus; payments are not timely; need to ensure drug kits and involvement in more public health activities. Almost two third of deliveries at the PHC/CHC were of SC and OBC, but coverage still low; need to further increase focus on marginal groups.
13.	WEST BENGAL	ASHAs not in position as yet; ANMs doing very well at Sub Centres; Doctors and Nurses meeeitng additional load at PHCs, Block PHCs and Rural Hospitals.

XV SYSTEM OF DISEASE SURVEILLANCE AND REPORTING

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory system of disease surveillance in place; regularity of report by Sub Centres; good quality labs at PHC/CHC level; IDSP getting well established. 108 and 104 emergency and Counseling services to be used for surveillance as well.
2.	ASSAM	Surveillance limited to TB and Malaria; District Surveillance Unit not fully functional; new computers supplied but not installed.
3.	BIHAR	Weak system; Disease Surveillance Team not effective; ASHA is active but not reporting to the surveillance team; need to activate below Block PHC for effective surveillance and reporting systems.
4.	CHHATISGARH	Disease surveillance through Mitanins and ANMs need to improve receptivity of PHCs, CHCs to information from below. Labs at PHCs level were found to be satisfactory with trained technicians. Mitanins visiting household regularly for fever survey. Mitanins having drug kits.
5.	GUJARAT	The system is working satisfactorily and the time taken for reporting surveillance data is within stipulated time frame; IDSP central monitoring cell has been established; District surveillance Officers placed and manpower trained.
6.	JAMMU & KASHMIR	Reporting of IDSP has started in selected districts.
7.	MADHYA PRADESH	Not commented upon separately. Needs attention; disease surveillance units need to be made active and functional; current focus is much more on maternal and child health alone;
8.	ORISSA	Surveillance system not functioning very effectively, though cell has been constituted.
9.	RAJASTHAN	No comment in the Report.
10.	TAMIL NADU	IDSP trying to integrate communicable and non communicable diseases; 28 District Surveillance Units fully functional; Lab facility modernized under IDSP.
11.	TRIPURA	IDSP Centres are operating at all levels and registers are being maintained; Supervisors and ANMs/MPWs have been trained under IDSP and are sending reports; PHCs have received computers but software is not installed yet; data operators being shortly placed at PHCs.
12.	UTTAR PRADESH	Not reported on.
13.	WEST BENGAL	ANM doing disease surveillance work as well; involved in leprosy, TB, Malaria and blindness control programmes; malaria a focus;

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

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Untied funds of VH&SCs and Sub Centres have been used for sanitation and water purification activities; wider publis health focus will emerge.
2.	ASSAM	VH&SC Not set up as yet waiting for Panchayat elections; spray of DDT, etc. reported but specific efforts for inter-sectoral convergence were not visible.
3.	BIHAR	Community involvement in select Kalazar districts in DDT spray; new initiative of 'Muskaan' for 100 % immunization and 100% institutional delivery involves ICDS Centres, AWWs and ASHAs together as a team; Constitution of VH&SC in partnership with the water and sanitation committee (as proposed) under the umbrella of PRI will be helpful in inter sectoral convergence.
4.	CHHATISGARH	Mitanins playing critical role in the behaviour change communication and community activities.
5.	GUJARAT	The measures for control of vector borne diseases under NVBDCP guidelines are in position and working satisfactorily; involvement of PRIs has been there; inter sectoral convergence for vector control in position through institutions.
6.	JAMMU & KASHMIR	Inter sectoral convergence not started as yet.
7.	MADHYA PRADESH	Nutrition Resource Centres have been established in 60 places; effective in handling extreme forms of malnutrition; a pilot initiative; more inter-sectoral convergence required.
8.	ORISSA	Malaria major vector borne disease; New measures involvement of NGOs in spray, epidemic response team in each district, sensitization of traditional healers, message transmission through school students and SHGs, ASHA trained on a pilot basis in 50 Blocks, GIS mapping, etc.
9.	RAJASTHAN	Good partnership with ICDS through ASHA Sahayogini; Sub Centres have improved performance though untied funds and are better placed for convergence; Maternal, child and nutrition days being organized in every village; Village health and Sanitation Committees have been constituted at Gram Panchayat level but are not fully functional as yet.
10.	TAMIL NADU	Health Inspectors (MPWM) at PHC level doing malaria surveillance; VHNs trained in various diseases; Lab Technician available at every PHC; Regular system of monitoring and review besides availability of trained personnel with earmarked responsibilities.
11.	TRIPURA	Village Health Committees to be constituted by merging with the water and sanitation committee; PRIs fully involved;
12.	UTTAR PRADESH	RNTCP and malaria programmes in place, case detection in RNTCP poor due to lack of staff in some key facilities and poor coordination with private sector; more integration with district planning needed.
13.	WEST BENGAL	VH&SC constituted in 16770 villages as Gram Unnanyan Samiti, under the umbrella of PRI; PRIs involved at all levels; provides useful platform for inter-sectoral convergence.

