


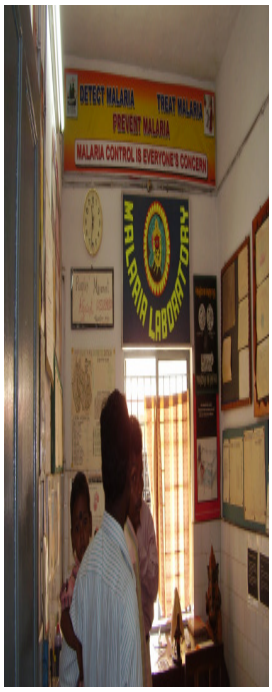

Final Report – State Orissa

Public Expenditure Review of DOH&FW, Orissa for 2008-09

January 2011

Technical & Management Support Team

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Issue and revision record

Revision	Date	Originator	Checker	Approver	Description
A	07.12.10	Bhaval Hemrajani	Anisur Rahman	Shoma Majumdar	Draft Report – State Orissa
B	31.01.2011	Bhaval Hemrajani	Anisur Rahman	Shoma Majumdar	Final Report – State Orissa

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Executive Summary

The report seeks to provide an independent assessment of the adequacy, appropriateness and effectiveness of the health sector spending in the state in order to inform refinement of the sector strategy and to identify the expenditure priorities and adjustments required to translate this sector strategy into reality through the budget process. Specifically, this objective is sought to be achieved by providing a broad overview and analysis of expenditure flows in Health Care from 2007-08 to 2009-10 and assessing the role of public spends in moving towards the state's health goals.

Orissa, with its state capital in Bhubaneswar, is divided into 30 districts for administrative purposes. Accounting for about 4.87% of the total area of India, it has a population of 367.06 Lakh, with 85% of the total population living in the rural areas.

The Public Health System in Orissa comprises various facilities in each district, like the District Headquarter Hospital (DHH), Sub-Divisional Hospital (SDH), Other Hospital (OH), Community Health Centre – I (CHC – I), Community Health Centre – II (CHC – II), Block Primary Health Centre (Block PHC), PHC(New) and Sub-Centres (SC). Apart from these, there are other medical facilities like Capital Hospitals and Medical Colleges which are also a part of the health system in Orissa.

While a District Hospital has been set up in each district of the state, the Sub-Divisional Hospital is available only in select districts. The maximum number of health facilities is in Mayurbhanj (702), while the minimum number of health facilities can be found in Deogarh (54).

This study was conducted at three levels – State Level, District Level and Facility Level. For the purpose of the study, a sample of eight districts was selected, where the survey and field visit was carried out. These districts were – Balasore, Jagatsinghpur, Jharsuguda, Kandhamal, Keonjhar, Nabarangpur, Nuapada and Sundargarh.

This study has been divided into two broad subjects. On one hand, the Budget and Expenditure in the Public Health System in Orissa has been collected, studied and analyzed; and on the other hand, a total of 806 Field Surveys of the IPD, OPD and JSY Beneficiaries in Orissa have been conducted along with extensive discussions with Front-line Service Providers (ie. ASHAs) in the state regarding various health programmes functioning in the state.

There are three major components that have been considered for analysing the public expenditure on health in Orissa – Expenditure incurred under Health and Family Welfare Department (Demand No. 12), Expenditure incurred on Health by other Departments (Works Department, Labour Department, Rural Development Department) and Expenditure incurred under National Rural Health Mission (NRHM). The total Health and Health-related budget has been INR 102223.5 Lakh, INR 177111.0 Lakh and INR 221626.9 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively. On the other hand, the total expenditure has been INR 76096.8 Lakh and INR 115277.4 Lakh for the years 2007-08 and 2008-09 respectively. The expenditure for the year 2009-10 has not been published for Health and Family Welfare Department and other Departments. The Health and Family Welfare Department (H & FW) is the primary source of fund allocation and expenditure relating to the subject of health in Orissa, contributing 94% of the total expenditure in 2007-08. On the other hand, NRHM expenditure has shown a progressive increase during the last three years, with its share of the total health and health-related budget reaching 25.5% in 2009-10 from 1.2% in 2007-08.

The total budget for H & FW has been INR 83331.0 Lakh, INR 118630.7 Lakh and INR 159943.9 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively. On the other hand, the total expenditure has been INR 71531.1 Lakh and INR 89912.4 Lakh for the years 2007-08 and 2008-09 respectively. Under various Heads of Account, it was observed that Medical and Public Health has contributed more than 80% across the budget and expenditure during 2007-08 and 2008-09. More than 67% of the budget and expenditure over the last three years has been devoted to Salary component. Expenditure under salaries has been made accordingly, showing budget utilization of 88.5% in 2007-08 and 77.3% in 2008-09.

The total budget relating to health care allotted in Other Departments has been INR 4830.7 Lakh, INR 4916.8 Lakh and INR 5200.5 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively. On the other hand, the total expenditure has been INR 3688.5 Lakh and INR 4400.8 Lakh for the years 2007-08 and 2008-09 respectively. The expenditure for the year 2009-10 has not yet been published for these different departments. Overall, the combined budget utilization has increased from 76.4% in 2007-08 to 89.5% in 2008-09.

The total budget for NRHM has been INR 14061.8 Lakh, INR 53563.4 Lakh and INR 56482.6 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively. On the other hand, the total expenditure has been INR 877.2 Lakh, INR 20964.3 Lakh and INR 38127.5 Lakh for the years 2007-08, 2008-09 and 2009-10 respectively. NRHM was still considered a new concept among various health facilities during 2007-08. With the benefits of NRHM programmes becoming clearly visible with time, the fund utilization increased to 39.1% in 2008-09, and to 67.5% in 2009-10.

Many of the facilities covered during the field visit suffered from lack of adequate staff at the facilities. In some cases, it was observed that the post of Medical Officer in Charge at the CHCs visited was also lying vacant.

During the field visit, it was observed that anti-biotic and anti-allergic injectibles were found to be in shortage at many of the facilities. Lack of trained operators and lack of repair facilities caused some equipment in many facilities to remain either unused or non-functional during the field visit.

During the field visit, records regarding Services Utilization (IPD, OPD, Institutional Delivery) at the various facilities were collected for FY 2007-08, 2008-09 and 2009-10. At the DHHs visited, the number of IPD cases was highest at DHH Keonjhar while the number of OPD cases was highest at DHH Sundargarh. The number of Institutional Delivery cases has been the highest at DHH Jagatsinghpur and DHH Nabarangpur over the last three years. Among the CHC / UGPHC / Block PHC visited during the study, it can be observed that the number of IPD cases was highest at CHC Soro, UGPHC Khariar and CHC G. Udayagiri during the last three years. The bed utilization at most of the DHH visited during the study was above 95%. While some CHCs had a bed utilization of more than 100% (like CHC G. Udayagiri, CHC Daringbadi and CHC Ghatagaon), on the other hand, some facilities showed a very poor bed utilization of below 25% (like CHC Brajrajnagar and CHC Salania).

During the field visit to various health-care facilities, a general observation of the services available for the patients and the cleanliness of the premises was also made. Most of the facilities were found to be neither clean nor well-maintained. This was especially true of Indoor Patient Wards at DHH Balasore, DHH Jagatsinghpur, DHH Kandhamal and most of the CHCs/UGPHCs/ Block PHCs visited . The pharmacies at the facilities were found to be lacking in the space and ventilation required for storage of medicines. Only two DHHs had an ICU facility. Out of eight DHH visited, only three had a functioning Blood Bank in the premises. The PHC(N) visited during the study were mostly equipped for only out-patient facilities. Most of

the facilities at CHCs/UGPHCs/ Block PHCs, PHC(N) and SC level suffered from an erratic water and electricity supply. Many of the sub-centres visited had no separate premises but functioned from homes of ANMs or rented premises. The toilets at almost all the facilities visited were found to be extremely dirty and sometimes unusable.

FGDs with ASHAs were also conducted in the districts that were covered during the field visit. A total of 160 ASHAs were contacted during the field visit. The average payment received per activity by ASHA varied from INR 314 in Nabarangpur to INR 350 in Balasore, Jagatsinghpur, Keonjhar and Sundargarh.

Field Surveys were also conducted with IPD, OPD and JSY beneficiaries in the districts covered during the field visit. While 243 IPDs were contacted during the field visit, the OPDs contacted were 241, along with 162 JSY beneficiaries. Most of the beneficiaries in Jagatsinghpur and Keonjhar had monthly household income between INR 2000 and INR 5000, while it was below INR 2000 for a significant proportion of beneficiaries in the other six districts visited. Various heads under which the IPD patients had to incur expenditure, like transportation and diet charges, along with expenditure on medicine and Pathology/ Radiology/Laboratory Test (conducted inside and outside the facility) were also tabulated for all the districts visited, thus preparing a comparative analysis. Similarly, findings related to Attendants expenditure were also tabulated to analyze the overall expenditure incurred by the In-patients and their attendants during their visit and stay at the facility. Overall, the Out-of-pocket expenses incurred by the In-Patients at public health facilities were highest in Balasore (INR 4226, excluding outliers) among the districts covered during the field visit. A similar procedure was undertaken to analyze the total expenditure incurred by the out-patients that included the Transportation charges incurred by the out-patients to reach the facility, expenditure incurred on medicine and in conducting the pathology, radiology or laboratory tests outside the facility. Overall, the Out-of-pocket expenses incurred by the Out-Patients at public health facilities were highest in Jharsuguda (INR 999) among the districts covered during the field visit. Along with services received and expenditure incurred by JSY beneficiaries, the status of JSY Scheme entitlement for the beneficiaries was also recorded and analyzed in the districts visited during the study.

Various bottlenecks were also observed and analyzed during the field visit to the sampled districts, in terms of allocation of budget for various activities and programmes, utilization of the funds allotted, staff resources availability and productivity, supply chain management of drugs and equipment, and proper and time financial management resources.

Based on the existing bottlenecks observed during field visit and various other findings relating to budget and expenditure in health-care in Orissa, some recommendations are made relating to fund allocation and disbursal process, utilization of funds in an efficient and timely manner, staff resource availability, data management, existing infrastructure and supply management practices of drugs and equipment.

