सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

15th Common Review Mission, 2022

Chitrakoot and Maharajganj, Uttar Pradesh

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Facilities visited in Chitrakoot

DH Karwi

CHC Mau, Pahadi, Sitapur, Manikpur, Ramnagar

PHC Tikra, Biyawal, Hatwa, e-PHC Manikpur

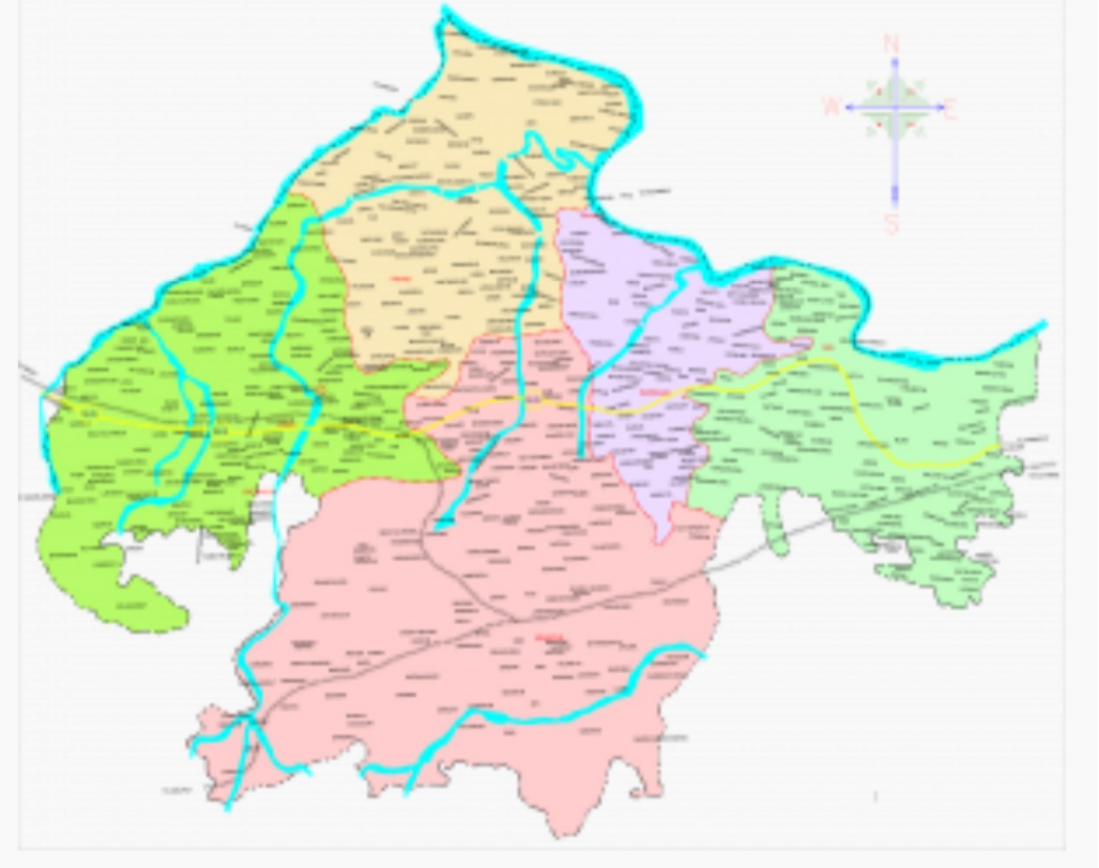
HWC Bhauri, Murkha, Puranpur

UPHC Sankalpganj Kurdana, Karwi

MCH wing

AYUSH Centre Murkha, Karwi

Government Primary School, Bhauri, Community Interactions in urban and rural areas, MAS, AAA meetings, Anganwadi Centres (Mankuwar, Bhauri), Primary Vidhyala Mankuwar, private USG clinics, Medical Mobile Units



Facilities visited in Maharajganj

DH Maharajganj

CHC Mithaura, Brijmanganj, Dhani, Siswa, Ghugli

PHC-HWC- Kolhui, Nausagar, Chowk, Nausagar, Kulhui

SHC-HWC: Sikandarjitpur, Munderi, Pakri , Pipra Rasoolpur, Gopalpur Shahu , Koriya

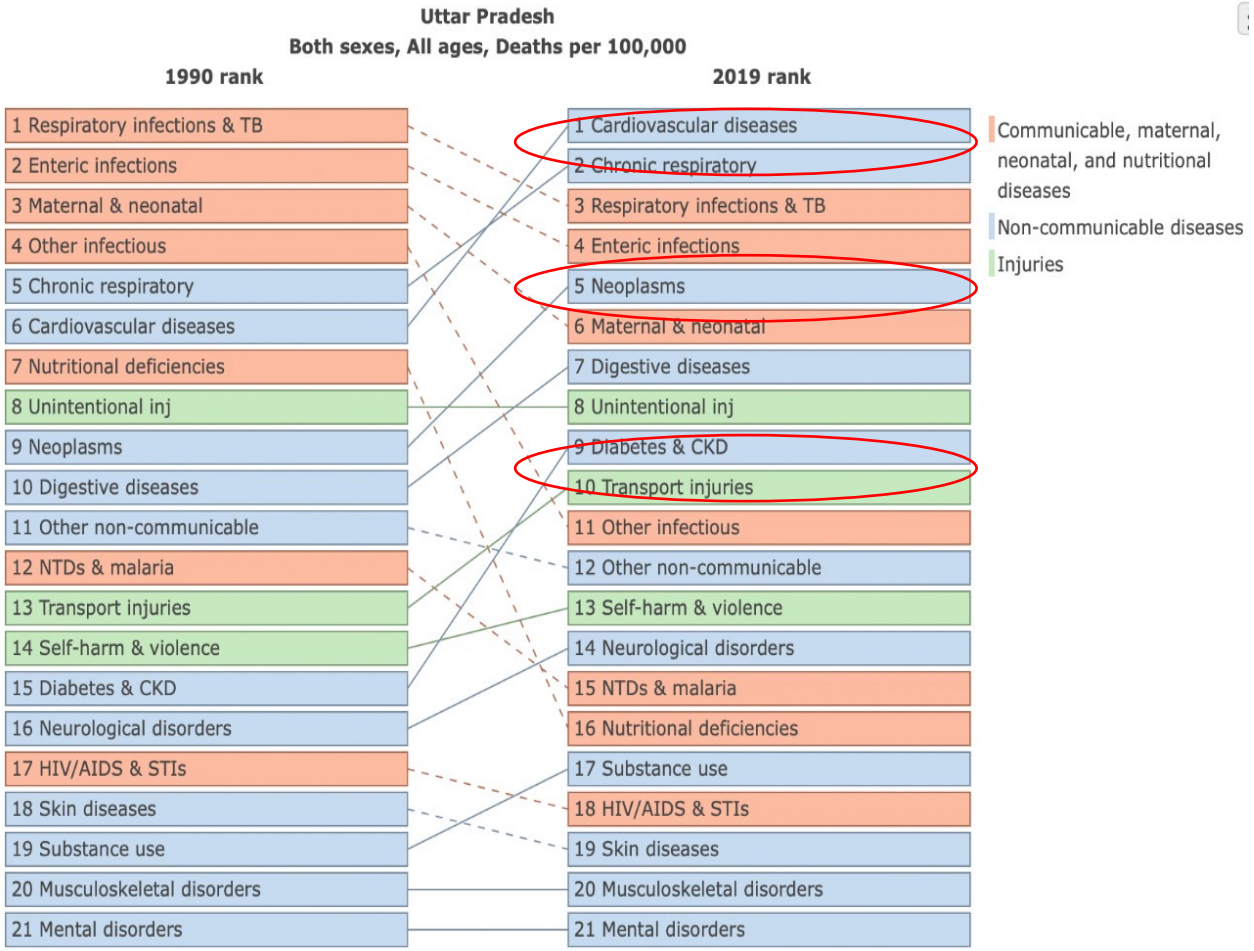
Government Primary Schools, Community Interactions in urban and rural areas, MAS, AAA meetings, Anganwadi Centres (Mankuwar, Bhauri), Medical Mobile Units