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XVII EFFECTIVENESS OF THE DISEASE CONTROL PROGRAMMES

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory performance of disease control programmes; apprehension in RNTCP that integration of Labs could affect DOTS performance; need for integration of services.
2.	ASSAM	Satisfactory within the limitation of resources available in health institutions; PHCs have facilities for sputum examination for TB and blood smear for malarial parasite; Rapid diagnostic kits are available; consumables are available; Malaria Surveillance Workers and MPW(M) are being engaged; need to break verticality in diagnostic activities.
3.	BIHAR	Thrust on Kala azar treatment visible in Block PHCs and District Hospital; Loss of wage payments from RKS for Kala Azar; Improved case detection for TB and Malaria due to improved diagnostic facilities and functional Block PHCs; Health system strengthening has positive impact on disease control programmes.
4.	CHHATISGARH	Malaria, Leprosy, TB programmes need better follow up. Better monitoring required by sector medical officers.
5.	GUJARAT	Merger of programmes has taken place under the Mission Director; supervisory cadre vacancies; contractual Lab Technicians help;
6.	JAMMU & KASHMIR	RNTCP has done well; Lab services at PHC are integrated; technician doing routine and TB work; case detection is satisfactory.
7.	MADHYA PRADESH	It has not been commented upon. Report does say that the focus in MP seems t be on JSY and other family welfare programmes; need for a public health approach covering all sectors has been reported.
8.	ORISSA	Sectoral Microscopy Centre not working in some places due to shortage of Lab Technicians; RDT available in plenty; ASHA may be trained as FTD; use of RDT Kits. Leprosy needs more attention; Blindness Control programme audited statements are pending; Need for improvement in record keeping of RNTCP.
9.	RAJASTHAN	TB programme doing well; ASHA sahyogini involved in DOTS; 1978 treatment centres in the State; ASHA Sahyogini involved in bringing cataract patient in camp; ASHA Sahyoginin involved in distribution of anti malaria drugs; high incidence of malaria in State.
10.	TAMIL NADU	Very effective implementation with clear responsibilities at each level; Human resources and effective monitoring makes the difference.
11.	TRIPURA	Malaria prone are with drug resistance as well; RDKs are being used by peripheral level health workers; slide examination at PHC level; RNTCP staff positions filled up and satisfactory cure rate; teleophthalmology being tried out; good IEC;
12.	UTTAR PRADESH	
13.	WEST BENGAL	Satisfactory performance of all disease control programmes; ANMs and Sub Centres fully involved; shortage of Lab Technicians; need for integrating TB and Malaria Lab Technicians.

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XVIII PERFORMANCE OF MATERNAL HEALTH, CHILD HEALTH AND FAMILY PLANNING

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	More attention needed for child health; satisfactory performance of family planning; maternal health facilities being up graded.
2.	ASSAM	Remarkable increase in institutional deliveries; need to keep women in facility longer; Family Planning services need improvement; erratic distribution of condoms and pills; IUD services not provided by ANMs.
3.	BIHAR	Family planning picking up; useful PPP with Janani; need to improve quality of institutional delivery and hospital stay; basic availability of equipments in Labour Rooms needed immediately.
4.	CHHATISGARH	Need to improve quality of maternal and child health.
5.	GUJARAT	Appreciable new initiatives for maternal and child health; blood storage facilities need attention; Lab technicians have helped JSY; Chiranjeevi Scheme of PP for BPL women in institutional deliveries has contributed in a big way;
6.	JAMMU & KASHMIR	Compromise of quality seen at many places; low performance on family planning; need to improve quality of services.
7.	MADHYA PRADESH	RCH activities have received thrust resulting in significant increase in institutional deliveries; family planning services have also picked up;
8.	ORISSA	Significant increase in institutional delivery; multi skilling for Anaesthesia and Emergency Obstetric Care being tried out; 33% increase in institutional deliveries; need to improve referral transport system.
9.	RAJASTHAN	Dramatic increase in institutional deliveries; PPP for JSY and sterilization programmes; additional posts created to meet large demand for maternal health services; IMNCI being implemented in 9 districts; immunization performance is satisfactory; improvement in sterilization after decline over the last two years.
10.	TAMIL NADU	High quality maternal health, child health and family planning services being provided at institutions; quality of labour rooms and wards is very good; shift from private sector to government sector in the last one year.
11.	TRIPURA	Strategies need to be developed to reach out to remote areas; arrangements tackling neo natal mortality need to be strengthened;
12.	UTTAR PRADESH	Health facilities are clean even where there is over crowding; shortage of nurses is a limiting factor in quality of care. With only one ANM at SC and many hamlets to cover, absence of ANM limiting care; ASHA not yet given second round training. Neonatal unit being opened in the district hospital, but difficulties of transport.
13.	WEST BENGAL	Excellent Sick and New Born Care Units established; increasing institutional deliveries along with strengthening of the system; family planning picking up with more functional health system at all levels.