1. Introduction

1.1 Orissa - Basic Economic, Demographic & Health Indicators

Orissa, with its state capital in Bhubaneswar, was formed as a linguistic province in 1936. After independence, the ex-princely states were merged and the state was organized into 13 districts, which were further re-organized in 1993-94 into a total of 30 districts.[1] The state is located between the parallels of 17.49N and 22.34N latitudes and meridians of 81.27E and 87.29E longitudes.[2] Lying on the eastern coast of India, it is bounded by the Bay of Bengal on the east; Chhattisgarh on the west and Andhra Pradesh on the south. It has a coast line of about 450 kms and extends over an area of 155,707 square kilometres, accounting for about 4.87 of the total area of India.

Table 1.1: Basic Details of the State

Particulars	Details	Particulars	Details
Divisions	3 (Northern, Southern, Central)	Area (Sq. Kms)	155,707
Districts	30	Total Population	367.06 lakh
Blocks	314	Sex Ratio	972

Source: Population Census 2001, http://www.orissa.gov.in

Orissa is a diverse state in terms of its culture, ethnicity, weather and geographical distribution. Orissa is the ninth largest state by area in India, and the eleventh largest by population. As per the 2001 Census, the population of Orissa is 367.06 lakh, with 85% of the total population living in the rural areas. The scheduled tribe (ST) population in Orissa (22%) is larger than the national average of 8%.[3] The scheduled caste (SC) population is 16%. Together they account for 38% of the population.[4] The density of population which was 203 per sq km in 1991 has increased to 236 per sq km in 2001, which is lower than the All India average of 313 per sq km.[5]

Table 1.2: Demography of the State

Particulars	Orissa	India
Total population (Census 2001) (in million)	36.80	1028.61
Sex Ratio (Census 2001)	972	933
Population below Poverty line (%)	47.15	26.10
Schedule Caste population (in million)	6.08	166.64
Schedule Tribe population (in million)	8.15	84.33
Female Literacy Rate (Census 2001) (%)	50.5	53.7
Decadal Growth (Census 2001) (%)	16.25	21.54
Crude Birth Rate (SRS 2008)	21.4	22.8
Crude Death Rate (SRS 2008)	9.0	7.4
Total Fertility Rate (SRS 2008)	2.4	2.7
Infant Mortality Rate (SRS 2008)	69	53
Maternal Mortality Ratio (SRS 2004 - 2006)	303	254

Source: http://www.mohfw.nic.in/NRHM/State%20Files/orissa.htm

1 as.ori.nic.in/gis/khurda/revenue.htm
2 http://www.orissa.gov.in/Portal/ViewDetails.asp?vchglinkid=GL012&vchplinkid=PL049
3 http://www.orissa.gov.in/health_portal/plans/vision2010.pdf
4 http://www.orissa.gov.in/health_portal/plans/vision2010.pdf
5 http://india.gov.in/allimpfrms/alldocs/10523.pdf

The Crude Birth Rate (CBR) in Orissa was 21.4 (SRS 2008) which is lower than the all-India figure of 22.8 but the Crude Death Rate (CDR) in the State (9.0) is much higher than the all-India figure (7.4).The Total Fertility Rate of the State is 2.4 (Source: NFHS-III). The Infant Mortality Rate is 69 and Maternal Mortality Ratio is 303 (SRS 2004 - 2006) which is higher than the national average.

While the median age at first birth for women aged between 25-49 years is 20 (thus showing an early fertility amongst the young women), the immunisation coverage of the state is 52% as per NFHS-III, published in 2005-06.

Available disaggregated indicators point to a poorer health status among these deprived social groups. Under-nutrition, stunting of growth and underweight are higher among SCs, STs, and backward communities. Coverage of antenatal care is lower among deprived socioeconomic groups. Geographic and other reasons have led to lower access and utilization of health care.[6]

Though Orissa's gender ratio is higher than many other Indian states, it has declined over the decades from 1037 females per 1000 males in 1901, to 971 in 1991 and increased nominally to 972 in 2001 (all India average 933 in 2001).[7] However, in the critical 0-6 years age group it has declined from 967 to 950.[8]

Orissa is predominantly an agricultural state, although the State Domestic Product (SDP) composition has been changing rapidly. The State economy has been undergoing a structural change, with the services sector becoming more and more pronounced. As per advanced estimates for 2009 -10, the 'Service Sector accounts for 56.30%' of the real GSDP, followed by 'Industry sector (25.44%)' and 'Agriculture and Allied sectors (18.26%).[9] At the time of 2001 Census, agriculture provided a livelihood for nearly 75 % of the working population. Paddy is the main crop of the state. Other crops, including pulses, oil seed, jute, mustard, turmeric and sugarcane, are also extensively cultivated.

Figure 1.1: Map of Orissa

6 http://www.orissa.gov.in/health_portal/plans/vision2010.pdf

7 Census 2001

8 http://www.orissa.gov.in/health_portal/plans/vision2010.pdf

9 Orissa Economic Survey 2009-10

Orissa has a long coastline and is one of the maritime states of India. The harbour at Paradeep is a major exporter of iron ore to Japan and other countries. Prawns and fish are also exported from this port, reflecting a rapid increase in pisciculture within the state as well as an increasing number of deep-sea fishing trawlers owned by private companies

The State is also endowed with vast mineral deposits like coal, iron-ore, manganese-ore, bauxite, chromite, dolomite, nickel, precious and semi precious stones, etc. Of the major rivers of the country, the Mahanadi, which is a deltaic river, passes through the State with a large number of tributaries and distributaries.

1.2 Background to Health Expenditure Review

Good health is a significant contributor to productive and economic growth of any nation. Hence, the role of government and more so its investments in healthcare is essential in order to achieve better health indicators, particularly in developing countries like India. As per the Constitution of India, while the provision of health care by public sector is a responsibility shared by the State, Centre and local governments, in terms of service delivery, the responsibility primarily rests with the State.

The Government of Orissa has developed a comprehensive Orissa Health Sector Plan 2005-2010(OHSP), that provides a detailed overview of key areas where the health sector has to emphasise upon. Accordingly, the government can prioritise the health needs of the state and make a plan for resource allocation. The essential role of the state in health sector is to regulate health care services besides offering a safety net for the poor and vulnerable sections of society. The public health system in Orissa bears a large burden, because of high dependency of people on public health care delivery system as the bulk of the preventive and curative services happen to be in public domain.

Financial Management is the key to the successful implementation of health care programs. Considering the high dependence on public health systems, it is necessary that public expenditure should be devoted to interventions with public goods characteristics and should be biased towards the poor.

In order to improve the equity and efficiency of health financing systems and to achieve the strategic objectives, it is critical to improve the efficiency of public spending by the Health Department. A Public Expenditure Review (PER) is a comprehensive report that apart from providing details of resource allocation being done would help the state to understand its health spending pattern, current weaknesses and gaps in order to enhance the effectiveness of spend in the future.

1.3 Study Objectives

The **Overall objectives** of the current assignment are:

- To provide an independent assessment of the adequacy, appropriateness and effectiveness of the health sector spending in the state in order to inform refinement of the sector strategy and to identify the expenditure priorities and adjustments required to translate this sector strategy into reality through the budget process. The assessment should be made in conjunction with the Government of Orissa (GoO) and the ultimate effort is to ensure ownership of the conclusions and recommendations by the Government.

- To support the Government in building capacity related to the recommendations of the PER in particular, and to develop the monitoring and evaluation processes in general. The support will take a form of the process to implement recommendations the PER team and the government agree upon,

and of recommendations regarding the implementation of a permanent monitoring and evaluation process within the State Health Department.

Specific Objectives: The proposed Public Expenditure Review is expected to provide a broad overview and analysis of expenditure flows in the Department from 2005-06 to 2008-09 and assessing the role of public spends in moving towards the state's health goals. It will, in particular, address issues of:

- Budget, revised and actual spent during these years under revenue and capital heads, particularly in terms of their planning, budgeting and alignment with sector priorities;
- Fund flow mechanisms within the sector, especially with reference to the Samities at State, District and Block levels and their current role, capacity and spending capability;
- Performance of the recently formed Rogi Kalyan Samities in collecting and utilising user charges, and their relation with district samities;
- Review of public expenditure on drugs, with special reference to functioning of SDMU/district drugs stores, procurement process, distribution of drugs to facilities to beneficiaries, and beneficiary feedback on availability and quality of drugs;
- Review of financial management systems and practices in the Government health sector including efficacy of financial control & management system;
- Appropriateness of delegation, accountability and reporting mechanism.

1.4 Approach and Methodology

Health being in the service sector, human resource is the largest cost component, the rest being consumed as part of health programs. Public Health being the responsibility of the State, much has been done over the past few decades in terms of creating infrastructure, implementation of new programs, decentralized administrative set-up, external assistance and all other support provisions that go in the making of a system of public healthcare in the state.

The general welfare of the state can be measured by its investment in public health by the government and therefore the current study begins by taking stock of these investments reflected in budgetary allocations in the sector, a brief retrospective look at the facilities existing in the State, the institutional set up and the individual projects & programs and the overall goals of the State.

Broadly, expenditure can be classified as public and private. In case of public sector set up, transfer of funds occur from Centre to State and then to lower levels of administration. Under this expenditure review, a detailed study of the pattern of expenditure under various categories is made and budgetary expenditure classifications under major heads are analysed. With public money being invested in public health, there emerges a need to understand how the system of allocation has fared vis-à-vis the health goals and priorities of the State, has the process of resource allocation been efficient enough so as to effect a change in line with stated objectives?

With District Level forming a miniature replica of the State, the process of budgeting, allocation, and expenditure also needs to be studied in depth for few districts, which are selected as true representative sample of the State.

The effectiveness of any robust financial management system lies in its process of budgeting and the expenditure based on the same. An account of the State's allocation process from a top-down fund allocation approach i.e., the States allocation to districts and the bottom-up approach of budgeting mechanism from lower levels of administration will have to be mapped in details. The gap between the needs and what is allotted will bring out the allocative efficiency.