How Uttar Pradesh is Performing ? SDG vis-à-vis National Goals

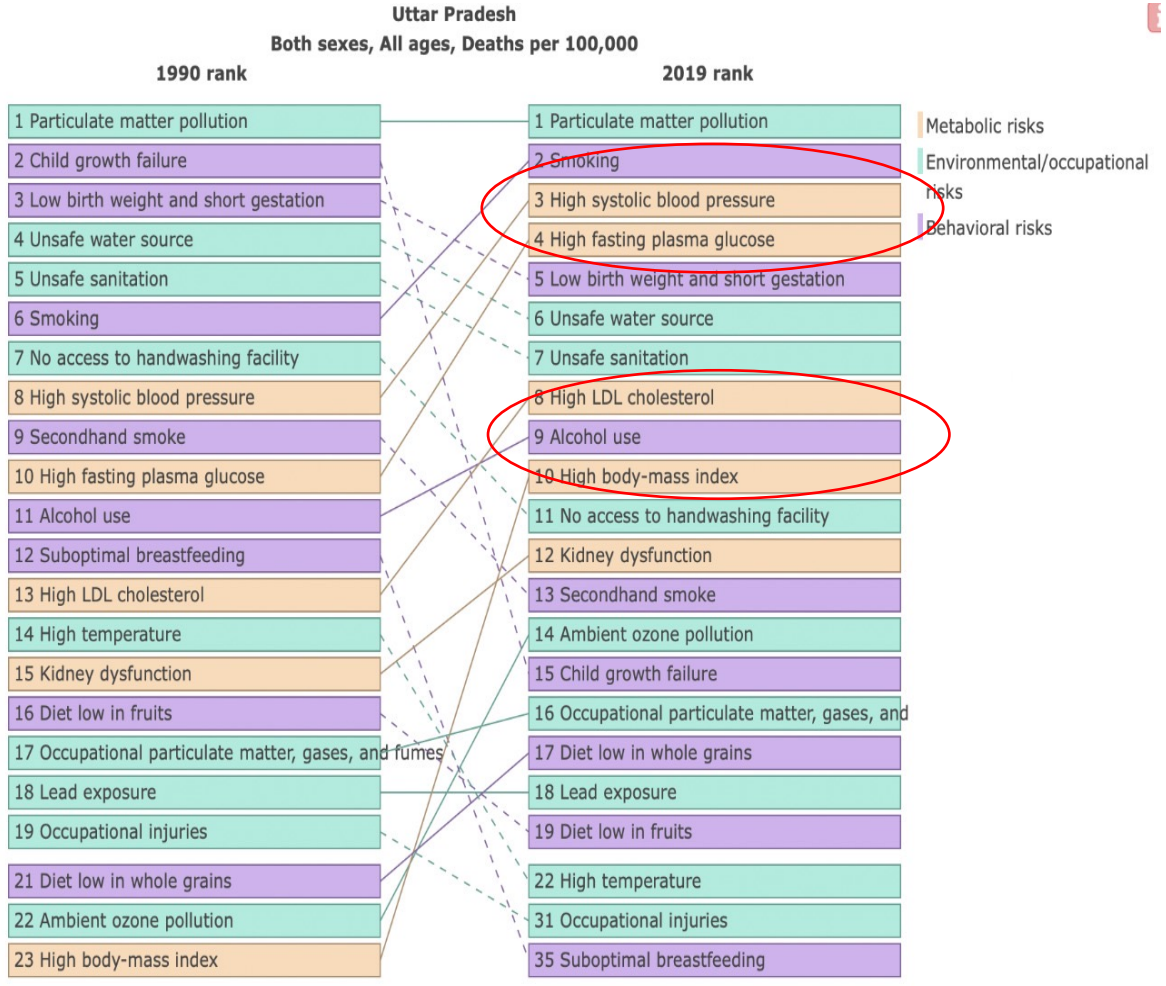
Indicator	SDG by 2030	NHP 2017	India	Uttar Pradesh
MMR	70/ lakh LB	100/ lakh LB	**103/ lakh LB** *(SRS 2017-19)*	**167 / lakh LB** *(SRS 2017-19)*
U5MR	25 / 1000 LB	25 / 1000 LB by 2025	**32 / 1000 LB** *(SRS 2018-2020)*	**43/1000 LB** *(SRS 2018-2020)*
IMR	-	28 / 1000 LB by 2019	**28/1000 LB (SRS 2020)**	**38/1000 LB (SRS 2020)**
NMR	12/1000 LB	16/1000 LB by 2025	**20/1000 LB** *(SRS 2018-2020)*	**28 /1000 LB** *(SRS 2018-2020)*
AIDS, TB, Malaria/NTD	End Epidemic	HIV/AIDS- 90:90:90 TB: Elimination target by 2025	**Prevalence TB -304/100000** (NTPS 2019-21) Prevalence HIV-0.22% (India HIV estimation 2019)	**Prevalence TB-479/100000** (NTPS 2019-21) Prevalence HIV-0.10% (India HIV estimation 2019)
NLEP		<1 per 10,000	**Prevalence 0.57 per 10,000** (Annual Report 2019-20)	**Prevalence 0.43 per 10,000** (Annual Report 2019-20)
Out of Pocket Expenditure	Substantial decrease	Decrease in catastrophic health expenditure by 25%, by 2025	**48.2 % of THE** *NHA (18-19)*	**71.3 % of THE** *NHA (18-19)*
Proportion of GDP spent	5.99 (globally)	Increase in State sector health spending to > 8% of their budget by 2020	**1.28% (Total Health Expenditure as % GDP)**	**1%(Government Health Expenditure as % GSDP)**

Causes & risks of Mortality, 1990-2019

Causes of Death



Risk Factors for Death



For both gender, all ages, mortality . Institute for Health Metrics and Evaluation (IHME). Findings from the Global Burden of Disease Study 2019. Seattle, WA: IHME, 2019

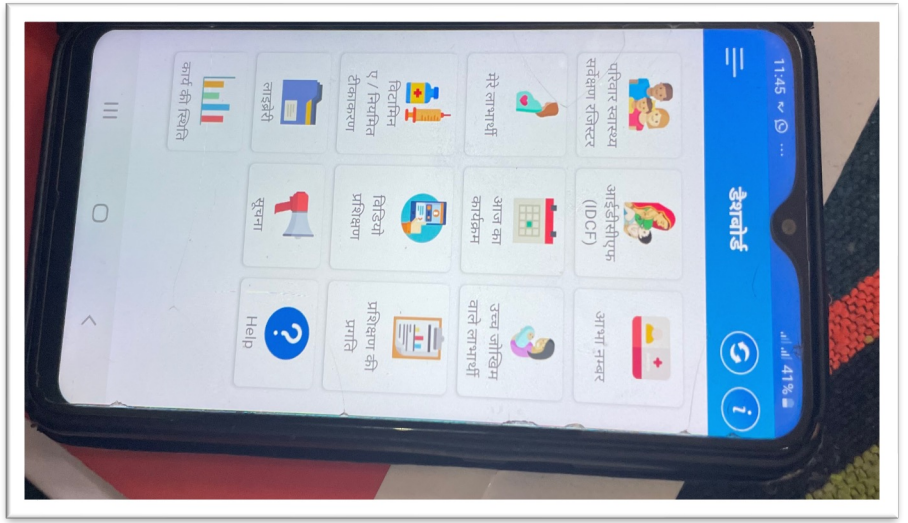
Best Practices

Maharajganj and Chitrakoot

Liquid waste Management

Maintained Drug Stock

Basket of Choice available at all facilities



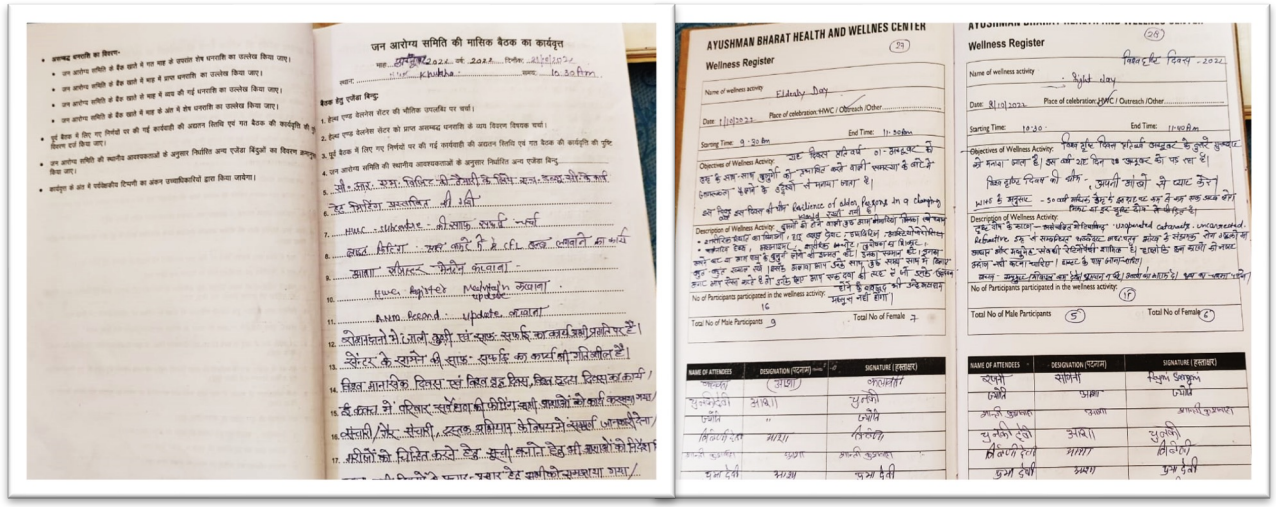
E-Kawach utilised by ASHAs

Well maintained OT

Play areas in NRCs

Practice of medicine upkeep using FIFO

Interaction with AAA with CRM team



Well-documented JAS and wellness registers format

SNCU death audits are conducted regularly

Maintained Labour room

Case Study: CHC Ramnagar

CHC Ramnagar has been efficiently using the AB PMJAY scheme and was able to generate **more than 15 lakhs rupees** without any surgical procedure being done in the facility. They have utilised the packages under PMJAY such as enteric fever, PUO, GE etc to get claims from PMJAY. The revenue was utilised for ACs in wards, solar panels, construction of approach roads etc.

- Around 50% of the Staff nurses posted in labour room were SBA trained. Most of them were well versed with the technical protocols but gaps observed in Maharajganj.
- Partographs were available and were being filled in all facilities.
- Clean and well maintained labour rooms were there, well equipped with drugs, equipments and consumables.
- Autoclaved delivery tray at DH in both districts with varied presence down below.
- Conventional Labour tables were available as per the delivery load
- Birth companions were allowed.
- Chart for at-birth screening for birth defects was available in all labour rooms

- Stamp made with “FP Basket of Choices” for awareness generation is present in all facilities.
- FPLMIS is being rolled out effectively in Maharajganj upto sub-centre level.
- Functional AFHC clinics at DH and CHCs in Maharajganj
- Functional RBSK team with records for screening by RBSK teams. No stock out faced by the teams. However, RBSK teams were comparatively inactive in Chitrakoot.
- Essential drugs, equipments, zero dose vaccines available till CHC level.
- Electronic Vaccine Intelligence Network (e-VIN) status is functional at all vaccine stores and temperature record is visible at for all Cold Chain Points. No stock out of vaccines and syringes at Cold Chain Stores.

- Mini skill station is available at the labour room complex for regular training on key topics such as AMTSL, PPH management, NNR etc. Nurse mentors present till CHC
- KMC area identified at DH & CHC with proper IEC
- Maternity emergency, SNCU and a 10 bedded NRC available in both districts along with functional 100 bedded MCH wing along with adequate staff and PICU in Maharajganj.
- SNCU deaths are being monthly audited at SNCU in DH, Chitrakoot.
- Strict actions has been taken against private unregistered nursing homes doing illegal C-section in district Maharajganj.
- MoU for Obstetric USG services with private facilities in place at Maharajganj but missing at Chitrakoot.