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XIX PRFORMANCE OF MOBILE MEDICAL UNITS/ SYSTEMS OF AMBULANCES

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Outstanding system of emergency medical service throughout the State; excellent example of PPP; provides opportunity for Mandal pooling as transport system ensures timely referrals.
2.	ASSAM	Ambulances available in all PHCs with drivers; log books provide details of referrals and other use; MMUs established in 8 districts; Boat clinics in four districts.
3.	BIHAR	Ambulances by PPP in every Block PHC working very well; PPP experiment in MMU did not work well has been discontinued.
4.	CHHATISGARH	Not set up as yet.
5.	GUJARAT	85 GPS enabled Mobile units working in the State; more strengthening of the Mobile Health unit will improve access in difficult areas; Ambulance service also started on EMRS pattern.
6.	JAMMU & KASHMIR	Ambulance services available in each health facility visited; MMUs not procured as yet.
7.	MADHYA PRADESH	Deendayal Chalit Aspatal (Mobile Health Clinics) for remote tribal pockets, providing all services; Janani Express Yojana by PPP for meeting referral transport need; improved availability of ambulances in most areas.
8.	ORISSA	NRHM Mobile Units not procured as yet; State's own Mobile Health Units are functional; need to improve planning and monitoring of Mobile unit.
9.	RAJASTHAN	Orders have been placed for 52 Mobile Medical Units; tenders for 52 diagnostic vans and 100 ambulances have been floated;
10.	TAMIL NADU	100 mobile outreach units working; another 146 units proposed in 2008-09; successful mobile health camps; ambulances available on call.
11.	TRIPURA	Ambulances are available at PHCs; Referral transport funds are also spent through the RKS; demand for ambulances to bring patients from villages;
12.	UTTAR PRADESH	Not functional in the districts visited.
13.	WEST BENGAL	Ambulances at all Block PHCs with the involvement of NGOs working well.

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XX PROGRESS OF INFRASTRUCTURE AND SYSTEMS FOR IMPROVEMENT OF CIVIL WORKS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory progress in infrastructure development;
2.	ASSAM	Community perceives improvement in health infrastructure; need for improvement in design of civil works; demolish unusable old buildings; waste management needs attention.
3.	BIHAR	Excellent use of Finance Commission funds to improve Block PHCs; Sub Centres being constructed with in built ANM residence; low utilization of NRHM funds for infrastructure so far due to Finance Commission works; 24X7 generator and ambulance at Block PHCs working very well.
4.	CHHATISGARH	Civil construction completed. Over all improvement needs more attention.
5.	GUJARAT	Project Implementation Unit is the nodal agency for infrastructure; has done commendable job in construction and repair; need to delegate minor repairs to districts and institutions;
6.	JAMMU & KASHMIR	Need to plan the entire health facility in a systematic way; current approach is piecemeal; need for detailed facility survey and institutional plan; three different agencies are doing construction work in J&K.
7.	MADHYA PRADESH	Not commented upon.
8.	ORISSA	6 public sector agencies have been entrusted the civil works task for up gradation of infrastructure in Hospitals.
9.	RAJASTHAN	Civil works planned very systematically in conjunction with RHSDP; Facility Survey completed in 290 out of 352 CHCs; planned up gradation of facilities with a focus of NRHM on residential quarters; work complete in 42 CHCs and under progress in232.
10.	TAMIL NADU	Funds for up-gradation of 75 PHCs has been given to PWD.
11.	TRIPURA	PWD doing the infrastructure up gradation; progress is slow; PWD note able to cope with work load; need to explore possibility of central construction agencies for infrastructure up gradation.
12.	UTTAR PRADESH	Sub Centre buildings needed on a priority; up gradation work has been taken up in many places; need to speed up infrastructure development, electricity connections and provision of quarters.
13.	WEST BENGAL	Civil works development through the PWD; progress is satisfactory; need to further improve the pace of infrastructure development.