1.4.1 Secondary Review

Despite gradual improvement in health status over many years, preventable mortality and morbidity in Orissa are high. The root causes of poor health continue to be poverty, social deprivation, lower levels of literacy, inefficient health systems and infrastructure for health care and control of diseases, particularly communicable diseases. Socio-cultural inequities and barriers, insufficient assertion and demand for health care, inadequate geographic spread of service outlets and poor quality health care reduce access to and effectiveness of public services. Women, children and tribal people are the worst affected.[10]

1.4.2 Health Care Infrastructure in Orissa

For providing basic health service to the people throughout the State, Orissa has got fairly large network of health facilities.

The Public Health System in Orissa comprises various facilities in each district, like the District Headquarter Hospital (DHH), Sub-Divisional Hospital (SDH), Other Hospital (OH), Community Health Centre – I (CHC – I), Community Health Centre – II (CHC – II), Block Primary Health Centre (Block PHC), PHC(New) and Sub-Centres (SC). Apart from these, there are other medical facilities like Capital Hospitals and Medical Colleges that are also a part of the health system in Orissa.

The term District Hospital is used here to mean a hospital at the secondary referral level responsible for a district of a defined geographical area containing a defined population. It provides effective, affordable healthcare services (curative including specialist services, preventive and promotive) for a defined population, with their full participation and in co-operation with agencies in the district that have similar concern. It covers both urban population (district headquarter town) and the rural population in the district. It also functions as a secondary level referral centre for the public health institutions below the district level such as Sub-divisional Hospitals, Community Health Centres, Primary Health Centres and Sub-centres. It provides wide ranging technical and administrative support and education and training for primary health care. The essential services provided include OPD, indoor and emergency services, in specialities like General Medicine including Nephrology, Cardiology, and Pulmunory Medicine; General Surgery including Urology and Plastic Surgery; Obstetrics & Gynaecology; Paediatrics including Neonatology; Emergency (Accident & other emergency) (Casualty); Critical care (ICU); Anaesthesia; Ophthalmology; ENT; Dermatology & Venerology including RTI/STI; Orthopaedics; Radiology; Dental care; Public Health Management. Para-clinical services like Laboratory services, X-ray facility, CT scan services, Sonography (Ultrasound), ECG, EEG, Echocardiogram, Pathology, Blood Bank, Physiotherapy and Dental Technology (Dental Hygiene). Drugs and Pharmacy services are also expected to be provided at the District Hospital.[11]

A Sub-district (Sub-divisional) hospital is below the district and above the block level (CHC) hospitals. Acting as a First Referral Unit for the Tehsil /Taluk /block population in which it is geographically located, it

10 http://www.orissa.gov.in/health_portal/plans/vision2010.pdf

11 http://xa.yimg.com/kq/groups/16184943/2093145615/name/IPHS

has an important role to play in providing emergency obstetrics care and neonatal care and help in bringing down the Maternal Mortality and Infant Mortality. It forms an important link between SC, PHC and CHC on one end and District Hospital on other end. It also saves the travel time for the cases needing emergency care and reduces the workload of the district hospital. A subdivision hospital caters to about 5-6 lakh people.[12]

An Area Hospital is a hospital established in a district which has an unusually high load of patients that may not be adequately catered to by the CHCs of the district. This hospital has 30 beds, along with facilities like Paediatrics, Surgery, Anasthesia X-Ray, and Operation Theatre.

A CHC is established by the State Government, manned by four medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations.[13]

A PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. It acts as a referral unit for 6 Sub Centres. The activities of PHC involve curative, preventive, primitive and Family Welfare Services.[14]

The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. As per the population norms, one Sub-centre is established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/desert areas. However, as the population density in the country is not uniform, it shall also depend upon the case load of the facility and distance of the village/habitations which comprise the subcentres. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker- MPW(M). Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children.[15]

A tabulation of the health facilities mentioned above has been given below –

Table 1.3: District-wise Health facilities in Orissa

S.No.	District	DHH	SDH	OH	CHC-I	CHC-II	Block PHC	PHC(N)	SC	Total
1	Angul	1	2	3	4	0	5	27	166	**208**
2	Balasore	1	1	3	7	2	6	66	275	**361**
3	Baragarh	1		2	6	2	7	42	204	**264**
4	Bhadrak	1		3	6	0	1	49	178	**238**
5	Bolangir	1	2	3	6	2	7	37	226	**284**
6	Boudh	1		2	0	1	2	10	67	**83**

12 http://www.mohfw.nic.in/NRHM/iphs.htm
13 http://www.mohfw.nic.in/NRHM/iphs.htm
14 http://www.mohfw.nic.in/NRHM/iphs.htm
15 http://www.mohfw.nic.in/NRHM/iphs.htm

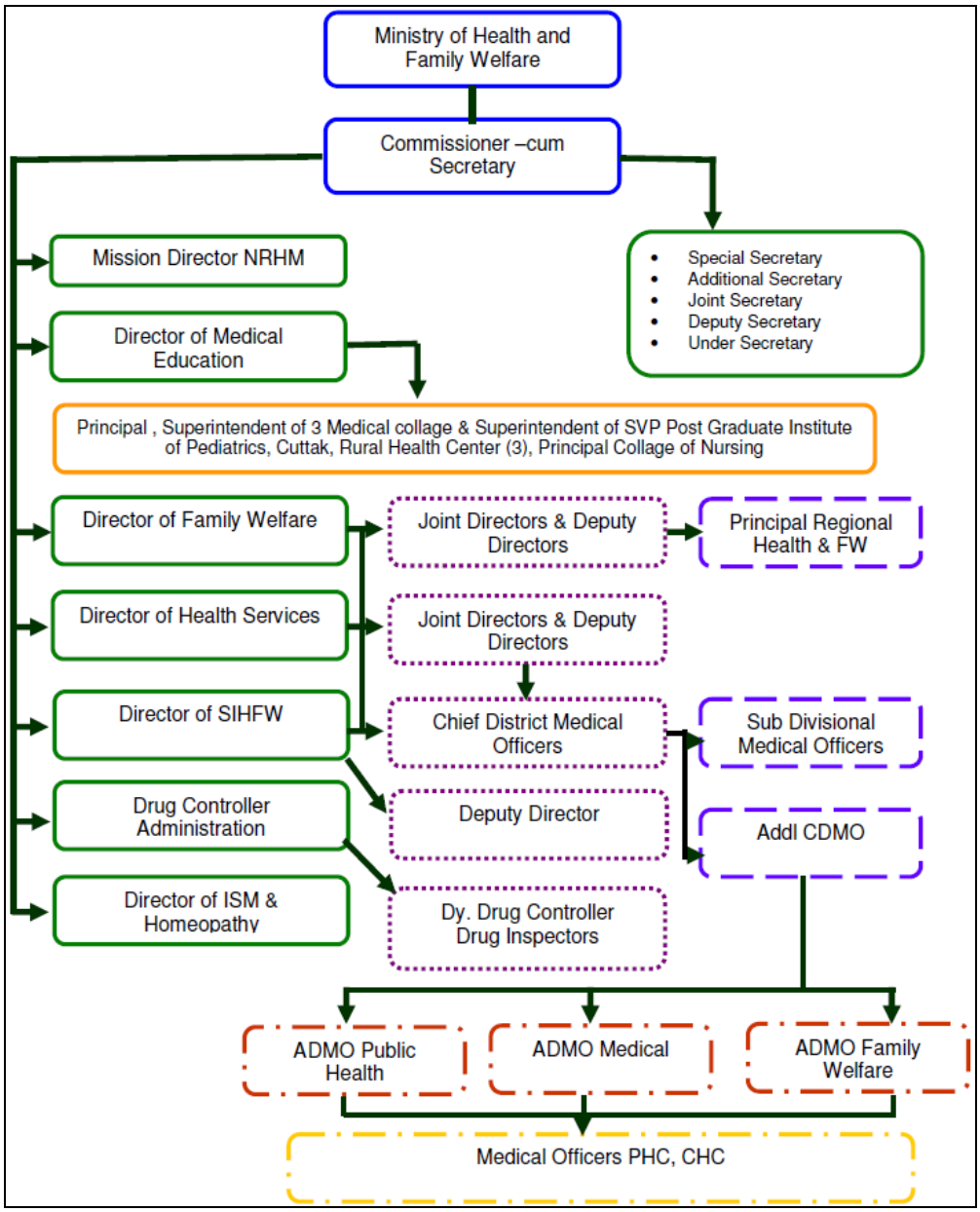
S.No.	District	DHH	SDH	OH	CHC-I	CHC-II	Block PHC	PHC(N)	SC	Total
7	Cuttack	1	2	11	7	2	5	52	332	**412**
8	Deogarh	1		1	1	1	2	6	42	**54**
9	Dhenkanal	1	1	5	6	1	3	31	167	**215**
10	Gajapati	1		2	4	1	2	18	136	**164**
11	Ganjam	1	2	9	12	7	7	82	460	**580**
12	Jagatsinghpur	1		1	5	1	2	36	189	**235**
13	Jajpur	1		3	9	0	2	54	260	**329**
14	Jharsuguda	1		1	2	1	3	14	66	**88**
15	Kalahandi	1	1	6	8	2	4	39	242	**303**
16	Kandhamal	1	1	5	7	1	5	34	172	**226**
17	Kendrapara	1		1	7	2		44	227	**282**
18	Keonjhar	1	2	7	10	1	5	56	351	**433**
19	Khurda	1		8	6	1	4	59	202	**281**
20	Koraput	1	1	3	5	4	5	46	307	**372**
21	Malkanagiri	1		4	5	0	3	25	158	**196**
22	Mayurbhanj	1	3	7	14	3	11	74	589	**702**
23	Nawarangpur	1		2	6	1	3	37	289	**339**
24	Nayagarh	1		9	5	1	2	32	166	**216**
25	Nuapada	1		1	4	0	2	15	95	**118**
26	Puri	1		9	7	2	4	43	241	**307**
27	Rayagada	1	1	2	5	0	6	34	235	**284**
28	Sambalpur	1	1	2	6	3	2	29	167	**211**
29	Sonepur	1		2	4	1	1	17	89	**115**
30	Sundargarh	1	2	3	9	5	6	54	390	**470**
31	Capital Hospital Bhubaneswar	1			0					**1**
32	RGH Rourkela	1			0					**1**
33	SCBMCH Cuttack	1								**1**
34	MKCGMCH Berhampur	1								**1**
35	VSSMCH Burla	1			0					**1**
	Total	**35**	**22**	**120**	**183**	**48**	**117**	**1162**	**6688**	**8375**

Source: Health and Family Welfare Department, Government of Orissa

While a District Hospital has been set up in each district of the state, the Sub-Divisional Hospital is available only in select districts. The maximum number of health facilities is in Mayurbhanj (702), while the minimum number of health facilities can be found in Deogarh (54).