Points for Discussion | Primary Care

Community Processes

Thematic Area	Key Observations	Recommendations
ASHA/ASHA Facilitators /Block Community Mobilizer	• Most of the ASHAs in position **(88% in Chitrakot and 99% in Maharajganj)** • Most of the **ASHA Sanginis in position** (90% in Chitrakoot and 71% in Maharajganj) • Support structure at block level adequate with all blocks having BCPM • ASHA facilitators being selected from among the ASHAs as part of the career progression of ASHAs **GRIEVANCE REDRESSAL:** • A **grievance redressal committee is in place**; most of the committees have not received any grievance; some had observed derogatory treatment at DH and VHSNDs	• All **vacant positions of ASHAs** are to be filled as per the choice of community in the ward/gram sabha • **Quantitative and Qualitative performance** tracking mechanisms may be devised for BCM/AS/ASHA • Focused awareness among ASHAs about the **social security schemes** • Need for **capacity building** of FLHWs, facility linkages, follow up & documentation

Community Processes

Thematic Area	Key Observations	Recommendations
Community Platforms- VHSNC/MAS	• **Limited convergence between MAS/ VHSNC and ULB/ PRI** • However, **CHO+AAA meeting are conducted and records maintained** • **MAS in urban slums at Chitrakoot is well functioning.**	• The block-level mechanism for constitution and performance tracking of VHSNC to be instituted • Include the **HWC ambassador** in VHSNC • Focus on inter sectoral convergence • **Discussion on social determinants** and local problems to be focused and linked with inter departmental actions. • **Induction and refresher Training for VHSNC members** on their role in socio-cultural and environmental determinants of Health and village health planning • **Leverage active Civil society/NGOs/Development partners for strengthening VHSNC/MAS**

Community Processes

Thematic Area	Key Observations	Recommendations
VHNDs/Mid Day Meal/ AWCs	• **Centers were shifted to school premises** • **No dedicated space** for examination • Equipment was defunct • **Seating arrangement inadequate** • **Low attendance of children** because of discontinuation of cooked meal provision while mid-day meal continued at the school in the same premises	• Regular growth monitoring and referral to SHC-HWC and PHC-HWCs • **Linkage with RBSK, SHC-HWCs and PHC-HWCs for nutrition rehabilitation and healthcare services**
Other national programmes	• NMHP, NTCP, NPHCE, NPPC, NPCB+VI not functional at SHCs	• **Training of the primary healthcare teams** to be prioritized • **Integrated screening** for mental health, visual impairment, geriatric and palliative care and build linkages with treatment and rehabilitation services • **Opportunistic screening and counselling for tobacco and alcohol cessation** • **Engage VHSNCs, PRIs and other line departments for their action on social determinants of health**

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
Infrastructure	• CHO OPD outside the existing SHC building • **Quarters not available** for CHO & ANM • **Branding not uniform** • **Labour room hygiene not maintained** • Water supply, electricity, computers and internet connectivity are sub optimal • **Waiting area not available** in SHC-HWC, separate toilets for male and female not available and poorly maintained with **no water supply and functional toilets.** • **Earmarked space for wellness room activity is not available** at SHCs, but available at few of the PHC-HWCs • **Disability-friendly structures** (ramps) & boundaries not present at most of the AB-HWCs	• The **physical boundary of the AB-HWC to be mapped** • **Separate Toilets for males and females** at SHC-HWC • **Vaccine storage, and Routine immunization at AB-HWC** • **Leverage XV Finance Commission and PM-ABHIM** for building and equipping AB-HWC

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
Human Resource and capacity building	• **Functional HWCs against the target- 74% at State level, 82% in Chitrakoot & 72% in Maharajganj** • CHO in position (79% in Chitrakoot & 81% in Maharajganj) • **CHOs and ANMs work in verticals and in separate identified spaces. Interpersonal coordination not adequate.** • **Training on CPHC** – Most of the modules for CHO, except for TB, were imparted in virtual mode at times with reduced duration, as was reflected in the quality of service delivery. • ASHAs/ANMs orientation in NCD care is not adequate • Performance-linked payment of CHOs not disbursed for the past 6 months • **ASHA is not fully aware of their incentives** • CHO attendance app not initiated	• The *total **salary of CHOs is to be disbursed** through two components that is 25000 as part of salary and 15000 as part of the performance-linked payment* • **Role Clarity and Team Building** at AB-HWC • **Team Building exercise** for the AB-HWC team with an understanding of the AB-HWC ecosystem • **Orientation of MOs** on his/her role as the team leader of the CPHC ecosystem at the PHC level

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
MCH Services	• ASHAs and ANMs aware of RCH services, **line-list maintained, Nishchay kit, IFA and calcium tablets were present i**n most of the facilities • The school-based and facility-based screening was done. • ASHAs were maintaining a line list of HRPs • **Microplanning is not available**, HRPs is restricted to anaemia, RCH registers and MCP cards are not being filled correctly and without RCH ID • **ANC drugs distribution & home delivery of contraceptives lacking** despite the adequate stock • **Late reporting for deliveries indicating inadequate follow up in last month of pregnancy.** • **FIC (Full Immunization Coverage) is less than 75% for some blocks.** • Mobilization of pregnant women for **PMSMA days low** • **Adequate number of HBNC visits are not being conducted** (patient interaction) and ASHA/ANMs fail to identify sick newborns, SAM children, and LBW babies.	• Training on HBNC and AMB is required for the cadre. • Distribution of Iron supplements needs to be ensured through RBSK • **BCPM to be oriented** and assigned for micro plan and also its triangulation with ASHA duelist.

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
NCD Care	• **NCD package rolled out** (NCD screening, diagnosis, treatment and follow-up) • **NCD screening is being conducted in Maharajganj,** registers maintained • ASHA, ANM and CHOs trained • NCD screening is being done at both facility and community levels and registers maintained • Revised CBAC not being used • Application of CPHC –NCD app to monitor NCD care progress lacking • Patient support groups, and sanjeevani groups not formed in communities	• **Systematic approach** to service delivery through the continuum starting from health promotion to screening to diagnosis & treatment and follow-up lacking across all programs and needs strengthening. • **Focus on population-based screening** and follow-up for identified cases needed.

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
Medicines and Diagnostics	• Though Drugs & diagnostics are available but not as per EML and type of diagnostics tests for SCs, PHCs and UPHCs. • DVDMS - Requirement-based indenting initiated & drugs directly received from warehouse in some facilities	• Expansion of **diagnostics** from 7 to **14 tests** and 11 to **63 tests** at SHC-HWC and PHC-HWC respectively. • Expansion of **Essential Drug list** to 30 to **105** and 45 to **172** at SHC-HWC and PHC-HWC respectively. • **DVDMS to be strengthened and regular maintenance to be ensured till SHC level.**
Quality Improvement	• Limited focus on quality certification • Disposal was not according to the guidelines • Safety pits were overflowing • ETP not in place	• Prioritize Kayakalp and NQAS certification of AB-HWC • **Disinfection protocols –** Autoclave/Sterilizer at SHC-HWC delivery points • **Prioritize Implementation of Bio-Medical Waste Management** across all levels

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
IT Platforms/ Telemedicine	• Digital technology is being used by CHOs despite IT infrastructure constraints. • **AB-HWC portal & app being regularly updated** • Teleconsultations via e-Sanjeevani are being conducted • Some of **the e-Sanjeevani prescriptions were irrational** and substitute medicines were issued. • **Use of CPHC-NCD app for NCD monitoring being used by CHOs** • **COMCARE functional** (digitized supportive supervision application for ASHA Facilitators) • At some places, ASHAs were conveyed *"they may loose job if entries are not through mantra".* • **Data security remains an issue with too much IT software.** • **Low ABHA ID creations that too through e-Kawach.**	• **Teleconsultation infrastructure and connectivity should be established on priority (BharatNet)** • **e-Sanjeevani prescriptions audit to be initiated along with the orientation of registered service providers.** • **Regulatory mechanisms and certification for data security**

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
Health Promotion	• **Limited focus and awareness regarding wellness activities like yoga and annual health calendars amongst service providers and the community.** • **Ayushman Bharat Health and Wellness Ambassador initiative** yet to be implemented. • **Eat right campaign has not yet been initiated in both districts.**	• **Hire Yoga instructors** as per norms • Focus on the celebration of **Annual Health Calendar days** with active community participation • Monitoring and reporting of Wellness activities • **Initiate Weekly Health and Wellness Day in schools** as per guidelines • Coordination between the AB-HWC team and school health ambassadors in health promotion activities • Training on eat right campaign.

AB: Comprehensive Primary Health Care Services

Thematic Area	Key Observations	Recommendations
Continuum of Care	• **Ill-defined mechanism for upward and downward referral** • **Poor documentation and tracking**	• Mechanism for tracking of **Upward and Downward referral** from AB-HWCs to be established and displayed in all Primary Health Care facilities • **Adoption of AB-HWCs by Medical Colleges** in the District to be initiated
JAS	• JAS largely constituted, some under progress. Regular meetings are being conducted, JAS register is well maintained.	• Training for JAS to strengthen action on social determinants of health • **Ensure constitution and functioning of JAS/RKS committees** • Undertake **training of JAS/RKS members**. Leverage existing NGOs/Development partners for training • **Training of CHOs on financial management** and JAS functions

Points for Discussion

Secondary Care Services

Secondary Care Needs

Thematic Area	Key Observations
Planning for secondary care services	• There is **no focused plan either to meet the NHP goals or the IPHS goals** for the number of beds for Public Health Facilities. • Both Maharajganj and Chitrakoot DH have beds for 100 beds each with a population of 30 lakhs and 10 lakhs respectively, **indicating 33% and 60 % beds only** against at least 1 bed per 1000 (IPHS 2022). • Similarly, none of the districts is meeting the surgical, emergency, blindness, TB and other such diseases needs of the population. • **The bed occupancy rate for both DHs is more than 90%.** The demand for a number of beds has not been met which inadvertently leads to OOPE. • The **utilisation of public health facilities (CHCs, PHCs) is restricted to MCH services** and overall utilisation is 14% for OPD and 24% for IPD. • There is **no state/ district level plan to address the disease burden of the population or meeting the targets of SDGs.**
DH strengthening	• DNB courses are offered in eight District hospitals in the states. • ROP sanctioned posts 140, sanctioned by DNB 69, under training 60 10 specialities (Departments). • In both the district's hospitals (Chitrakoot and Maharajganj), no DNB courses are offered. • There is no nursing college in the districts.