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

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	Satisfactory system of procurement and logistics; drugs available every where;
2.	ASSAM	Procurement from TNMSC and by State Government; improved drug availability everywhere; needs to be made need based; logistics and demand for drugs needs to be incorporated with procurement system (as in TNMSC); need based system being put in place.
3.	BIHAR	Remarkable improvement in drug availability; rate contract with manufacturers at State level and resources with District Health Societies; cash and carry system working well; wants to do TNMSC like procurement and logistics system.
4.	CHHATISGARH	Availability of drugs is satisfactory. Quality of procurement needs more attention.
5.	GUJARAT	Efficient system of drug and equipment procurement in place; system is working well.
6.	JAMMU & KASHMIR	Mixed picture regarding drug availability and its management; need for improvement; storage facility available in health facilities; need to monitor drug availability.
7.	MADHYA PRADESH	Non-availability of medicines to certain patients reported; significant portion of RKS expenditure on medicines, logistics support to peripheral facilities needs strengthening.
8.	ORISSA	State Drug Management Unit in place; has improved system but there are shortages in the field. Inventory management needs to be improved.
9.	RAJASTHAN	Very good availability of medicines at all levels;
10.	TAMIL NADU	TNMSC doing a remarkable job of procurement and logistics not only of drugs but also of equipments.
11.	TRIPURA	Adequate availability and off take of drugs in facilities; need to sensitize doctors to prescribe generic drugs. Equipment/ drug procurement is also being done through the RKS and Sub Centre committees.
12.	UTTAR PRADESH	Drugs are available everywhere. But prescription for buying from outside also high. The procurement and disbursement system needs to be rationalized to prevent delays in procurement by the central store and make distribution responsive to demands.
13.	WEST BENGAL	Good system of procurement of drugs by districts based on rate contract; further refinement attempted to make it need based, like TNMSC. Availability of drugs is satisfactory.

ASSESSMENT OF NON GOVERNMENTAL PARTNERSHIPS FOR PUBLIC HEALTH GOALS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	EMRI excellent example of PPP that helps professional emergency ambulance services in the entire State.
2.	ASSAM	Very few partnerships other than the MNGO programme.
3.	BIHAR	A few PPPs working well diagnostics, ambulance, generator; NGO partnership for running Additional PHCs has been discontinued as payments are not timely; lack of trust; need for clear responsibilities and time lines for payment and assessment by both sides; another attempt to give Additional PHCs to NGOs and Panchayats.
4.	CHHATISGARH	NGOs involved in Mitanin programme on a large scale.
5.	GUJARAT	Strong tradition of partnerships; Chiranjeev scheme; many small partnerships with NGOs for specific tasks.;
6.	JAMMU & KASHMIR	Not seen in any of the institutions visited.
7.	MADHYA PRADESH	Useful innovations in Jananai Express and Deendayal Chalit Aspatal (Mobile Health Clinic); supporting SC/ST trainees from remote villages for nursing in private institutions;
8.	ORISSA	MNGO scheme is working well; very few other PPPs.
9.	RAJASTHAN	Private institutions accredited for JSY, sterilization and IUD insertion.
10.	TAMIL NADU	NGOs helping in operationalizing the toll free ambulance system.
11.	TRIPURA	Telemedicine partnership established for eye care; PPP Medical College and Nursing College recently started.
12.	UTTAR PRADESH	Several NGOs evidently working in the health field but public health services not yet develop partnerships.
13.	WEST BENGAL	Large number of partnerships in ANM training, ambulance services and mobile clinics, diagnostic services, etc.

PREPARATION FOR MEETING HUMAN RESOURCE NEEDS, SPECIALLY WITH REGRAD TO NURSING AND PARA MEDIC STAFF AND FUNCTIONING OF ANM TRAINING SCHOOLS AND OTHER NURSING INSTITUTIONS