Apart from these facilities, the state has 3 state owned and 3 private medical colleges; and 200 mobile health units (for providing services in inaccessible areas and difficult terrains). At present, 185 health units (163 CHCs, 20 area hospitals, and 2 SDHs) have 24x7 service facilities and another 150 units are proposed to be up-graded to 24x7 service facilities. Besides, 50 units are functioning as First Referral Units (FRUs) and 90 more units are proposed to be converted into FRUs.

Besides, 619 Ayurvedic, 560 Homoeopathy and 9 Unani dispensaries are also functioning in the State. The state also has 8 Ayurvedic hospitals (5 state owned and 3 private colleges); and 6 Homeopathic hospitals (4 state owned colleges and 2 private colleges). The following diagram represents the Organogram of the health system in Orissa –



The Department of Health and Family Welfare in Orissa is responsible for formulating and executing schemes to ensure adequate health services to the people in Orissa in line with the National Health Policy. At the state level, it is headed by the Commissioner-cum-Secretary, who is responsible for coordination and overall performance of the various Directorates and Associated Bodies like Directorate of Health Services, Directorate of Family Welfare, Directorate of Medical Education and Training, Directorate of State Institute of Health and Family Welfare (SIHFW), Directorate of ISM and Homeopathy, Drug Control Administration and National Rural Health Mission. While The Mission Director looks after NRHM, each of the other

Directorates is headed by a Director and is responsible for achieving the relevant objectives of that specific directorate. They are assisted in their endeavours by Deputy Directors and/or Joint Directors. The Chief District Medical Officer (CDMO) of all the districts, reporting to the Director of SIHFW, is responsible for the health administration in a district. He is assisted in his/her duties by ADMOs – Medical, Public Health and Family Welfare, and/or Sub-Divisional Medical Officers. While the ADMO-Medical is in charge of the health administration of District Headquarter Hospital, the CHCs/UGPHCs/Block PHCs/PHCs have a Medical Officer in charge for that specific purpose.

1.4.3 Methodology used for the Study

This study has been divided into two broad subjects. On one hand, the Budget and Expenditure in the Public Health System in Orissa has been collected, studied and analyzed; and on the other hand, Field Surveys of the IPD, OPD and JSY Beneficiaries in Orissa have been conducted along with extensive discussions with Front-line Service Providers (ie. ASHAs) in the state regarding various health programmes functioning in the state.

For the purpose of the study, a sample of eight districts was selected, where the survey and field visit was carried out.

1.4.3.1 Broad Methodology

This study was conducted at three levels – State Level, District Level and Facility Level.

At the State Level, the study involved detailed discussions with the health and administrative officials in the Health and Family Welfare Department (Govt of Orissa) regarding the Budget and Expenditure patterns in the state over the last three years, along with discussions with SDMU officials and various officials of NRHM regarding the Drug supply and Health conditions in the state respectively.

At the District Level, the study involved detailed discussions with the CDMO of the district in order to gain a holistic understanding of health facilities and health issues in the district. Similar discussions were also conducted with the District Programme Officer (DPM) to gain an insight on overall NRHM functioning in the district. Besides the district hospital, 3 CHCs, 3 PHC(N) and 3 Sub-centres were also covered as part of the study. The selection of these facilities was based on their relative distance from their reporting facility. In order to take a holistic view of the block covered, the facilities selected were the farthest, nearest and median to the reporting facility.

At the Facility Level, detailed discussions regarding the services provided, expenditure patterns and other issues were conducted with the Medical Officers in Charge, NRHM representatives (BPO and BADA) and the pharmacists. In addition, data regarding allocation and expenditure of funds, health indicators and services provided was also collected. A general observation was also conducted to gauge the infrastructural condition of the facility.

1.4.3.2 Sampling

For verification of data at the district level, the study was carried out in 8 districts and in each district, 3 blocks were selected – thus, 24 blocks in all.

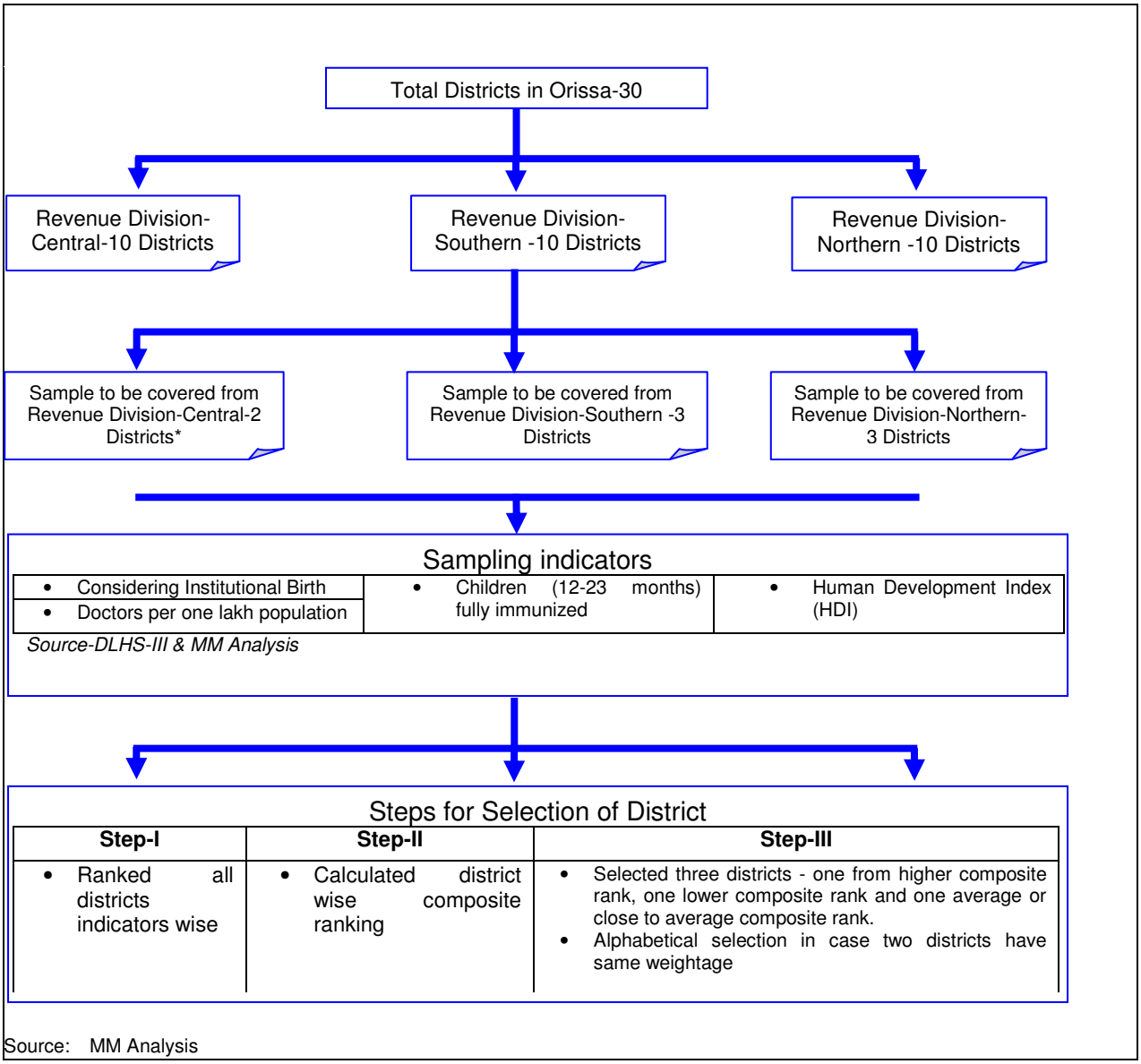
1.4.3.3 Selection of Districts

The study districts have been selected using a set of critical social and health indicators. The indicators have been identified from the DLHS-III report of the districts of Orissa and the Human Development report. The indicators selected are as follows

Table 1.4: Indicators Used for Selection of Districts

Indicators Considered	Source of Information
Considering Institutional Birth	DLHFS-3 -2007-08
Children (12-23 months) fully immunized,	
Human Development Index(HDI),	Human Development Report 2004 data based on Year 2001
Doctors per one lakh population	MM Estimates based on data provided by Human Resource Management Unit, Directorate of Health & Family Welfare

These parameters were listed against each district (categorised as per revenue divisions) and then ranking was done based on each of the four parameters. Based on this ranking, the eight study districts have been selected. The following diagram gives a schematic representation of the selection of the eight study districts –



Source: MM Analysis

Based on the above indicators and method, the following study districts were originally selected:

Table 1.5: List of Original Sample Districts

Revenue Division	Number of Districts	Number of Districts Selected	Name of Selected District
Central	10	2	Cuttack
			Kendrapara
Southern	10	3	Kandhamal
			Nabarangpur
			Nuapada
Northern	10	3	Keonjhar
			Sundargarh
			Jharsuguda
Total	**30**	**8**	

Source: MM Analysis

However, as per the request from the Department of Health and Family Welfare (DoHFW), Government of Orissa, the districts of Cuttack and Kendrapada were replaced by the districts Balasore and Jagatsinghpur respectively.

Based on these suggestions, the final selection of the districts for the purpose of this study is as follows –

- Balasore
- Jagatsinghpur
- Jharsuguda
- Keonjhar
- Kandhamal
- Nabarangpur
- Nuapada
- Sundargarh

1.4.3.4 Selection of CHCs

In each study district, three blocks were randomly selected based on their distance from the district headquarter. In each of these blocks one CHC was randomly selected, such that two of these CHCs are non-FRU and one is a FRU. This selection was done based on discussion with the CDMO of the respective districts. Interactions were also carried out with the Medical Officer-in-charge of the CHC to collect the relevant information.

1.4.3.5 Selection of PHCs

Three PHCs were selected in each district – one in each block/CHC area, such that these are located at an average distance from the selected CHC. This selection was done based on discussion with the CDMO of the respective districts. The study team met the MO-in-charge of the PHC to collect the relevant data.