Critical Care Services

Key Observations

A large part (about 3/4th) of the space in the rooms was being used by service providers leaving very little space for service seekers leading to a compromise in the delivery of quality services.

Emergency:

- Although the emergency department was separate the **space allocated was not adequate** in both districts
- **Separate triaging for the emergency unit is not in place**. No dedicated staff nurse, for the emergency unit is available.
- **Beds were not supported with Multi para monitors, ventilators and other life-saving equipment. Where available (Maharajganj) equipment was non-functional, no training of service providers.**
- The **staff training on the emergency protocols was found to be inadequate or missing**.

Critical Care Services

Key Observations

- Maharajganj DH has PICU, 2 mini PICUs and a 10-bedded NRC, 100 bedded MCH wing functioning with adequate staff.
- **The ICUs created during COVID, NICU, PICU** and other critical care areas for intensive care were **not functional as per ICU protocols** largely due to either lack of functional equipment or trained staff.
- **20 unused ventilators were observed in ICUs**
- Surgeries such as **IND, Hydrocele etc are added under major surgeries** which ideally should be kept in the minor.
- In both districts, inadequate number of OTs that too, without an **HVAC system.**
- The uninterrupted power supply is not available in the OT complex in some of the facilities visited.
- **Cleaning protocols including decontamination of critical care areas are compromised.**
- **Capacity building**: Knowledge and skills on the various treatment protocols need strengthening for all levels of staff. In Chitrakoot, Nursing Staff never received any training in the last 2 years to assist with surgeries.

Support Services

Key Observations

- **Organised dietary services, Mechanized laundry and CSSD services were not available** at any level of health facilities in district Chitrakoot and Maharajganj. In Maharajganj, the available laundry was not mechanised, clothes were not being segregated at the source of generation and had no linkages with CSSD.
- **No diet protocol** is being followed because of the non-availability of in-house Kitchen and dieticians/nutritionists in both districts.
- **Quality of dietary services, hygiene and infection control measures are inadequate.**
- Security services at District Hospital and other facilities were not available at district Chitrakoot however at DH Maharajganj the security services were actively working.

BMMP:

- The programme is rolled out in both districts buts implementation, coverage and actual maintenance of equipment are skewed. Toll-free numbers are hardly been used and information about these numbers is missing in service areas.

Secondary Care Services

Thematic Area	Key Observations
Medicines	• **DVDMS is not completely implemented,** wherever implemented, the indents are not based on departmental consumption. • **UPMSCL supplies drugs based on its procurement and availability and not on the indents from the facilities.** Many supplies are verticals with short expiry at the point of consumption. • No tracking for fast/ slow moving drugs, stock-outs, critical store of drugs, auto-generation of three-month expiry, ensuring 5/6th of the expiry at least at District or divisional store are all completely missing. • Random samples being sent to the state for testing leads to delays in utilisation of drugs. • Temperature-sensitive drugs are not being monitored throughout the supply chain.
Medicines (Drug Warehouse)	• The temperature is not recorded and monitored in the District Drug Warehouse of UPMSCL, District Drug Store , CMSD and the other facilities. • Conditions of existing DWHs is poor. • There is **no standardized indenting and issuing process followed by the UPMSCL.**

Inadequate upkeep of Drugs in the warehouses

Secondary Care Services

Thematic Area	Key Observations
Dialysis Programme	• Run by DCDC with 6 Functional Dialysis Machine in Maharajganj in PPP mode. • 18 Dialysis per day and 468 dialysis in October 2022, **roughly 3 dialysis per DT per day.** • 15 patient are still in queue for dialysis appointment. • Chitrakoot Unit has 3 machines reporting manually only and the programme is yet to finalize other operational formalities like BMWM, Nurses Duty Station etc.

Secondary Care Services

Thematic Area	Key Observations	Recommendations
Pradhan Mantri Jan Arogya Yojana	• **The number of golden cards issued to individual beneficiaries under PMJAY for District Chitrakoot and Maharajganj is 121868 and 259,413 respectively.** • **Around 25% of golden cards were generated in both districts.** • The number of beneficiaries provided services under PMJAY in districts Chitrakoot and Maharajganj are 4500 and 10650 respectively. • **Limited coverage of the eligible population** • **Limited awareness of the provisions of the scheme**	• Steps for improving PMJAY coverage may be linked with ASHAs, MAS, and ANMs for expediting enrolment.

National Ambulance Services

Key Observations

- Both districts have around 20 minutes of response time and 4-5 trips with about 120- 130 km travel per day.
- Generally, **ambulances are travelling short distances indicating left-out of villages and far-flung areas.**
- Almost all ambulances bring referral cases to DH except those for deliveries indicating a **lack of emergencies and assured services at identified FRUs and SDHs**.
- Driver and EMTs were available.
- Both the 102 and 108 ambulances are running like a transport vehicle. The full range of critical equipment was not functional.
- The list of medicines and consumables is less than the national norms.
- Indications for medicines or treatment for common ailments not known by EMTs.

National Ambulance Services

Key Observations

- 6 months trained EMT under "Skill India" said, *"insulin to be given for controlling hypertension"*. Another EMT had written "BP *3 times and monitored the patient which he brought but while interacting with the patient, no cuffs were applied on her arm during the transit."*
- **Supervisory visits and monthly certification by District Authority completely missing.**
- **3 toll-free numbers 112, 102 and 108 are functional creating confusion and need INTEGRATION.** The situation in Maharajganj was further bad and 5-digit numbers by a service provider were operational but not known to service seekers.
- **ALS ambulances are also running separately, all ambulances need integration and thoughtful planning for a single toll-free number.**

Medical Mobile Unit

Key Observations

- Both districts have 3 MMU each and conduct 24 camps in a month.
- On average **30-35 OPD is conducted, 20-25 types of tests per day being conducted.**
- In Chitrakoot, one of the interior sites visited had one functional SC and another e-PHC with just a 1-1.5 k.m. radius indicating irrational deployment of MMUs.
- **Service coordination and follow up lacking.**

Recommendations: Secondary Care

Recommendations:

Planning :

- **The planning division of NHM should steer hold the facility plan including gap assessment under IPHS 2022 linked with action plan for gap filling.**
- Every district should have DHAP addressing the disease burden, SDG targets and population needs for critical care and reduction in OOPEs.
- Addressing the bed needs of the population.
- Facility inputs should be based on output for services as per IPHS 2022.
- Capacity building should be part of the comprehensive training plan.
- Prioritise assured critical and surgical services for the population along with the requisite manpower.
- While budgeting for various activities, such budgets are short-term, scheme-specific needs to be utilised first before placing funding requirements under state resources.

Recommendations: Secondary Care

Recommendations:

DNB courses:

- The quality of teaching and training under DNB needs to be monitored with a defined checklist. The DNB-trained doctors should provide at least a few years of specialised services at public health facilities. Trained manpower needs to be mapped and linked with such facilities which require more specialists.

Drugs :

- Monitor availability as per the EML list and out-of-stock drugs. May follow IPHS indicators for monitoring.

Diagnostics:

- Utilise XVFC funds to ensure a full range of diagnostic services. All equipment of health facilities should be enrolled under the BMMP. Every piece of equipment should be tagged with equipment details like manufacturing service records and other key parameters.
- Toll free number should be known to all service providers along with physical displays in service areas.

Recommendations: Secondary Care

Recommendations:

NAS:

- Single call centre number
- ALS/BLS and PTVs under one umbrella or a maximum 2.
- Capacity building of EMTs
- Supervisory checks and district-level certification for functionality.
- Monitoring the distances covered including rural and interior areas.
- Operationalising FRUs to decongest higher referral centres

MMUs:

- Rationale plan for deployment along with plan of phasing out and operationalising of SCs and PHCs.

Points for Discussion | RMNCHA+N

RMNCHA+N – Key observations

Family Planning

- Family Planning orientation of staff nurse is very poor and uptake of Family Planning methods is overall low.
- The discontinuation rate is high (40% and 59% in Chitrakoot and Maharajganj respectively) for ANTARA (1st dose to 2nd Dose) in both the MPV districts due to lack of follow up and tracking mechanism in-place
- Patients were not being counselled on post partum family planning methods.
- In Maharajganj, eight (8) trained minilap providers and four (4) lap providers are available, but the services are being provided majorly by 2-3 providers only. Maharajganj and Chitrakoot each have 5 NSV providers. But still the NSV service uptake is very low.
- Comprehensive abortion care (CAC) services are not present anywhere except district hospital.
- There was no information about the IUCD/PPIUCD expulsion rate.
- Female and male sterilization certificates are not being distributed in both the districts, this will grossly effect the reimburse process of FP indemnity scheme.

RMNCHA+N – Key observations

Maternal Health - Infrastructure

- In the 5 blocks of Chitrakoot - 58 functional Delivery points are available, out of which majority are L1 (50) and only 04 are L3.
- In 12 blocks of Maharajganj – 97 delivery points, out of which majority are L1 (80) and only 3 are L3.
- Majority of the deliveries are conducted in the L2 and L3 levels while L1 delivery points are under utilised.
- Two 50-bedded FRU CHCs are designated at Maharajganj but not functioning as FRUs. In Chitrakoot, CHC, Manikpur was functional but round the clock availability of OBGYN and anesthetist is lacking.
- Structural and organizational deficits present in MCH Wing lay out at DH Maharajganj. (LR in new building, OT, PICU & SNCU in old building).
- The newly constructed 200-bedded MCH wing in Chitrakoot is yet to be operationalized due to non-posting of doctors, speacialist and nurses.