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	State needs to focus on multi-skilling of doctors for anaethesia and obstetrics; no shortage of nursing training institutions; quality needs attention.
2.	ASSAM	ANM Training Schools are functional but need to improve quality of their infrastructure and training; repair work funds provided under NRHM and plans approved but work yet to begin; more practical orientation required in ANM curriculum hands on!!!
3.	BIHAR	Highest focus needed on Nursing institutions as that is the most important and critical constraint; mopping up of trained ANMs and Nurses not enough; 12 ANM schools have started again but they are not in a satisfactory state; much faster improvement of infrastructure, equipment and trained human resources needed to make ANM Training Schools vibrant; funds are already available under NRHM.
4.	CHHATISGARH	State needs to develop long term and short term plan for enhancing health human resource in the State. Three year programme started in Chhattisgarh some years ago.
5.	GUJARAT	State needs to plan its nursing staff needs; ANM vacancies; Staff Nurse vacancies; thrust needed on strengthening ANM/Nurse training Schools.
6.	JAMMU & KASHMIR	While manpower availability is good, need to guard against over deployment without service guarantees; ANMs and Staff Nurses being recuited;; Staff Nurses need.
7.	MADHYA PRADESH	SPMUs and DPMUs in place and functional; DPMUs may need more synergy with district officials and block level staff..
8.	ORISSA	State is aware of the long term needs of human resources; many actions already initiated; further long term strategy to be firmed up.
9.	RAJASTHAN	State has tried to strengthen ANM Training Schools; faster implementation required; MPW (M) is neglected;
10.	TAMIL NADU	No ANM School needed; 6000 Nurses completing from Nursing Institutions are adequate to meet State's needs. More thrust on Staff Nurses.
11.	TRIPURA	State has drawn up a plan for human resources; new institutions will help;
12.	UTTAR PRADESH	Need to prioritize human resource thrust, especially nursing personnel. ANM TCs reopening and MPW (M) need a priority thrust.
13.	WEST BENGAL	Exemplary focus on selecting local ANMs and creating additional capacity to train them; high vulnerable group representation; thrust on under performing areas.

ASSESSMENT OF PROGRAMME MANAGEMENT STRUCTURE AT DISTRICT AND STATE LEVEL

S. No.	STATE	KEY FINDINGS
1.	ANDHRA PRADESH	State is in the process of setting up SPMU and DPMUs; currently being managed by regular Directorate of Health services team; need for administrative re-arrangements that provide a convergent platform; too many Directorates currently managing health services in AP.
2.	ASSAM	SPMU/DPMU/BPMU actively and enthusiastically involved in the field; lack of adequate participation of Directorate staff needs to be consciously addressed; need to push integration of all programme management structures for effectiveness and efficiency.
3.	BIHAR	Enthusiastic Block Managers, DPMU and SPMU; need for better integration with mainstream; enthusiasm for service delivery not internalized by mainstream task leaders;
4.	CHHATISGARH	SPMU & DPMU is in place, but linkage with directorate needs further attention. Role and functions need clearer articulation.
5.	GUJARAT	System is in place and working very well; DPMUs and BPMUs are functional; coordination is effective; need for integration of programmes in spirit not only in letter.
6.	JAMMU & KASHMIR	SPMU/DPMU in place since April 2007; need for PMU teams to visit facilities more often; capacity building needs should be met on priority.
7.	MADHYA PRADESH	SPMU/DPMU working very effectively.
8.	ORISSA	SPMU/DPMU in place; BPMU in some Blocks; improved monitoring system.
9.	RAJASTHAN	SPMU and DPMUs are fully functional; BPMUs being established; Management systems have greatly improved performance; Directorate staff also involved in implementing NRHM; greater integration will be beneficial.
10.	TAMIL NADU	Directorate of Public Health staff provides support for programme implementation; efforts to set up SPMU/DPMU; care should be taken to ensure that the involvement of DPH staff remains total.
11.	TRIPURA	Coordination of contractual NRHM staff with mainstream staff needs to improve. Staff is in position.
12.	UTTAR PRADESH	SPMU/DPMU not in place as yet; need to set them up on a priority basis, or to give management training to the existing CMO/deputy CMOs.
13.	WEST BENGAL	Strengthening of accounts system at all levels; mainstream well integrated with implementation of NRHM; need for further convergence of functions at State level.

ANDHRA PRADESH

THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- Dr. I.P. Kaur Dy. Commissioner., Maternal Health, MoHFW
- Manish Kakkar, Public Health Foundation Of India
- Shri Rajesh Kumar, Consultant Finance, FMG, MoHFW
- Dr. Kamla Mohan, Regional Director, MoHFW

ASSAM

THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- Mr Amardeep Singh Bhatia, Deputy Secretary, MoHFW.
- Dr J N Sahay, Advisor, NHSRC.
- Dr. Parthajyoti Gogoi, Regional Director, MoHFW.
- Mr. K.K. Kalita, Advisor, RRC, NE, Guwahati.

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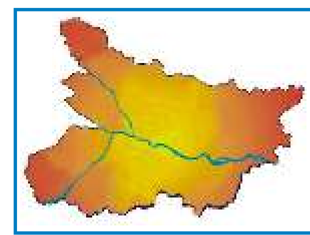
BIHAR



THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- Dr.Thelma Narayan, Public Health Specialist.
- Dr. D. Thamma Rao, Mission Director, NRHM, Puducherry.
- Dr.M.S.Jayalakshmi, D.C. Family Planning MoHFW.
- Dr. Dileep Kumar, Nursing Advisor, MoHFW.
- Mr. Amarjeet Sinha , Joint Secretary, MoHFW.