1.4.3.6 Selection of Sub-centre

In each district, three Sub-centres were selected – one in each PHC area, such that the sub-centre are at an average distance from the PHC. This selection was done based on the discussions with the MO-in-charge of the PHC. All the relevant data pertaining to budget and expenditure at the Sub-centres was collected from the ANM-in-charge and the male MPHW of the Sub-centres.

Thus, in all, the study team visited and undertook stakeholder consultations in 24 CHCs, 24 PHCs and 24 sub-centres.

1.4.3.7 Facilities Covered During Field Visit

In some cases, the facilities selected for field visit and survey had to be replaced because of inaccessibility during that time (waterlogging on roads, landslides, Maoist violence in the area). In such cases, the replaced facility that was selected was the second-in-line based on the sampling procedure for the study. The Key Informant Interviews (IPD and OPD) were conducted in these facilities visited, while discussions with ASHAs and JSY Beneficiaries were held in the entire district.

Based on the methodology mentioned above and after incorporating the required changes, the following health facilities were covered during the field visit –

Table 1.6: List of Selected Facilities During Field Visit

District Name	Block Name	PHC Name	SC Name
Jagatsinghpur	CHC Manijanga	PHC(N) Kolar	Kolar
Jagatsinghpur	UGPHC Ersama	PHC(N) Balitutha	Balitutha
Jagatsinghpur	PHC Mandasahi	PHC(N) Kaduapada	Sidhal
Balasore	CHC Rupsa	PHC Remuna	Nualdhai
Balasore	CHC Simulia	PHC Ishwarpur	Marigaon
Balasore	CHC Soro	PHC Gopalpur	Paudadiha
Keonjhar	CHC Padmapur	PHC(N) Baradapal	Mahadeaijada
Keonjhar	UGPHC Ghatagaon	PHC (N) Jharbeda	Toranipokhari
Keonjhar	CHC Salania	PHC (N) Tukuna	Jaswantpur
Sundargarh	CHC Kinjirkela	PHC(N) Balisankara	Rauldaga
Sundargarh	CHC Lahunipura	PHC(N) Khuntagaon	Naldikudar
Sundargarh	CHC Baragaon	PHC (N) Barangakachhar	Kulugaon
Jharsuguda	CHC Mundrajore	PHC (N) Sahaspur	Pakalpada
Jharsuguda	CHC Brajrajnagar	PHC (N) Sripura	Badmal
Jharsuguda	CHC Lakhanpur	PHC (N) Kumarbandha	Sarandamal
Kandhamal	CHC Daringbadi	PHC(N) Simanabadi	Kirkuti
Kandhamal	CHC G.Udayagiri	PHC(N) Gressingia	Gressingia
Kandhamal	CHC Gumagarh	PHC(N) Bisipada	Pullani
Nabarangpur	CHC Kosagumuda	PHC(N) Asanga	Madeigam
Nabarangpur	CHC Papadahandi	PHC(N) Biriguda	Dengaguda
Nabarangpur	CHC Jharigaon	PHC(N) Ichhapur	Santemera
Nuapada	CHC Khariar Road	PHC(N) Darlimunda	Godfula
Nuapada	CHC Komna	PHC(N) Tarbod	Siallati
Nuapada	CHC Khariar	PHC(N) Duajhar	Nehena

Source: MM Field Visit

1.4.3.8 Private Expenditure Analysis

Since private investment and expenditure on health has been gaining importance in the past few years, the study was incomplete without an understanding of how much is being spent and by what sections of the society on private healthcare. In each district, wherever applicable, the study team visited two private hospitals. The criteria for selection of private health institutions included:

- Size of the hospital (Number of beds)
- Type of services (X-Ray, Pathological, Urine Examination, Pathological services, Ambulatory services etc)
- Geographical Location

1.4.3.9 Stakeholder Consultation

Qualitative data for the study was collected by semi-structured interviews. At the State and District levels, various stakeholders were consulted to get the first-hand data from the field. At the state level, our team interacted with the following officials to get the relevant financial data and understand the financial structure in the state:

Table 1.7: Stakeholder Consultations

Department	Person contacted
▪ Mission Director, NRHM ▪ Director of Medical Education ▪ Director of Family Welfare ▪ Director of Health Services ▪ Director of State Institute of Health & Family Welfare ▪ State Drug Management Unit ▪ Director of ISM & Homeopathy ▪ Directorate of Treasuries & Inspection ▪	▪ Directors ▪ State Program Manager of SPMU ▪ Financial Adviser ▪ Budget Controlling Officer ▪ Estimating Officer ▪ All DDOs

At the District and Block level, our team interacted with the CDMO, the Medical Officer-in-charge of CHC and PHC and the ANM in-charge of Sub-centre.

District Health Accounts and Block Health Accounts exercise was conducted in 8 districts and selected blocks by using semi-structured questionnaires for the assessment of sources and use of funds including Flexi funds and untied fund for different years.

1.4.3.10 FGDs with ASHAs and Survey of Beneficiaires (IPD, OPD, JSY)

Apart from discussions with medical staff, interviews with front-line service provider (ASHA), JSY beneficiaries, in-patients and out-patients was also conducted. The number of interviews that were scheduled according to the sampling plan has been given below –

Table 1.8: Original Sample - Number of Front-Line Service Providers (ASHA) and Beneficiaries

Type	Balasore	Jagatsinghpur	Jharsuguda	Kandhamal	Keonjhar	Nawarangpur	Nuapada	Sundargarh	Total
ASHA	20	20	20	20	20	20	20	20	**160**
JSY beneficiary	20	20	20	20	20	20	20	20	**160**
In-Patient	30	30	30	30	30	30	30	30	**240**
Out-Patient	30	30	30	30	30	30	30	30	**240**
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**800**

Source: MM Sampling Procedure

However, during field visit, the number of interviews conducted for each category of respondents was in some cases, marginally higher than mentioned in the sampling plan. The actual number of interviews conducted has been given below –

Table 1.9: Actual Sample - Number of Front-Line Service Providers (ASHA) and Beneficiaries

Type	Balasore	Jagatsinghpur	Jharsuguda	Kandhamal	Keonjhar	Nawarangpur	Nuapada	Sundargarh	Total
ASHA	20	20	20	20	20	20	20	20	160
JSY beneficiary	22	20	20	20	20	20	20	20	162
In-Patient	30	31	31	30	30	31	30	30	243
Out-Patient	31	30	30	30	31	30	30	29	241
Total	**103**	**101**	**101**	**100**	**101**	**101**	**100**	**99**	**806**

Source: MM Field Visit

With a total of 806 interviews conducted from IPDs, OPDs, JSY beneficiaries and ASHAs in each of the eight districts visited, a dataset of Key Informants' Interviews (IPD, OPD), Beneficiary Survey (JSY) and FGDs (ASHA) was prepared and analyzed.

1.4.3.11 Process of Field Survey and Time/Duration of Survey

At the State Level, detailed discussions and data collection was done at various governmental departments in Bhubaneswar.

At the District Level, detailed discussions and data collection was done at the Office of the CDMO and at District Programme Management Unit (DPMU) of the district.

At the Facility Level, while discussions with medical officials were undertaken at their respective offices/facilities, interviews with In-patients and Out-Patients were conducted at the respective wards of the various facilities. Interviews with JSY beneficiaries and ASHA were conducted in the respective blocks visited during the field visit.

The field visit and survey for the study was undertaken in the months of July and August 2010.

2. Public Health Expenditure in Orissa

2.1 State Budget and Expenditure – State Orissa

The State Budget and Expenditure of Orissa incorporate fund availability and utilization of all the departments in the state in the form of an Annual Budget.

Note: All fund-related figures in this chapter have been rounded off to the nearest first decimal-place.

Table 2.1: State Budget - Orissa

Year	Receipt (Amount in INR Crore)	Expenditure (Amount in INR Crore)
FY 2007-08	104106.7	104780.1
FY 2008-09	134710.2	134884.5
FY 2009-10	58620.8	Not Available

Source: Orissa Budget 2007-08, 2008-09, 2009-2010

As can be observed in **Table 2.1**, the Utilization of the overall State Budget has been just more than 100% in 2007-08 and 2008-09. The receipt and expenditure, furthermore, has grown at a rate of 29.4% in Receipt and 28.7% in Expenditure in 2008-09. However, the decline of State Budget for the year 2009-10 by 56.5% can be explained by the decrease in Public Account Receipt for the said year.

2.2 Overall Health Expenditure – State Orissa

This chapter describes the patterns and trends in public expenditure on health care in Orissa. For this purpose, three major types of expenditure have been considered for analysing the public expenditure on health in Orissa –

- Expenditure incurred under Health and Family Welfare Department (Demand No. 12)
- Expenditure incurred on Health by Other Departments (Works Department, Labour Department, Rural Development Department)
- Expenditure incurred under National Rural Health Mission (NRHM)

Data presented in this study has been drawn from various budget documents of the state government pertaining to the last three years. While Health and Family Welfare Department fund details have been obtained from Demand For Grants – Demand No. 12, fund position for Other Departments has been obtained from Annual Financial Statements. NRHM Fund details have been detailed and analyzed after obtaining them from the SPMU – Orissa. The broad picture of the data can also be gleaned from Finance Accounts and Budget at a Glance for the last three years. However, except NRHM, expenditure relating to Health and Family Welfare Department and other departments was not available for 2009-10.