RMNCHA+N – Key observations

Maternal Health – Service Delivery

- All labouring women admitted at DH deliver within 2 hours unfailingly. Records checked since April- maximum admission to delivery interval was 4 hours.
- Very high episiotomy rates (80%) were observed in Maharajganj.
- The Partographs were partly and wrongly filled. Most partographs indicated the first plotting of the cervical dilatation started at fully dilated which indicates either delay in reaching hospital or use of augmentation methods.
- All markings in the partograph followed the alert line.
- Triaging in labour room along with functional and equipped triage beds were missing.
- Magnesium sulphate for the management of eclampsia was not available in Chitrakoot, however, staff was orientated on management of complications during labour.
- Labour room – LMO was not present during night shift at one facility in Maharajganj

RMNCHA+N : Key observations

Maternal Health – Cross cutting areas

- LaQshya/NQAS is under process. MusQaN is yet to take off. Quality circle committees have been formed.
- Audits for C-Section/ Prescription audits/referral audits are yet to be implemented.
- Bio-Medical Waste Management / IPC protocols precariously followed across facilities in both the districts and standard consumables found in short supply.
- Insufficient knowledge on LR protocols/ BMWM for SN/ANMs/Doctors (Tobacco pouch photo)
- There is no OOPE on transportation, drugs, blood tests in Chitrakoot. The expenses on these activities were being incurred in Maharajganj by the patients.
- Informal payments at delivery and expenses on USGs were common in both districts at all levels.
- USG machine available at L3 facilities (DH Maharajganj and CHC, Manikpur, Chitrakoot) are not being utilised despite availability of OBGY specialist in these facilities.

RMNCHA+N – Key observations

Maternal Health – Critical care areas

- 24X7 emergency services with continuous oxygen supply available at DH but emergency radiology services are not adequate.
- Elective OT services present at DH in both the districts, but designated FRUs and CHCs not providing emergency night services.
- Night Emergency surgical services including C Section facility not available in both the districts.
- Complicated cases manageable at DH are being referred to MC Gorakhpur, because of unavailability of emergency obstetric services at night at DH Maharajganj. Night caesarean section from 12-6 am is zero since last 10 months.
- Zoning of maternity OT was by and large missing.
- Both the districts did not have provision for HDU/ICU (general or obstetric)
- Unused ventilators, oxygen concentrators and other equipments in abundance at Maharajganj. (MCH Wing converted in to Dedicated COVID hospital with 20 critical care beds & ventilators lying unused).

RMNCHA+N – Key observations

Maternal Health – MDSR

- MPCDSR software is not being utilized yet.
- Maternal Death Surveillance and Response (MDSR) committees are formed but regular meetings not conducted.
- In Maharajganj, during April to Oct. 2022, 12 maternal deaths reported but review done for 9.
- In Chitrakoot, 16 maternal deaths have been reported out of which only a few have been reviewed.
- Referral linkage mechanism from peripheral facilities in complicated cases not defined

RMNCHA+N – Key observations

Neonatal & Child Health – Availability of infrastructure/ equipment

- Functional NBCC available at all delivery points – functioning radiant warmers and suction machine, however, staff nurses were not well versed with resuscitation SOPs.
- Only 2 out of 5 NBSUs were functional in Maharajganj and few were non-functional in Chitrakoot as well.
- In Maharajganj, dust laden equipments and a shortage of AMBU mask were also observed.
- At birth screening chart for birth defects was available in all labour rooms but use of the chart for screening and linkages were RBSK could not be seen with an exception of CHC, Ramnagar, Chitrakoot.
- Functional PICU with paediatrician was there in Maharajganj in which ventilators were present, but not used for invasive ventilation- only CPAP/ BIPAP.

RMNCHA+N – Key observations

Neonatal & Child Health – Critical care area

- In Maharajganj, a 26-bedded SNCU is present, while at Chitrakoot a 12-bedded SNCU is present.
- Bed Occupancy Rate in SNCU in both districts is more than 100%, at Maharajganj the BOR is 197%.
- 6 paediatricians are available in both the districts, however, only 3 out of 6 paediatricians are being utilised in the SNCU at Chitrakoot.
- The referral rate was 9% at Maharaganj, but was 25% at Chitrakoot. Feedback from SNCU staff in Chitrakoot was that many referrals from block and labour room of DH came directly without any pre-referral management being done.
- In Maharajganj, transfer of newborns from LR to SNCU in Maharajganj requires traversing a long passage with risk of exposure to cold.
- In Chitrakoot, both outborn and inborn unit was present in the same room and the distance between two beds was <4 fee
- Overall follow up of SNCU cases was around 70% for Chitrakoot and irregular follow ups were seen with no mechanism for verification in Maharajganj.

RMNCHA+N – Key observations

Neonatal & Child Health - DEIC & NRC

- Both districts do not have DEIC but linkages with the medical colleges have been established.
- NRC is well maintained, with good admission rate till few months back. Provision for in house kitchen, medicines and a trained MO present in Maharajganj. However, the admission rate has halved at DH Maharajganj since recent amendment in admission criteria.
- Additionally, the NRC at Chitrakoot is manned by a paediatrician and has a play room within the NRC. The drastic decline in admission rate is consistent with the finding at Maharajganj.
- At NRC, Chitrakoot average weight gain was 8.055 g/kg/day and at Maharajganj was 14g/kg/day.
- Percentage of 1st follow up – 90% and 2nd follow up – 40%, at Chitrakoot.
- Interactions with community mobilisers revealed that protocols related to management of low birth weight babies and uncomplicated SAM were not clear to them.

RMNCHA+N – Key observations

Neonatal & Child Health - Child Death Review

- Child Death Surveillance and Response (CDSR) is absent and needs special attention.
- Reporting in across facilities very less and in community even lesser.
- Reviews not happening.
- No clarity on CDSR process and medical officers orientation is nil.
- Awareness regarding the reporting process is not there among ASHAs/ ANMs.

RMNCHA+N – Key observations

Adolescent Health & Nutrition

- RBSK teams are available in both the districts and had adequate resources and microplan for visits in Maharajganj, however, the effectiveness of the programme was lacking.
- Improper methods of screening and lack of knowledge of staff were observed during some of the school visits in both the districts.
- The referral documents were being handed over to the children and RBSK teams were not maintaining any documentation of the referrals. Hence, there was no mechanism to follow up children referred to higher centres.
- At Maharajganj it was observed that knowledge regarding identification of Bitot spots was lacking and children with Vitamin A deficiency were being referred to higher centres without any treatment being given.
- Health check up was being done by looking into eyes, ears and mouth without application of clinical skills to diagnose, and just asking a question “Koi Dikkat Taklif?”

RMNCHA+N – Key observations

Adolescent Health & Nutrition

- The components of Anaemia Mukt Bharat were overseen by different health workers such as RBSK team/ ANM/ ASHA and lacked a holistic approach.
- IFA tablets were available at all levels, but were not getting distributed in the community
- Knowledge regarding the schedule, dosage and method of administration of IFA was missing among community level workers in some cases.
- Tracking of distribution and use of iron syrups and tablets was also missing.
- Since in Maharajganj RBSK team was visiting the schools IFA tablets, Vitamin A & D were being distributed to the school going children, however, non-school going were being left out.
- Multiple stakeholders are there in the program (Anaemia) but no one taking the leadership for coordinating the implementation of AMB .
- Block leadership like BPM and MO were unaware of AMB program and were not taking ownership of it.

RMNCHA+N – Recommendations

Key recommendations

- Re organization of services flow at DH and MCH and lower facilities to attain a structured flow of services as per the guidelines provided from national level/IPHS standards.
- Protocols, processes and organization in LR to be revamped as per recommendations under LaQshya.
- The provision of all emergency services at night in DH including cesarean sections to be ensured (12-6am). Referral only for indicated cases.
- Administrative issues like chronically absent staff/doctors / leave without pay needs to be solved on priority.
- Rationalization of HR and equipments at all levels is needed.

RMNCHA+N – Recommendations

Key recommendations

- 20 bedded COVID ICU at DH Maharajganj (not operational) with an equal number of ventilators - may be taken up for setting up of General & Obstetric HDU/ICU for critical patients.
- Post partum mothers at DEIC, SNCU & NRC to be offered services under Aneamia Mukt Bharat & Family Planning.
- Ensuring availability of all drugs and diagnostics under FDI as per the level of facility with strict curtailing of expenditure on drugs and diagnostics and informal payments by patients.
- Utmost care and due diligence to be practiced while discharging a child with Weight/ Height (-3SD) for management at community level/ home care.
- Setting up of SUMAN committees at all levels to oversee the various RMNCHA initiatives including JSSK, MDSR, CDSR, LaQshya, PMSMA , SNCU, PICU, NRC & DEIC

RMNCHA+N – Recommendations

Key recommendations

- Need extensive capacity building and further handholding on following topics:-
  - LR protocols, C-section audits, Rx audits, BMWM, Quality standards under LaQshya and NQAS
  - Orientation on MDSR & CDSR, FBNC, PMSMA , SUMAN, NSSK
  - MPCDSR Portal orientation and roll out
  - Referral linkage and chain to be strengthened.
  - Staff nurse need training in PICU.
  - Medical Officers for CEMONC/BEMONC/CAC.
  - USG training for OBGY specialist recommended
  - Counselling Skills to be strengthened (RTI/STI Counselor)
- Strong supportive supervision & Monitoring at all levels
- Coordination between CHOs, ANM & ASHAs needs to be ensured.