Timely vaccination saves life

CHATTISGARH

THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
▫ Successfully put in place community health activists- Mitanins- with high degree of commitment. ▫ District Health Mission established and functional. ▫ Effective involvement of PRIs and Community Processes noticeable. Panchayat health diary introduced for panchayat sarpanches. Village health planning systematic. ▫ Hospital development committees (Jeevan Deep Samities) have focus on quality care and provide for adequate representation of NGOs ▫ State health resource center effective and makes a positive contribution to health planning and community processes. ▫ 24 districts have completed District health plans.	▫ Issues of "Governance of NRHM" are critical and need immediate attention. Poor co-ordination at the senior levels. ▫ Health Infrastructure neither properly maintained nor fully utilized, needs immediate action steps for improvement. ▫ Increase in institutional delivery not matched by any quality of care improvement. ▫ Programmes of CHCs into FRUs/IPHS standards doing poorly. ▫ HMIS functioning poor. ▫ Financial Management, especially in some programmes like annual maintenance grants :

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- Ms Ganga Murthy, Economics Advisor, MoHFW.
- Ms. Neidino Angami, NGO, Mizoram.
- Dr. K. S. Gill, MoHFW.
- Manoj Kar, Advisor, NHSRC.

GUJARAT

THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- K. S. Srinivasan, Consultant and former Secretary, MoHFW.
- Madhukar Chaudhury, Mission Director, Maharashtra.
- Sandhya Ahuja, Senior Consultant, NHSRC.

JAMMU & KASHMIR

THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

- **District Udhampur:** medical aid center at Jhajjar kotli, PHC at Tikri, CHC at Chennai and Batot, and Katra and sub-center at Jakhani
- **District Jammu and district Samba:** CHCs at Ramgarh, Akhnoor,Vijaypur,PHC at Anandpur, SHC at karalia,District hospital at Samba and Missionary Hospital at Samba.

THE REVIEW TEAM:

- Dr Amarjeet Singh, Mission Director & Commissioner, Health, Gujarat.
- Dr Tarun Seem, Director, MoHFW.
- Dr AC Baishya, RRC, Guwahati.

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MADHYA PRADESH

THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

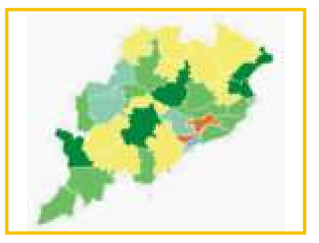
- Jabalpur: Office of Collector, District Victoria hospital,Lady Elgin Hospital,Civil Hospital, Tehsil Sinhora, CHCs, Patan;, Majhauli; PHCs: Chargaon and Sub Health Centers, Nunsar, Bijori and village Gosalpur, Tehsil Sinhora.
- Barwani: CMHO office;DPM office;District Hospital, Barwani;CHCs at Thikri;Pati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

THE REVIEW TEAM:

- Mr. Praveer Krishn, Joint Secretary, MoHFW.
- Mr. Sushil Kumar Lohani, NRHM Mission Director, Orissa
- Dr. Abhay Shukla, Senior programme coordinator, SATHI-CEHAT, Pune
- Ms. Shruti Pandey, Senior Consultant, NHSRC.

Timely vaccination saves life

ORISSA



THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

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

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RAJASTHAN

THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- Mr. Arun Baroka, Director, MoHFW.
- Dr. T. Bir, Faculty, NIHFW.
- Dr. D. C. Jain, Deputy Commissioner, MoHFW.
- Dr. Sunil D. Kharpade, Deputy Commissioner, MoHFW.
- Dr. A. K. Shiva Kumar, Consultant, Member MSG, NRHM.
- Dr. H.P. Yadav, Regional Director MoHFW.

Timely vaccination saves life

TAMIL NADU

THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- Shri Javed Chaudhary, Former Secretary, MoHFW.
- Shri P.K. Agarwal, Consultant Finance, FMG, MoHFW.
- Ms. Vandana Krishna, Commissioner Family Welfare, Maharashtra.