Table 2.2: Total Budget and Expenditure on Health Care - Orissa (Amount in INR Lakh)

Programme	FY 2007-08			FY 2008-09			FY 2009-10		
	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (in %)	Budget (in INR Lakh	Expenditure (in INR Lakh)	Utilization (in %)	Budget (in INR Lakh	Expenditure (in INR Lakh)	Utilization (in %)
Health and Family Welfare Department	83331.0	71531.1	85.8	118630.7	89912.4	75.8	159943.9	N/A	N/A
Other Departments	4830.7	3688.5	76.4	4916.8	4400.8	89.5	5200.5	N/A	N/A
National Rural Health Mission (NRHM)	14061.8	877.2	6.2	53563.4	20964.3	39.1	56482.6	38127.5	67.5
Grand Total	**102223.5**	**76096.8**	**74.4**	**177111.0**	**115277.4**	**65.1**	**221626.9**	**38127.5**	**17.2**

Source: For Health and Family Welfare Department - Demand for Grants;
For Other Departments - Annual Financial Statements;
For NRHM - SPMU (NRHM), Govt of Orissa
Note: N/A = Not Available

While the overall Health and Health-related budget grew by 73.3% in 2008-09 and 25.1% in 2009-10, the overall expenditure on the other hand showed an annual growth rate of 51.5% in 2009-10. Health and Family Welfare Department (H & FW) is the primary source of fund allocation and expenditure relating to the subject of health in Orissa. While the other departments contribute less than 5% to the total health and health-related expenditure for the state, the H & FW Department contributed 94% of the total expenditure in 2007-08. However, its share of this total came down sharply to 78% in 2008-09, primarily due to increasing importance of NRHM in health-related expenditure. While NRHM expenditure was a meagre 1.2% in 2007-08, it jumped to 18.2% in 2008-09. By 2009-10, its share of the total health and health-related budget had reached 25.5%.

Looking at a comparative picture, it can be observed that while the health care expenditure (comprising Medical and Public Health and Family Welfare) of Orissa was 53.8% of that of Bihar in 2007-08, the figures for 2009-10 show that the Budget Estimates of Orissa was almost similar (91.4%) to that of Bihar. On the other hand, expenditure in Orissa in 2007-08 was more than that of Chattisgarh by 56.1%, while the Budget Estimate for 2009-10 was higher by 73.1%.

Table 2.3: Comparison among States - Health Care (Medical and Public Health and Family Welfare)

(Amount in INR Crore)

State	2007-08	2008-09	2009-10
	(Accounts)	(Revised Estimates)	(Budget Estimates)
Orissa	746.6	1229.78	1642.75
Bihar	1387.03	1761.79	1797.95
Chhattisgarh	478.19	818.01	949.03

Source: RBI

Looking at the Health Care Budget and Expenditure over the last three years compared to the total State Budget and Expenditure of Orissa state, it can be observed that the share of Health care funding has been less than 1.5% till 2008-09. Only during the period of 2009-10 has the Revised Estimate of Health Care managed to capture a share of 3.8%, primarily due to a disproportionate decline in the total State Budget for that year.

Table 2.4: Comparison - Health Care vis-a-vis Total State Budget - Orissa (Amount in INR Crore)

Year	FY 2007-08		FY 2008-09		FY 2009-10	
	Budget	Expenditure	Budget	Expenditure	Budget	Expenditure
Health Care	1022.2	761.0	1771.1	1152.8	2216.3	N/A
Other State subjects	103084.43	104019.08	132939.10	133731.75	56404.53	N/A
Total State Budget (includes Contingency Fund & Public Accounts)	104106.67	104780.05	134710.21	134884.52	58620.80	N/A
% of Health Care of Total State	1.0%	0.7%	1.3%	0.9%	3.8%	N/A

Source: http://www.orissa.gov.in/finance/Budgets/2010-11/Vote_on_Account/Budget_at_glance/Budget_at_glance.pdf

A detailed analysis of the three components constituting Health Care in Orissa has been presented in the following sections.

2.2.1 Health and Family Welfare Department (Demand No. 12)

This section records the detailed budget and expenditure of Health and Family Welfare Department by major heads, sub-major heads, minor heads, plan and non-plan expenditure, type of inputs and health care functions. It excludes resources routed outside the state budget.

During the period of 2007-08 to 2009-10, the health budget and expenditure of the Health and Family Welfare Department has been classified under these major heads - (1) Medical and Public Health (Code-2210); (2) Family Welfare (Code-2211); (3) Secretariat and Social Services (Code-2251); and (4) Capital Outlay on Medical and Public Health (Code-4210).

Table 2.5: Budget & Expenditure under H & FW - Head of Accounts Wise

Head of Account	FY 2007-08			FY 2008-09			FY 2009-10		
	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)
Medical and Public Health	67640.3	58663.8	86.7	101907.4	76645.4	75.2	115367.9	N/A	N/A
Family Welfare	13755.3	11085	80.6	15475.4	12171.3	78.6	43395	N/A	N/A
Secretariat – Social Services	760.0	607.2	79.9	1060.0	907.8	85.6	1179.3	N/A	N/A
Capital Outlay on Medical and Public Health	1175.4	1175.2	100.0	188.0	188	100.0	1.8	N/A	N/A
Total	**83331.0**	**71531.1**	85.8	**118630.7**	**89912.4**	75.8	**159943.9**	**N/A**	N/A

Source: Health and Family Welfare Department – Detailed Demand FY 2006-07, 2007-08, 2008-09, 2009-10, Govt of Orissa
Note: N/A = Not Available

While overall utilization pattern has fallen in FY 2008-09 over FY 2007-08, utilization has improved in Secretariat – Social Services as opposed to Medical and Public Health as well as Family Welfare. Budget Utilization has been 100% for Capital Outlay on Medical and Public Health, both in FY 2007-08 and 2008-09.

Under the Budget of Health and Family Welfare, Revenue expenditure constitutes Medical and Public Health, Family Welfare and Secretariat and Social Services; while Capital expenditure constitutes Capital Outlay on Medical and Public Health.

Table 2.6: Budget & Expenditure under H & FW - Revenue and Capital Expenditure

Head	FY 2007-08			FY 2008-09			FY 2009-10		
	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)
Revenue	82155.6	70355.9	85.6	118442.7	89724.4	75.8	159942.1	N/A	N/A
Capital	1175.4	1175.2	100.0	188.0	188.0	100.0	1.8	N/A	N/A
Total	**83331.0**	**71531.1**	85.8	**118630.7**	**89912.4**	75.8	**159943.9**	N/A	N/A

Source: Health and Family Welfare Department – Detailed Demand FY 2006-07, 2007-08, 2008-09, 2009-10, Govt of Orissa

Note: N/A = Not Available

As can be observed, the share of budget allocation and expenditure under Capital Outlay on Medical and Public Health (the only constituent of Capital Expenditure) has been minimal, less than 2%. The reason behind this sharp decrease of Capital Budget and Expenditure over the last two years is because of cessation of allotment of funds and expenditure in 'Construction of Buildings and equipments etc. (Code: 37161) for the Institute of Paediatrics, Cuttack (Code: 0725). While INR 1,115.2 Lakh was budgeted and utilized for FY 2007-08, the budgeted amount came down to INR 188.0 Lakh in FY 2008-09 as the requisite construction work neared completion. Furthermore, no amount was budgeted or utilized in FY 2009-10. However, it can be observed that in both FY 2007-08 and FY 2008-09, the Budget Utilization under this head has remained close to 100%. On the other hand, Revenue expenditure has shown a slightly declining trend in terms of budget utilization in 2008-09 as compared to 2007-08.

Medical and Public Health has been the most important head under which budget is allocated and expenditure incurred in the Health and Family Welfare Department. Except in the Budget of 2009-10 where its share slipped to 72.1% of total Budget, this head has contributed more than 80% across the budget and expenditure during 2007-08 and 2008-09.

Table 2.7: Budget & Expenditure under H & FW - Share of Head of Accounts

Code	Head of Account	FY 2007-08		FY 2008-09		FY 2009-10	
		Budget (in %)	Expenditure (in %)	Budget (in %)	Expenditure (in %)	Budget (in %)	Expenditure (in %)
2210	Medical and Public Health	81.2	82.0	85.9	85.2	72.1	N/A
2211	Family Welfare	16.5	15.5	13.0	13.5	27.1	N/A
2251	Secretariat - Social Services	0.9	0.8	0.9	1.0	0.7	N/A
4210	Capital Outlay on Medical and Public Health	1.4	1.6	0.2	0.2	0.0	N/A
Total		**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**N/A**

Source: MM Analysis

Note: N/A = Not Available

Expenditure under the 'Medical and Public Health' head includes expenditure on various health care facilities, including sub-centres, PHCs, CHCs, district and sub-divisional hospitals; medical colleges and hospitals; and for prevention and control of diseases, promotion of other systems of medicine, and national malaria and filaria control programmes. This expenditure incurred under the 'Medical and Public Health' head is largely sourced from the state government's own resources. On the other hand, a major chunk of resources under the 'Family Welfare' head comes from the central government and covers expenditure incurred on family welfare programmes including, postpartum centres, rural family welfare and urban family

welfare centres, sub-centres, reproductive and child health services, training of nurse-midwives, expenditure on state institutes of health and family welfare and other activities related to improving maternal and child health. Family Welfare ranks second in terms of the fund allocation and expenditure under this department. Medical and Public Health expenditure exceeds 70% of the total Budget & Expenditure under H & FW.

Expenditure under the Health and Family Welfare Department has also been classified as Plan and Non-Plan expenditure. Plan Expenditure covers all expenditure, both capital and recurrent, incurred on programmes and schemes that have been initiated by the state during the current five-year plan. The size of the total planned expenditure is determined through a negotiation process between the state and the Planning Commission. The rate of development in the health sector depends primarily on the growth in plan expenditure which tends to fund new initiatives. Non-Plan expenditure, on the other hand, is spent for continuation of the programmes which were initiated in the previous plans. It mostly comprises salary spending and a small proportion of drug spending.

Table 2.8: Budget & Expenditure under H & FW – Plan and Non Plan

Head	FY 2007-08			FY 2008-09			FY 2009-10		
	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)
Plan	27434.2	21132.0	77.0%	33210.2	23421.3	70.5%	59829.0	N/A	N/A
Non Plan	55896.9	50399.1	90.2%	85420.6	66491.1	77.8%	100114.9	N/A	N/A
Total	**83331.0**	**71531.1**	**85.8%**	**118630.7**	**89912.4**	**75.8%**	**159943.9**	**N/A**	**N/A**

Source: Health and Family Welfare Department – Detailed Demand FY 2006-07, 2007-08, 2008-09, 2009-10, Govt of Orissa

Note: N/A = Not Available

During the last three years, it can be observed that Non-Plan Budget and Expenditure has taken up more than 60% of the entire budget and expenditure, indicating that expenditure on the continuation of initiatives planned during previous plans far outweighs the new initiatives in the current plan.