National Tuberculosis Elimination Programme

Key Observations

- National TB prevalence survey 2019-21: **UP 427 TB cases per lakh population** (National average: 312)
- Prevalence to notification ratio: UP 3.10 **[missing almost 2 cases and notified 1 case of TB]**
- Against the target of ~2000 per lakh TB testing, the detection rate is 882 per lakh (40%)
  - Maharajganj – 275 per lakh population
  - Chitrakoot – 665 per lakh population
- **TB notification- 76% against target (public - 102%; private - 72%)**
- Nikshay Poshan Yojana - 60%
- **Community survey / active case finding is being conducted** with collaboration of Dastak and NCD survey.

National Tuberculosis Elimination Programme

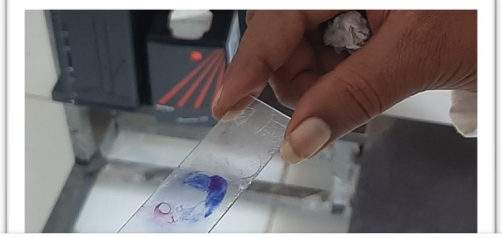
Key Observations

- **Treatment success rate- 83.6%;** ASHAs are involved in DOT adherence monitoring.
- Line list of TB patients is available at HWC-SC. **No line list/TB notification maintained at PHC**
- **Sputum microscopy is not available** in all PHC; quality of testing and availability of light source is an issue at some facility
- **No Random Blinded Re-checking** and On-site evaluation visits for quality sputum microscopy being done
- **TB drugs are not available at PHCs**
- **Contact tracing is weak**; TB preventive treatment (~30% in HHC <5years and ~10% in HHC >/=5years)

National Tuberculosis Elimination Programme

Key Observations

- **Decentralized DR-TB centres** at district level and initiation of patients on newer drugs
- **Assured linkages with x-ray** facilities below DH needs augmentation
- **In-adequate skill in lab. tech.** for following up quality parameter for diagnosis TB at DMC
- 2/6 TU in Chitrakoot and 6/15 TU in Maharajganj have functional NAAT;
- **Average utilization of NAAT <100 tests per month in visited districts**
- Lack of collaboration with RBSK and other comorbid clinics for bi-lateral TB & disease screening
- **Informant incentives not yet started** in either of the districts – Chitrakoot or Maharajganj



New microscope available and set up by CRM team

Facilitation at PHC Tikra, CHC Mau

Idle x-ray machine at CHC-Ramnagar

National Leprosy Eradication Programme

Key Observations

- **Line list of leprosy patients available at DH and CHC.** However, PHC and SC not having a line list of Leprosy patients on treatment in the respective areas.
- Free MDT, MCR chappal and self-care kits are available at DH and CHC.
- **Lack of adherence monitoring of on-treatment patients**; no line list at SC or PHC level on treatment leprosy patients (average treatment duration is >6 months in PB and >12 months in MB)
- **Lack of contact screening;** Rifampicin is not available for post-exposure prophylaxis in contacts of leprosy patients; local procurement of Rifampicin not yet done
- Deformity report - **Nil in Chitrakoot and higher than the state average in Maharajgand**; deformity patients referred to Gorakhpur

National Leprosy Eradication Programme

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National Vector Borne Disease Control Programme

Key Observations

- RDT for malaria and Dengue available upto SC level.
- Malaria not endemic in both the district. However, increasing dengue cases is a cause of concern.
- **Demarcation of dedicated beds for VBD at DH and CHC.**
- Coordination committee meeting held for NVBDCP with other departments.
- **Surveillance activity is being conducted** by the district health team. However, PHC and SC is not aware about **micro-plan**.
- There was a **gap in information communication** between CHC and PHC medical officer leading to inadequate monitoring of survey and challenge of quality surveillance for VBD.

Integrated Disease Surveillance Programme

Key Observations

- Desk review: % reporting → P form (25%), L form (23%), S form (12%)
  - Maharajganj: **P form (66%), L form (56%)**
  - Chitrakoot: none of the visited SC, PHC, CHC and DH filling up the necessary record and submitting over the portal in Chitrakoot.
- Report of a number of disease outbreaks/ early warning signals:
  - **463 (year 2017) → 156 (Y-2021)**
  - Outbreak/ early warning signals in districts not systematic in monitored
- Lack of adequate monitoring for filling up necessary records.
- **Public health surveillance is weak** in the districts

Recommendations: Communicable Disease

Recommendations

- **Increased awareness** and integrated screening linked with assured diagnosis and treatment is the need
- **Awareness drives** through VHSNC
- **Intersectoral coordination** for insecticidal spray in fields, outreach and slums needs improvement
- The **wellness component of HWC** for all communicable diseases **needs to be prioritized** both at PHC and SC.
- The equipment like a microscope and others needs to be covered under **BMEMP**
- **Testing and detection rates for TB need augmentation** by increased awareness, better collaboration with the private sector, RBSK and scaling up of integrated outreach.

Recommendations: Communicable Disease

Recommendations

- **Monitoring of village wise TB examination rate** for targeted active case finding activity
- **Making available molecular testing (NAAT) for TB detection** at least at block level; ensure establishment of **linkage for sputum collection** and transportation
- **Capacity building of programme officers** and service providers are few critical steps required targeted intervention.
- **TB Preventive Treatment** should be expanded in all the districts
- **Making available loose Rifampicin and ensure PEP of Leprosy contacts**
- Involve medical officer of PHC and health staff of SC in **microplanning of surveillance** activity.

Points for Discussion

Non-Communicable Diseases

Non-Communicable Diseases

Key Observations

- **District NCD cell:**
- As per the NPCDCS Operational Guidelines the District NCD Cell comprises of:

Designation (as NCD division)	Number of Posts	Chitrakoot	Maharajganj
District Programme Officer	01	00	00
District Programme Coordinator	01	00	00
Finance cum Logistics Consultant	01	00	00
Data Entry Operator (optional)	01	00	00

- In Chitrakoot only the District Nodal Officer, NCD is present.
- In Maharajganj the District Nodal Officer was not in position

Non-Communicable Diseases

Key Observations

- **District NCD cell:**
- In **Chitrakoot District NCD Clinic was physically functional** but in **Maharajganj it was non functional** and is run by one Staff Nurse appointed under NPCDCS programme.
- The Clinic is performing **Opportunistic Screening** of the patients and is not linked with all OPD cases as it should have been as per the NPCDCS operational guidelines.
- It currently **does not have any follow-up mechanism** for tracking the disease status as well as treatment adherence and is used predominantly for checking Blood Pressure and Random Blood Sugar by pre-diagnosed patients only. It also **lacks counselling services** on modifiable and non-modifiable risk factors and wellness activities.
- Moreover, the **Clinic does not have screening services for Oral, Breast and Cervical Cancers after the transfer of only trained Physician in the year of 2019.**

Non-Communicable Diseases

Key Observations

National Programme for Control of Blindness and Visual Impairment:

- The programme is non-functional in Chitrakoot but functional in Maharajganj.
- Each District have **one Ophthalmologist.**
- **No cataract surgeries are being performed** in the districts however in Maharajganj, the *records of few surgeries were provided but on cross-checking, it was not established.*
- The districts **do not have Vision Clinics** in all Health Institutions.
- **Lack of basic equipment** in the Eye OPD Clinics.
- The District Hospitals **do not have marked Eye OT** for surgical procedures.
- The Programme **lacks coordination with the RBSK programme** for providing Refraction Services in the Districts to the school-going kids too.

Non-Communicable Diseases

Key Observations

National Programme for Health Care for Elderly and National Programme for Palliative Care:

- The **geriatric wards are not marked in Chitrakoot but 4-bedded ward is functional in Maharajganj**.
- **No separate registration window** is demarcated in the District Hospital with **no separate OPD services and training.**
- **One Physiotherapist** was appointed under the programme *but is attached to the Orthopedic Unit of the District Hospital and was found unaware of the NCD Clinic in the same Hospital premises.*
- **Palliative Care Clinics** and Day Care Clinics are non functional in the district with Predominantly focus on individual patient care.
- **Systemic approach to ensuring continuum of care was lacking.**

National Oral Health Programme:

Designation of HR	Sanctioned Position	Chitrakoot	Maharajganj
Dental Surgeon	02	01	01
Dental Hygienist	02	02	00
Dental Assistant	01	00	00

- Dental Chair was available at District Hospital, in few CHCs and also in few PHCs.
- Common dental services such as Root Canal Treatment, filling etc. were not available except dental extraction.
- Autoclaved dental equipments were not used uniformly.
- Overall the HR was not aware of the National Oral Health Programmes in the district.
- The young Dental Surgeons were not able to perform dental procedures due to non-availability of x-ray machine.
- However, the systemic approach of the National Oral Health Programme is missing in the districts.

Non-Communicable Diseases

Key Observations

National Programme on Climate Change and Human Health:

- The programme is currently **non functional.**
- The concept of climate change, resilient infrastructure, disaster preparedness, orientation and capacity building was found missing for implementation of the programme.
- The **rain harvesting system, liquid waste management and efficient ETP was also not in place at all health institutions.**
- The Maharajganj was found using **ETP.**
- The use of LED bulbs, solar panels at few health institutions was some of the good practices seen in the health institutions.

Non-Communicable Diseases

Key Observations

National Tobacco Control Programme:

- **Tobacco Cessation Clinics** were not functional in the Districts

National Mental Health Programme:

Mental Health OPD was functional in Chitrakoot on Monday, Wednesday and Friday for the patients.

- Chitrakoot Clinic provides counselling these days with the help of Counsellors and on camp mode too.
- The District does not have a **Suicide Prevention Helpline.**
- In Maharajganj, **no psychiatrist was available**, however, one Psychologist, **one psychiatrist Nurse and a psychiatrist Social worker were in position,** but the programme is non-functional.