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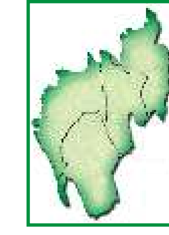
TRIPURA



THE KEY FINDINGS

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

THE DISTRICTS/INSTITUTIONS VISITED

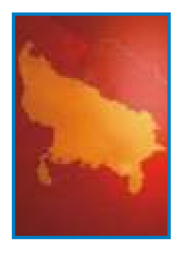
- **Dhalai District:** Gandachara and Kamalpur Hospital, PHC- Ganganagar, Kulai, Salema, Sub Centres- Harinchara, Durbajoy, East Nalichara, Kolachari, Training Institute- District Health Training Institute, Village- Baligaon
- **West Tripura District:** SDH - Sonamura and Bishalgarh, CHC Mohanpur, PHC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

THE REVIEW TEAM:

- Ms. Archana Varma, Deputy Secretary, MoHFW,
- Mr. Praveen Srivastava, Director M&E, MoHFW,
- Dr. Charan Singh, Joint Director-NVBDCP, MoHFW, and
- Mr. Gautam Chakraborty, Senior Consultant - Health Care Financing, NHS.

Timely vaccination saves life

UTTAR PRADESH



THE KEY FINDINGS

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

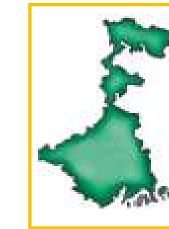
THE DISTRICTS/INSTITUTIONS VISITED

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

THE REVIEW TEAM:

- Dr. T. Sundararaman, Executive Director NHSRC
- Dr. Shalini Bharat, Dean, School of Health Systems studies, TISS
- Dr. Ritu Priya, Advisor, NHSRC.
- Dr. Dinesh Biswal, Asst Commissioner, MOHFW.
- Dr. Siddharth Choudhury,Regional Director, GOI.

WEST BENGAL



THE KEY FINDINGS

THE POSITIVES	AREAS FOR IMPROVEMENT
▫ Sub-centre doing fixed day clinics ▫ GPs authorized to hire doctors for few days in a week ▫ Drug availability increase institutional deliveries ▫ Up-gradation of PHC's & BPHC's ▫ Appointment of doctors, specialists & nurses ▫ Satisfactory immunization ▫ Strong nursing cadre & Directorate ▫ Physical infrastructure handed over to Panchayats maintenance ▫ Active involvement of panchayats in the management of health system	▫ Demand for PPP for diagnostics ▫ Getting specialists ▫ To integrate data sets effectively ▫ Satisfactory indicators for ASHA's in tribal & minority concentration areas (ASHA's not in position) ▫ Shortage of lab technician's ▫ Need for integrating & Malaria lab technician's levels ▫ Need to improve pace for infrastructure development ▫ Refinery of system of procurement of drugs to make it need base, like TNMSC key findings ▫ Further convergence of functions of accounts system at staff level

THE DISTRICTS/INSTITUTIONS VISITED

- **District Birbhum:** BPHC Illambazar, Sub Centre Ruppur, PHC Sattare, RH Labour, ANM Trg Centre Suri, Distt Hospital Suri
- **District Bankura:** Bankura Sarmelini Medical College Hospital, Nursing Training Centre Bankura, RLTRI Gauripur, BPHC Amarkanan, PHC Beliatod, SC-W, Beliatod

THE REVIEW TEAM:

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

Dear Sir,

I happened to see the "Rashtriya Gramin Swasthya Mission Patrika (in Hindi). I came to know that its English version (NRHM Newsletter) is also being brought out. This is a very informative magazine. A lot of information was provided on Dengue, Chikungunya, etc. May I request you to kindly add my address in the mailing list of these magazines (in both languages) at the address given below:-

Dr. K.N. Pandey,
B-289/B, Sector 19,
NOIDA 201 301

Dear Sir,

I am working as a Block Health Officer at Taluka Anjar, Distt. Kutch, Gujarat. I have gone through your NRHM Newsletter. It is very informative to us. Kindly include my name in your mailing list.

Mr. Rajnikant,
Block Health Officer,
Community Health Centre Compound,
D-1, Medical Officers Quarter, Nagalpar Road,
Anjar Kutch,
Gujarat 370 110.

Dear Sir,

I am working as a Senior Tuberculosis Supervisor in Health Department of Punjab. Your newsletter gives clarity on our health status and the actions being planned. Kindly keep me on mailing list and also request you to send newsletter regularly.

Shri N.K. Sharma,
Senior Tuberculosis Supervisor (STS),
Sharma's Bhawan, Nehru Gate, Opp. Bobby Studio,
Batala 143 505
Distt. Gurdaspur, Punjab.

Dear Sir,

I would like to request for subscription of NRHM Newsletter for our institution. If it is available free kindly do the needful. The newsletter will definitely be useful to all faculty members, students and other paramedical staff.