Budget utilization under both Plan and Non-Plan has remained steady over the years 2007-08 and 2008-09, with Non-Plan Budget being utilized slightly better than Plan expenditure. All the funds allocated during 2007-08 and 2008-09 have been found to be fully utilized with regards to Capital Outlay on Medical and Public Health. Also, while most of Medical and Public Health expenditure is incurred as Non-Plan expenditure, it is the opposite case with Family Welfare with less than 15% expenditure incurred under Non-Plan expenditure. Furthermore, expenditure under Secretariat - Social Services is incurred exclusively under Non-Plan and vice-versa with Capital Outlay on Medical and Public Health. Most of the Plan expenditure is met by Central and State Plan, while contribution from Centrally Sponsored Plan has been marginal.

Table 2.9: Budget Utilization under H & FW - Plan and Non-Plan

Code	Head of Account (Demand No.12)	FY 2007-08		FY 2008-09	
		Plan (in %)	Non-Plan (in %)	Plan (in %)	Non-Plan (in %)
2210	Medical and Public Health	72.3%	90.4%	64.4%	77.8%
2211	Family Welfare	80.1%	85.6%	79.1%	75.6%
2251	Secretariat - Social Services	71.6%	80.0%	78.5%	85.7%
4210	Capital Outlay on Medical and Public Health	100.0%	N/A	100.0%	N/A
Overall		**77.0%**	**90.2%**	**70.5%**	**77.8%**

Source: MM Analysis

Plan expenditure has been further divided sector-wise, with expenditure incurred under State Sector and District Sector. Over the last three years, expenditure under District Sector has gradually overshadowed that of State Sector, signifying greater autonomy to the districts under Health and Family Welfare.

Expenditure under Demand No. 12 has been further divided into major heads like Urban Health Services (Allopathy and Other Systems of Medicine), Rural Health Services (Allopathy and Other Systems of Medicine), Medical Education Training and Research, Public Health and General. However, major heads have not been used in Family Welfare and Secretariat - Social Services.

Table 2.10: Budget & Expenditure under H & FW – Major Head Wise

Major Head	FY 2007-08			FY 2008-09			FY 2009-10		
	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	e (in INR Lakh)	Utilization (%)
Urban Health Services	30637.8	27759.1	90.6	38781.4	30645.9	79.0	42748.6	N/A	N/A
Rural Health Services	21741.6	19055.6	87.6	38160.6	30770.1	80.6	42578.3	N/A	N/A
Medical Education Training and Research	5339.7	4858.7	91.0	9065.8	5997.5	66.2	11643.3	N/A	N/A
Public Health	10537.7	7689.0	73.0	15213.0	8762.5	57.6	17404.8	N/A	N/A
General	558.8	476.5	85.3	874.7	657.4	75.2	994.8	N/A	N/A
Non-Head Expenditure	14515.3	11692.2	80.6	16535.4	13079.0	79.1	44574.2	N/A	N/A
Total	**83331.0**	**71531.1**	85.8	**118630.7**	**89912.4**	75.8	**159943.9**	N/A	N/A

Source: Health and Family Welfare Department – Detailed Demand FY 2006-07, 2007-08, 2008-09, 2009-10, Govt of Orissa

Note: N/A = Not Available

It can be observed that more than 60% of expenditure is incurred on Urban and Rural Health Services. These major heads also show high budget utilization patterns in 2007-08 and 2008-09, especially for Urban Health Services and Rural Health Services.

Desegregation of these major heads into Sub-Major heads brings out details regarding specific activities which are undertaken under the Demand No. 12 and the budget allocation and expenditure during the last three years.

Table 2.11: Budget & Expenditure under H & FW – Sub-Major Head Wise

Code	Major Head (Demand No.12)	FY 2007-08			FY 2008-09			FY 2009-10		
		Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (%)
001	Direction and Administration	13389.3	10058.5	75.1	16033.5	11552.9	72.1	18511.4	N/A	N/A
003	Training	388.0	237.7	61.3	446.4	280.5	62.8	1064.8	N/A	N/A
101	Ayurveda	2397.4	2251.6	93.9	3547.5	3005.3	84.7	4150.7	N/A	N/A
101	Prevention and Control of Diseases	7347.8	4864.3	66.2	9888.8	5123.2	51.8	11249.0	N/A	N/A
101	Rural Family Welfare Services	6482.9	5557.0	85.7	7468.2	5546.2	74.3	18708.7	N/A	N/A
102	Homoeopathy	2032.6	1830.5	90.1	3054.5	2148.5	70.3	3458.7	N/A	N/A
103	Unani	22.1	20.2	91.6	33.5	26.3	78.6	39.1	N/A	N/A
103	Primary Health Centres	15454.5	13368.3	86.5	22486.3	18345.1	81.6	26151.3	N/A	N/A
104	Drug Control	436.6	370.3	84.8	912.6	416.0	45.6	784.2	N/A	N/A
105	Allopathy	4487.5	4246.1	94.6	7838.5	5304.1	67.7	10213.1	N/A	N/A
110	Hospital and Dispensaries	16761.4	15428.3	92.0	25108.6	20552.6	81.9	28425.1	N/A	N/A
796	Tribal Areas Sub-Plan	6560.0	5163.5	78.7	8385.4	6036.2	72.0	23161.3	N/A	N/A
	Others	7571.1	8138.8	107.5	13427.1	11579.6	86.2	14026.4	N/A	N/A
	Total	**83331.0**	**71535.1**	**85.8**	**118630.7**	**89916.4**	**75.8**	**159943.9**	**N/A**	**N/A**

Source: Health and Family Welfare Department – Detailed Demand FY 2006-07, 2007-08, 2008-09, 2009-10, Govt of Orissa

Note: N/A = Not Available

In terms of budget and expenditure incurred under DoHFW, one of the most important activities undertaken at the Sub-Major Head level has been Hospital and Dispensaries, with more than 20% of the entire budget and expenditure during 2007-08 and 2008-09. Even in the Revised Estimate of 2009-10, INR 28425.1 Lakh (17.4% of total DoHFW budget) has been allocated to this head. Direction and Administration also has received considerable though declining attention during the last three years, with its share in expenditure coming down from 14.1% in 2007-08 to 12.8% of total DoHFW budget in 2008-09. Only 11.6% of the entire budget has been allocated under this head in 2009-10. Primary Health Centres, established in villages, are facilities of first point of contact between the doctor and the patients. Consequently, it is but natural for expenditure under this head to remain high, with its share of 20.4% of the total expenditure in 2008-09 translating to an actual value of INR 18345.1 Lakh.

All the activities listed above as Sub-Major Head have been further broken down into minor-heads detailing how the funds have actually been utilized in Health and Family Welfare. As can be observed, most of the budget has been allocated keeping in mind the salary component of the large manpower that is involved in

the department at various levels. More than 67% of the budget and expenditure over the last three years has been utilised under Salary component. Expenditure under salaries has been made accordingly, showing budget utilization of 88.5% in 2007-08 and of 77.3% in 2008-09. This fall in utilization is primarily because of staffing issues faced by the Department of Health and Family Welfare. While budget utilization has been good for all such important activities listed here (except for Materials, Equipment and Supplies), it can be observed that none of the activities have been given so high an importance as the salary component. A budget is prepared for various medical supplies and equipment for use at hospitals and other facilities, however, the utilization of such a budget has gone from bad to worse in the years 2007-08 and 2008-09. This is mostly because of lack of proper equipment and supply distribution channels at block level where faulty equipments are sometimes found to have not been replaced for more than a year.

Table 2.12: Budget & Expenditure under H & FW – Minor Head Wise

Minor Head (Demand No.12)	FY 2007-08			FY 2008-09			FY 2009-10	
	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (in %)	Budget (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (in %)	Budget (in INR Lakh)	Expenditure (in INR Lakh)
Salaries and Salaries for Consolidated Pay Posts	56318.3	49818.2	88.5	85640.5	66236.0	77.3	125407.3	N/A
Office Expenses	2066.2	1749.5	84.7	2403.0	1917.3	79.8	2238.5	N/A
Diet	471.4	372.3	79.0	728.7	676.2	92.8	749.0	N/A
Medicine	1901.7	1842.4	96.9	3213.1	2730.6	85.0	2673.3	N/A
Materials, Equipment and Supplies	8412.4	5290.9	62.9	8533.9	3315.9	38.9	9087.9	N/A
Grants and Contributions	5163.5	5163.2	100.0	8373.0	6662.6	79.6	8142.4	N/A
State matching share for NRHM	5250.4	4012.8	76.4	5747.0	4815.3	83.8	6100.0	N/A
Others	3747.9	3282.3	87.6	3992.6	3559.3	89.1	5546.3	N/A
Total	**83331.8**	**71531.7**	**85.8**	**118631.7**	**89913.2**	**75.8**	**159944.6**	**N/A**

Source: Health and Family Welfare Department – Detailed Demand FY 2006-07, 2007-08, 2008-09, 2009-10, Govt of Orissa

Note: N/A = Not Available

Grants and Contributions received from various sources (share ranging between 5% - 7.4% during the last three years) have been well-utilized, showing 100% utilization during 2007-08 and 80% utilization in 2008-09. The budget allocation for medicines (INR 2673.3 Lakh in 2009-10) has been quite low during the last three years, because of which a shortage of medicines is perennial at various medical facilities in the state of Orissa across districts. Similar is the case for diet. In many of the facilities, lack of kitchen at the facility prevents the administration from utilizing the budget earmarked for diet (Refer observation chart on kitchen facilities at various facilities visited).

2.2.2 Expenditure on Health by Other Departments

Expenditure on health is not limited to Health and Family Welfare Department (though it is the primary department regarding budget and expenditure relating to health). Other departments, like Works Department, Labour and Employment Department and Rural Development Department make budgetary provisions and incur expenditure relating, directly or indirectly, to health infrastructure in Orissa.