Recommendations: Non-Communicable Diseases

Recommendations

- Shortfall of human resources needs to be addressed with Innovative options like ‘you quote we pay’ as per NHM guidelines.
- Staff including Medical Officers are to be oriented on coordinated and convergent care for NCDs.
- Provision of Refresher trainings on NCDs for all staff may be undertaken immediately.
- Continuum of care approach with assured treatment adherence should be explored by strengthening supply chain management across all levels of healthcare facilities with uninterrupted availability of drugs and diagnostics as per the EDL for NCDs.
- Supportive supervision from District and State NCD Cell should be strengthened.
- Fund utilization must be maximized to streamline provision of NCD services.
- Multisectoral action plan to be drafted and adopted for comprehensive NCD services.

Non-Communicable Diseases

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Points for Discussion | Cross-Cutting themes

Human Resource for Health

Key Observations

- 8626 regular and 2166 contractual posts of specialists. 10720 regular and 1807 contractual posts of GDMOs are sanctioned. **Out of this, 64% of specialists and 29% of GDMOs are vacant.**
- The specialist cadre and GDMO cadre have now defined pathways for promotion. Specialist joins at a level higher.
- The state has vacancies of **25 % nurses and 15% Lab technicians in the FY 2020-21.**
- **Production of specialists is less than required in the state.**
- **Recruitment: UPPSC** for the regular cadre and **EdCIL** (outsourced agency) for the non-regular cadre.
- There **is no systemic analysis and planning for the identification of gaps as per IPHS 2022 and the sanction of posts accordingly.**

Human Resource for Health

Key Observations

- Transfers and postings are done since 2019 on pre-fixed criteria through **“Manav Sampada”.**
- HRMIS is in process of integration with Manav Sampada”. **Pay slips are being generated but linkages with FAMS are under process.**
- **State HR cell:** 17 posts sanctioned, 8 in position, **MBA (HR): 5 out of 8.**
- **Gap identification against IPHS has NOT YET been initiated.**
- **Hard area allowance and TBI (Team based incentives) for MH services are being given.**
- **The DH Chitrakoot didn’t have routine specialist services. Irrational deployment of HRH is an issue.**

Human Resource for Health

Key Observations

- **Capacity Building:**

There is no systemic approach for facility-based training needs assessments of available HRH.

- Training need assessment is being done by the programme but a systemic and comprehensive approach is missing in almost all the programmes.
- Anecdotal evidence of field visits indicated 50-60% SBA-trained nurses mostly in FY 2018-19. No further orientation.
- Neither SIHFW nor the training division has any comprehensive training plan
- SIHFW is conducting some capacity-building training for higher-level functionaries, however, the field observations indicate that they **do not have the adequate capacity to monitor and mentor various programmes.**
- Induction training for various cadres has not been initiated, however, technical training for 2670 ANMs has recently been conducted.

Public Health Management Cadre and Indian Public Health Standards 2022

Key Observations

PHMC:

- Separate HR such as UDC, LDC ETC are sanctioned in the health structure at the District hospital and **thus need integration.**
- The **work has not been initiated in PHMC against creating of specialist and Health Management cadre.**
- The rationalisation of HR covered under HRH should include both clinical and managerial level staff.

IPHS 2022:

- The state has not undertaken a gap assessment to assess compliance for IPHS in public health facilities. **(Target: 20% for FY 2022-23)**
- The funds for IPHS compliance have been sanctioned in ROP 2022-24 but the gap assessment has not been initiated.
- None of the facilities has any guidelines on either IPHS 2012 or 2022.

Quality and patient safety

Key Observations
• **NQAS:** In FY 2020-21, 70 facilities are NQAS certified and getting incentives, 9 facilities have recently been certified, and Incentives are under process. Each district has identified 5 HWC-SC for NQAS assessment which includes 1 in Maharajganj. • **Kayakalp:** In FY 2020-21, 1075 Kayakalp certified, this year 92 Kayakalp certified facilities, CHC and below: assessment in progress • **SUMAN:** 582 notified. **None of them is certified.** • **SQAC meeting:** held last year under planning for this FY. • **DQAC**: Committee has been created but standalone meetings are irregular. • **Implementation of QA in health facilities:** Neat and clean facilities, waiting areas available, portable water etc.

Quality and patient safety

Key Observations
• Hand railing, disabled friendly toilets missing, fire fighting equipment available but periodic drills and functionality are compromised. • **Audits: Death, fire safety, prescriptions, electricity not being done.** • Critical indicators of NQAS: **Not Monitored** • **Mera Aspataal:** Mera – Aspataal is not integrated at any level for patient feedback • **MAS:** is constituted and well-functional, particularly in Chitrakoot. • **JAS:** not yet been created in all places.

Quality and patient safety

Key Observations
Infection control and HCW surveillance: • Infection control committee at DH-Chitrakoot and meeting regularly. • HCW surveillance is not a routine activity. • HCW is not routinely screened for Hepatitis B/C and is not fully vaccinated

National Urban Health Mission

Key Observations

- The state has a 22% Urban population.
- To cover the population, the state requires about 890 UPCs against 710 approved.
- Out of 603 functional UPHCs, **83% (506) are functional as UPHC-HWCs.**
- **Against 710 UPHCs, 461 MOs are in position and 35% vacant.**
- **Similarly, 45 % of staff nurses, 40% LTs and 25% ANMs positions are vacant.**
- **On average, 81 OPD per outreach camp, with 11 persons attending one UHND.**
- Under XV-FC, 847 UHWCs were approved, and space was identified for 819.
- Also, 70 polyclinics were approved.

National Urban Health Mission

Key Observations

- **Service Delivery:**
  - The timings are 9-5 pm which does not suit the slum population. Facilities visited in Chitrakoot are well maintained with proper signage and IEC material.
  - Also, a delivery point conducting 73 deliveries per month and 3/4th are also getting PP-IUCD.
  - Curative care is being provided for all **programmes but the focused approach to health and wellness services is missing.**
  - **About, 40% of the drugs and 1/5th of the type of diagnostics services against IPHS/ Free medicine and diagnostics were available.**
  - SSS test not available for leprosy.

National Urban Health Mission

Key Observations

- **Community and Outreach:**
  - **ASHA and MAS were in place, and** both the cadres are active and know their population, ASHA recognizes the health service gaps of the beneficiaries particularly women and children.
  - Tracking and follow-up are good.
  - **Social Determinant of Health although identified but not being addressed due to lack of inter-departmental coordination.** Urban Municipalities not active in slums, open drains, and mosquito breeding grounds were rampant.
  - **Sub-optimal supervisory visits.**
  - **Besides slums, other vulnerable pockets also need to be taken into the fold, orientation and capacity building at all levels is required with a specials focus on PRIs, Ward members etc.**

Legal Framework

Key Observations
• **CEA :** The States have adopted the CEA Act under clause (1) of article 252 of the Constitution but its implementation either in the state or the districts is not being followed. • **PC-PNDT Act:** 6966 clinics are registered, however, the state-level meetings are not held regularly. In Chitrakoot, 1 meeting of the committee has taken place and the registered clinic visited had kept all records meticulously and sent regular reports also. • **COTPA:** COTPA has been included in the monthly crime review meeting. Awareness is only through IEC posters and no capacity building for service providers. The name of the Nodal officers for implementation was not available in public domain.

Legal Framework

Key Observations
• **Disability Act:** District Hospitals are issuing certificates, however, the transparent procedures for application and the time-bound issue of the certificate are not available in the public domain at health facilities. • Ramps were available but railings, disabled-friendly toilets, and tactile pathways were missing in the facility visited. • **POSCH Act:** In the facilities visited, no training, or non-availability of written policy. The internal complaint committee was not available. • **Medico-legal care for Rape and Sexual Violence:** No designated room, written SOPs or capacity building of service providers on medical examination, or evidence collection. • **RBD Act: Certificates are being issued but information on the process for issue of certification was missing.**

Legal Framework

Key Observations
• **BMW**: Bins, baskets and transportation for disposal are being done but **segregation and decontamination are compromised.** • **None of the cleaning staff or housekeeping staff is trained in the cleaning protocols provision of BMW.** • **None of the District Officials has ever visited the site of disposal of BMW whether it is properly being disposed of or not.** • Cleaning staff at Chitrakoot were getting monthly remuneration of Rs. 6500 only. PPE for concerned cleaning staff is neither available nor being monitored for the gap.

Legal Framework

Key Observations

- **AEA act: In the health facilities, both AERB-certified and non-certified, radiological services could be seen, TLD batch were not being used, and wherever available it was expired.**
- **Mental Health Act:** DH is mostly providing clinical care but does not systematically take up the implementation of various provisions under the act.
- **Blood Bank: Licensed blood bank was in place.** The total number of blood bag stored was 5 in number but the capacity of storage was for 80-90 bags.
- In Maharajganj, *The blood bank's license has been expired during the year 2016 from the "Drugs Controller General (India)."* Despite several attempts by the blood bank staff the approval has not yet been received**.**
- Vertical supplies without any gap assessment for BBR were sent by the state.
- **A State Health Mission meeting was conducted last year. The SHS/DHS functional, meeting was held, and VHSNC was conducted.**

Accountability

Key Observations
• In district Chitrakoot, the MAS members are active and working together with ASHA but not capacity building for the team. • DHAP is not available neither any prospective plan for the layout designs, expansions etc. • District ROPs are being received but **not actively involved in their need assessment.** • **No specific planning for ADs, nor monitoring of implementation.** • **Grievance Redressal:** No systematic mechanism. One or two people from 108 or 102 services were available for any support which are not much of use. • **Citizen charter though available but not comprehensive as per IPHS 2022.**

Health Management and Supportive Supervision

Key Observations

- Besides CMO, the district has 30 posts of senior level managers and 33 number of posts for various programme monitoring.
- **Chitrakoot with 6 blocks has 19 posts functional from various partners working in siloes and not comprehensively utilised.**
- None of the supervisory cadres properly knows the points for programme-wise monitoring and mentoring, data analysis etc.
- CMO, CMS and DPM are the key people who have better information and knowledge on Monitoring and supervision but none of the other program officers has ever been oriented on supervisory points.
- **In brief, SS and mentoring are completely missing. Follow-up and supervisory visits are weak both from the state and districts.**

Newer Initiatives (ECRP II, XVFC and PMABHIM)

Key Observations

XVFC:

- **SLC has been constituted, however, DLCs is not constituted**
- **The certificate for the released grants is in process.**

1. **Building less SHCs, PHCs, and CHCs-** Agency identified for 20 HWCs in Chitrakoot and Maharajganj respectively. However, the layout plans as per IPHS 2022 and work have not been initiated. **The layout plans prepared are not as per IPHS 2022.**

2. **BPHU**- 1 sanctioned at Shivrampur (Chitrakoot) but work has not been started.