Dr. B.P. Gupta,
Professor & HOD,
Department of Community Medicine,
Gian Sagar Medical College and Hospital,
Ram Nagar (Banur), Patiala,
Punjab 140 601

Dear Sir,

I am working as Medical Officer (Mobile Unit) in Primary Health Centre, Bijepur, Tal: Salekasa, Distt. Gondia. It is in a very sensitive area. NRHM Newsletter is useful for medical and para medical staff and this newsletter helped me to do this job effectively. So please include my name and address in your mailing list for sending NRHM Newsletter regularly.

Dr. Sachin B. Dahiwale,
Opp. Police Station,
Near Sandip Kirana,
Chinchghad Road,, Deori.
Distt. Gondia
Maharashtra.

Dear Sir,

I am working as a Health Inspector in Primary Health Centre, Nainar Kovil in Tamil Nadu. I got a copy of newsletter in PHC. It is very useful for public health staff as well as for public also. Kindly register my name in the mailing list for regular supply of the said newsletter.

Dr. B. Dhilip Kumar,
3-14, S.M. Agraharam,
Paramakudi 623 707
Ramanathapuram Distt.
Tamil Nadu

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Dear Sir,

I am working as Evaluation Officer in the Government of India, Regional Office for Health & Family Welfare, located in Bangalore. This is a subordinate office working under the Ministry of Health & Family Welfare, Government of India. My job function consist of evaluation of NRHM-RCH programme, I am required to tour 3 states, Karnataka, Andhra Pradesh and Maharashtra for evaluation of NRHM including RCH-II components such as JSY, PNDR, ASHA, Dai's Training and 24-hour delivery care and other such components. I am regularly reading your newsletter by borrowing from the state government institutions wherever I visit during my monthly tours. I find the contents of your newsletter highly informative and quite relevant for our day-to-day work. Therefore, I want to have my own copies and keep them as references for my evaluation work and preparation of monthly evaluation reports. I request you to kindly register my name in the mailing list.

Shri J.V. Basavanthappa,
Evaluation Officer,
Regional Office for Health & Family Welfare,
F-Wing, II Floor, Kendriya Sadan,
Koramangala,
Bangalore 560 034

Dear Sir,

Rural Association for Women's Alligatory Tribute (RAWAT) is a non-profit making voluntary NGO registered under Indian Societies Registration Act XXI 1860. Ever since its birth in 1998, RAWAT is thoroughly and exclusively observe in activities which fall within the domain of National Rural Health Mission. During the long span of nine years, we have not only formally established ourselves in NCT of Delhi but have also spread to other adjoining states namely Haryana, Uttar Pradesh, Uttarakhand, and Rajasthan with the same momentum and zeal. Beside health which includes nutrition, sanitation, environment, education etc., RAWAT activists in other vital fields in national interest like elimination of illiteracy and eradication of poverty. We have come across the newsletter and other publication brought out by NRHM from time to time and has from them to be useful and of immense help to carry forward our activities beneficially.

Shri D.S. Rawat,
Chief Functionary,
Rural Association for women's Alligatory Tribute (RAWAT),
C-1/2, Vashist Park, Opp. Janak Cinema,
Pankha Road,
New Delhi 110046

Dear Sir,

Recently, I happened to see the special issue of NRHM Newsletter on Malaria, Chikungunya and Dengue and found it quite informative and useful. The content and quality of this Newsletter is improving regularly. All credit goes to you and your team for making it so attractive and also maintaining the punctuality. It is definitely going to be very useful to all those who are concerned for better health and well being of the nation and may prove to be a milestone in achieving MDG as well. I would be highly grateful if you can kindly put my name in your mailing list and keep sending all the issues of this Newsletter. Kindly also send me a copy of this special issue on Malaria, Chikungunya and Dengue on the address given below.

Dr. Rajni Kant,
Asstt. Director General (P&I Div.),
ICMR, P.Box 4911,
Ansari Nagar,
Delhi 110 029.

Dear Sir,

I recently read your newsletter and found that it is an excellent and updated newsletter which will be useful to medical and paramedical staff. We have a departmental library besides institution library. Kindly enroll our department in your mailing list and send a copy of the newsletter and other periodicals to our institution for the benefit of faculty and the trainees.

Shri B.B. Rajendra Prasad,
Health Education Extension Media Officer,
Regional Training Centre (F),
Opp. Dr. L.B. College,
Visakhapatnam A.P.

Dear Sir,

find the NRHM Newsletter very interesting, so kindly include my address in the mailing list and oblige.

Dr. Omesh Bharti,
Sector 9, Block 1,
U.S. Club,
Shimla 170 001.

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