PM-ABHIM:

1. AB-HWCs in rural areas-Agency nomination is in process for Chitrakoot

2. AB-HWCs in Urban areas-Nil, one on rental identified in Chitrakoot

3. BPHU- Construction started for 1 BPHU in Brijmanganj (Maharajganj)

4. IPHL- Gap assessment in Chitrakoot and Maharjganj

5. CCB- Funds for two 50 bedded CCBs have been sanctioned, the site identified in Maharajganj and no progress in Chitrakoot

Newer Initiatives (ECRP II, XVFC and PMABHIM)

Key Observations

ECRP II-

1. **32 Bedded Pediatric care Unit-** Construction in progress in Chitrakoot, no progress in Maharajganj
2. **20 Bed Covid care unit CHC** - Maharajganj: out of 4 CHCs identified, construction was completed in 2, and work started in the other two. Chitrakoot: out of 6, two have started construction, 3 units have layout approved and land is not available for one site.
3. **6 Bed Covid care unit -**

Maharajganj: out of 5 CHC identified, 3 are at the finishing stage and 2 work has started

Chitrakoot: out of 11 sanctioned, construction for 6 units is in progress and the layout for 4 units has been approved

4. **LMO plant-** 3 LMO plants were installed at 100-bedded DH Maharajganj and the same was installed at the MCH wing in Chitrakoot.

Recommendations for Cross-Cutting Themes)

Recommendations
Planning Process • Every district should have DHAP addressing disease burden, SDG targets, and population needs for critical care and reduction in OOPE. • Addressing the bed needs of the population: facility inputs should be based on the output for services as per IPHS norms. • While budgeting for various activities, the budgets which are short-term and scheme-specific, should be utilized first before placing funding requirements under NHM or state resources

Recommendations for Cross-Cutting Themes

Recommendations

HRH and Capacity Building:

- The rationalization of HR covered under HRH should include both clinical and managerial staff.
- ToR for all the supervisory staff needs to be reviewed and synchronised with IPHS.
- Performance monitoring as per IPHS norms to be initiated.
- To augment specialist services, various provisions of IPHS like non-rotational posting of GDMOs with specialist etc needs to be implemented.
- Capacity building should be a part of a comprehensive training plan. Prioritize assured critical and surgical services for the population along with the requisite manpower.
- **DNB**: The quality of teaching and training under DNB needs to be monitored with a defined checklist. DNB-trained doctors should provide at least a few years of specialized services at public health facilities.
- The trained manpower needs to be mapped and linked with such facilities which require more specialists.
- Identification of HR gaps based on IPHS 2022. Action should be taken for getting a sanction of regular posts against the required number.
- Fixing tenures for transfer, particularly for remote and interior area, introducing point based criteria for transfer with additional points for serving in remote and rural area.
- Performance-based incentives for critical HR.

Recommendations for Cross-Cutting Themes)

Recommendations

HRH and Capacity Building:

- Induction training for all cadres
- Periodic orientation and capacity building
- Promoting campus recruitment
- Posting of specialists linked with functional service area particularly OT, Critical care etc.
- Provision of good quality residential facilities/ transit hostels permitting commuting from such headquarters where distance is within 30-40 Kms.
- Working with school authorities for opening central schools/ navodaya vidyalayas in interior areas, far flung blocks.
- Brainstorming and reviving the transfer and retention policy of HR.
- Once all the minimum required facilities are given, CMOs to be accountable for absenteeism from workplace.
- Reservation of seats for in-service candidates for PG admission.
- District preference for posting can be considered.

Recommendations for Cross-Cutting Themes)

Recommendations
PHMC • GDMO and specialist cadre created, mapping of managerial HR needed along with creation of cadre. • Public health trainings to be augmented at identified institutes. • Support of CoEs can be taken in planning and implementation of PHMC • Quality of clinical services to be the responsibility of technical person and DHS while other health system aspects like procurement, logistics, finance etc should be taken care by administrative and finance personnel. **Supervision and Monitoring** • Capacity building of both clinical and program officials needed on critical points for monitoring and supervision • Defined number of field visits with a defined checklist to be undertaken from all levels of supervisory staff. • Selection of senior supervisory posts at state level should be based on defined competency framework

Recommendations for Cross-Cutting Themes)

Recommendations
Drugs and equipment- Monitor availability and out-of-stock drugs as per essential medicines list as per IPHS. The planning division of NHM should steer hold the facility plan including gap assessment under IPHS 2022 linked with the state action plan. **Diagnostics** Utilize FC-XV funds to ensure full range of diagnostic services **BMEMP** All the equipment of the health facilities should be included and tagged with equipment details like manufacturing, service records, and other key parameters. Toll-free number should be known to all the service providers along with a physical display in the service area. **AYUSH** Cross-pathy prescription are not legal and as such sometimes service providers may face medico-legal issues.

Recommendations for Cross-Cutting Themes)

Recommendations
ECRP-II, FC-XV, PM-ABHIM: • Systemic plan for parallel actions like layout plans, selection of agency for construction, gap assessment against available equipment to be initiated and accomplished on priority. • Work order for utilization of funds against the sanctions issued till 2022-23 needs to be prioritised. • Districts who have already initiated work, expenditure needs to be booked. • Entry in the PMS portal should be ensured along with capacity building of district and block officials for the same

AYUSH Services

Key Observations

- Mainly **Ayurveda dispensaries (25) are present** in the Districts through NHM. **Homoeopathy dispensaries were present in DH and urban PHC and through State AYUSH mission.**
- One 25-bedded Ayurveda has been sanctioned in district Chitrakoot. 1 Unani dispensary is there but medicines are unavailable.
- The average OPD was **25-30 per day. At places, AYUSH doctors prescribe allopathic medicine and conducting PMSMA sessions also, mainly when allopathic doctors are not there.**
- **Yoga classes running with 4-5 persons** attending daily in one centre in the entire district.
- The infrastructure of AYUSH dispensaries is **old and dilapidated** and mostly running in rented buildings.
- **Only 55% of total budget for medicines has been utilised**. Hence, only 20-25 types of medicines are available.
- Posts sanctioned through NHM are filled, however, **posts sanctioned through regular are mostly vacant**
- The **hospital is non-functional** due to the poor construction and lay out plan. Only three rooms are available – OPD, Pharmacy and Yoga wellness centre
- Ayurveda dispensaries are involved in conducting Aarogya mela once a month in outreach areas

Recommendations: AYUSH Services

Recommendations
• Digitalization of every AYUSH Wellness Centre • Medical Officers (Ayurveda) should be provided training in any of the procedures such as Panchakarma therapy, ksharsutra therapy • Procurement of Ayurvedic medicines by IMPCI should be increased. • Linkages between AYUSH and DH could be established for a holistic treatment of patients coming for various conditions such as fractures and injuries. • Crosspathy prescriptions are not legal and as such sometimes the service providers may face Medicolegal issues/ litigation.

Health Finance

Key Observations

- The SNA and Single Nodal Account is implemented at the District to block level.
- PFMS and FAMS reporting are being done
- **Delays in JSY** due to Aadhaar and bank verification; since 1.5 to 2 months.
- The **2021-22 statutory audit is currently ongoing** and the FY 20-21 is concluded
- The major findings of the statutory audit in 2020-21 were – quotations were not available, GST bills, and ASHA payment is maintained online BCPM MIS portal but no hard copy is being maintained
- The **concurrent auditor is yet to be appointed**
- **No expenditure has been done from the untied fund at VHNSC**
- **ASHA incentives were the key unspent of last year and the reasons are JSY** (Pvt. deliveries not paid, ASHA vacancies etc). Last year 6 lakhs was left over in the untied fund's SC and VHSNC

Health Finance

Key Observations

- The accounting procedure and record keeping were **sub-optimal** in both Districts.
  - Noting/approval, the work order was missing from the vouchers
  - Cashbook was not stamped,
  - No signature/verification of vouchers
  - Registers not maintained (age wise advance registers)
- The **OPD (user charges) has not been deposited** to the RKS Bank account for a long time. No entry was found for the same in Cashbook and Bank statement for the FY 2021-22 and FY 2022-23.
- More than Rs. 20 lakh is lying in RKS/Ayushman account at District Hospital.
- **It has been noticed some payments are being made by cheque instead of PFMS.**

Health Finance

Key Observations

- **Low Utilization** of funds as on 31.10.2022 under NHM:-

Level	Allocation	Expenditure as per FAMS	Percentage
DHS- Mahariganj	102.99	22.46	21.80 %
DHS- Chitrakoot	57.27	14.03	24.49%

- High unspent as of 09.11. 2022 as per PFMS balance is **Rs. 1951.89 cr**
- The Central Share of Cash grants of **Rs. 21.37 cr has not been transferred from State Treasury to SHS.**
- A **matching State Share of Rs. 627.61 Cr is also pending. Updated FMR received up to August.**
- **The vacant position HR for finance and accounts is 933 against 2055.**

Recommendations: Health Finance

Recommendations
• An internal control mechanism should be at all levels for monitoring. Presently, no such mechanism is available at Districts and below level. • The district needs to **monitor and train** the Accounts Personnel at the block level. • Boosting **Utilization of incentives of ASHA** (such as the RI component has low utilization) • Provision of Timely payments of Beneficiaries. • **Strict Compliance with audit reports** needs to be followed. • Smooth and fast procedures for providing Limits to facilities should be adopted.

Thank you