Table 2.13: Health-Related Budget and Expenditure by Other Departments

Demand No.	Department	Code	Head of Account	FY 2007-08			FY 2008-09			FY 2009-10		
				Budget (in INR Lakh)	Accounts (in INR Lakh)	Utili-zation (%)	Budget (in INR Lakh)	Accounts (in INR Lakh)	Utili-zation (%)	Budget (in INR Lakh)	Accounts (in INR Lakh)	Utili-zation (%)
Demand No 7	Works Department	2210	Medical and Public Health	1602	1088.3	67.9	1297.6	1108.7	85.4	0	N/A	N/A
Demand No 7	Works Department	4210	Capital Outlay on Medical and Public Health	1292.3	814.7	63.0	1462.1	1083.4	74.1	2163.8	N/A	N/A
Demand No. 14	Labour Department	2210	Medical and Public Health	1533.3	1495.4	97.5	2157.1	1989.4	92.2	2536.7	N/A	N/A
Demand No. 28	Rural Development	2210	Medical and Public Health	403	290.1	72.0	0	0	N/A	0	N/A	N/A
Demand No. 28	Rural Development	4210	Capital Outlay on Medical and Public Health	0	0	N/A	0	219.3	N/A	500	N/A	N/A
Total				**4830.7**	**3688.5**	**76.4**	**4916.8**	**4400.8**	**89.5**	**5200.5**	**N/A**	**N/A**

Source: Detailed Demands under Budget 2008-09, 2009-10, 2010-11 – Department of Finance, Govt of Orissa

Note: N/A = Not Available

Maximum expenditure has been incurred under the heads of Medical and Public Health as well as under Capital Outlay on Medical and Public Health in the Works Department. It can be observed that budget utilization has increased from 76.4% in 2007-08 to 89.5% in 2008-09. Utilization on health-related expenditure has been the highest for the Labour Department, with more than 95% utilization in both 2007-08 and 2008-09. On the other hand, it can be observed that funds are not well-utilized by the Works Department, especially in 2007-08 where budget utilization for both Medical and Public Health as well as Capital Outlay on Medical and Public Health stood below 70%.

2.2.3 NRHM Expenditure – State Orissa

NRHM was still considered a new concept among various health facilities during 2007-08. Though funds were released under various components and heads, there was widespread confusion regarding the procedural aspects for the use of these funds. As a result, it can be observed that the budget utilization of these funds was quite dismal in the initial years.

Table 2.14: NRHM - Fund Availability and Expenditure - Orissa

NRHM Component	FY 2007-08			FY 2008-09			FY 2009-10		
	Fund available (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (in %)	Fund available (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (in %)	Fund available (in INR Lakh)	Expenditure (in INR Lakh)	Utilization (in %)
RCH Flexible Pool (A)	9579.7	48.4	0.5	21042.3	12807.8	60.9	19695.5	15048.5	76.4
Routine Immunisation (B)	372.2	0.3	0.1	Not available	488.4	N/A	985.8	1015.8	103.0
IPPI (C)	521.7	0.5	0.1	Not available	1098.5	N/A	722.8	510.8	70.7
Mission Flexible Pool (D)	3588.2	828.1	23.1	32521.1	6569.6	20.2	31811.3	19645.9	61.8
Disease Control Programmes (E)	0.0	0.0	N/A	0.0	0.0	N/A	3267.3	1906.6	58.4
Grand Total (A+B+C+D+E)	**14061.8**	**877.2**	**6.2**	**53563.4**	**20964.3**	**39.1**	**56482.6**	**38127.5**	**67.5**

Source: State Programme Management Unit (SPMU), Orissa

Note: N/A = Not Applicable

With time, the systems fell in place and health officials, with support from State Programme Management Unit (SPMU) and various District Programme Management Units (DPMUs), streamlined the process of fund flow and utilization at various facilities and Block Programme Management Units (BPMUs). Consequently, the fund utilization increased to 39.1% in 2008-09. By 2009-10, the benefits of NRHM programmes were becoming clearly visible, providing motivation for further utilization of available resources, which brought the overall NRHM Fund utilization to 67.5%.

Table 2.15: NRHM Orissa - Component Share in Expenditure (in %)

NRHM Component	FY 2007-08		FY 2008-09		FY 2009-10	
	Fund available	Expenditure	Fund available	Expenditure	Fund available	Expenditure
RCH Flexible Pool (A)	68.1	5.5	39.3	61.1	34.9	39.5
Routine Immunisation (B)	2.6	0.0	N/A	2.3	1.7	2.7
IPPI (C)	3.7	0.1	N/A	5.2	1.3	1.3
Mission Flexible Pool (D)	25.5	94.4	60.7	31.3	56.3	51.5
Disease Control Programmes (E)	0.0	0.0	0.0	0.0	5.8	5.0
Grand Total (A+B+C+D+E)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: MM Analysis

Note: N/A = Not Applicable

While most of the expenditure in NRHM was under Mission Flexible Pool in 2007-08 (94.4%), this scenario changed in 2008-09 when more than 60% of the NRHM expenditure was accounted by RCH Flexible Pool. By the year 2009-10, it can be observed that the expenditure pattern has been moving towards a balanced share of expenditure between RCH and Mission Flexible Pool (with share of expenditure of 39.5% and 51.5% respectively). On the other hand, the focus on Immunization, IPPI and NDCP has remained low over the last three years, with a combined share of expenditure staying less than 10% in the last three years.

2.2.3.1 RCH

RCH has been a major component of NRHM in terms of expenditure, and incorporates major programmes like Maternal Health (includes JSY), Family Planning (includes Compensation for Sterilization), Infrastructure and Human Resource and Training. Other programmes like Child Health, Adolescent Health and Gender, Urban RCH, Tribal Health, Vulnerable Groups, Innovation/PPP/NGO, Institutional Strengthening, BCC/ICC, Procurement, Programme Management and Untied Fund have had a minor share in RCH across the three years. Expenditure and share of important programmes under RCH has been depicted in **Table 2.16**.

Table 2.16: Expenditure under RCH

RCH Component	Component-wise Expenditure (in INR Lakh)			Component-wise Share in Expenditure (in %)		
	FY 2007-08	FY 2008-09	FY 2009-10	FY 2007-08	FY 2008-09	FY 2009-10
Maternal Health	7058.8	8531.1	10419.5	73.7	66.6	69.2
Family Planning	1112.7	1217.8	1269.0	11.6	9.5	8.4
Infrastructure and HR	318.8	812.2	1000.8	3.3	6.3	6.7
Training	228.2	465.8	620.4	2.4	3.6	4.1
Others	861.3	1780.9	1738.8	9.0	13.9	11.6
Total RCH	**9579.7**	**12807.8**	**15048.5**	**100.0**	**100.0**	**100.0**
Total NRHM	**14061.8**	**20964.3**	**38127.5**	**N/A**	**N/A**	**N/A**

Source: State Programme Management Unit (SPMU), Orissa

As can be observed, Maternal Health and, to an extent, Family Planning are the major programmes that are implemented under RCH. However, their relative importance in the component, though still immense, has been showing a decline in the last three years. On the other hand, programmes like Infrastructure and Human Resource and Training have now come to the fore, and expenditure under those programmes has been increasing steadily. This shows an increasing focus on capacity-building efforts under NRHM which can help in sustaining its various programmes over a long-term period.

One of the most important programmes under RCH is Janani Suraksha Yojana (JSY) (further included in Maternal Health). In order to achieve its overall objective of reducing maternal and neo-natal mortality, it seeks to promote institutional delivery among women by providing financial incentives to beneficiaries. The importance of this endeavour can be gauged from the fact that more than 60% of total RCH expenditure has been directed towards JSY during the last three years.

Table 2.17: Expenditure in JSY

Programme	FY 2007-08	FY 2008-09	FY 2009-10
JSY (Amount in INR Lakh)	6747.8	8392.9	9269.0
JSY as % of MH	95.6%	98.4%	89.0%
JSY as % of RCH	70.4%	65.5%	61.6%

Programme	FY 2007-08	FY 2008-09	FY 2009-10
CAGR - JSY	N/A	24.4%	10.4%

Source: State Programme Management Unit (SPMU), Orissa

With an expenditure of INR 9269.0 Lakh in 2009-10, it had a growth rate of more than 10% over the last two years, showing the vast impact of its implementation in such a short period of time.

Compensation for Sterilization is another programme that has been quite prominent during the last three years, with a share of 97.6% of the entire Family Planning expenditure.

Table 2.18: Expenditure in Compensation for Sterilization

Programme	FY 2007-08	FY 2008-09	FY 2009-10
Compensation for Sterilization (Amount in INR Lakh)	971.4	1173.9	1238.2
As % of FP	87.3%	96.4%	97.6%
As % of RCH	10.1%	9.2%	8.2%
CAGR - CfS	N/A	20.8%	5.5%

Source: State Programme Management Unit (SPMU), Orissa

However, expenditure under this programme has not been increasing at the same pace as that of NRHM expenditure, leading to a corresponding fall in overall share of NRHM expenditure.

2.2.3.2 Mission Flexible Pool / NRHM Initiatives

NRHM Initiatives include activities undertaken by NRHM which have a wide scope and reach over the entire state. These Initiatives, or Mission Flexible Pool as they are also called, form the bulk of NRHM, constituting more than 51% of the entire NRHM Expenditure during 2009-10.

Table 2.19: Expenditure under Mission Flexible Pool

Mission Flexible Pool Component	Component-wise Expenditure (in INR Lakh)			Component-wise Share in Expenditure (in %)		
	FY 2007-08	FY 2008-09	FY 2009-10	FY 2007-08	FY 2008-09	FY 2009-10
ASHA	440.2	823.9	1624.5	12.3	12.5	8.3
Untied Fund (UF)	154.9	588.8	2340.0	4.3	9.0	11.9
Rogi Kalyan Samiti (RKS)	226.2	635.9	952.0	6.3	9.7	4.8
Civil Construction	1626.8	1140.1	1638.8	45.3	17.4	8.3
Additional manpower requirement	336.5	914.4	960.1	9.4	13.9	4.9
Procurement of Drugs & Logistic	526.4	1040.4	78.4	14.7	15.8	0.4
Mainstreaming AYUSH	117.6	553.8	1287.6	3.3	8.4	6.6
Gaon Kalyan Samiti (GKS)	0.0	228.4	8167.1	0.0	3.5	41.6
Others	159.6	643.9	2597.2	4.4	9.8	13.2
Total Mission Flexible Pool	**3588.2**	**6569.6**	**19645.9**	**100.0**	**100.0**	**100.0**
Total NRHM	**14061.8**	**20964.3**	**38127.5**	**N/A**	**N/A**	**N/A**

Source: State Programme Management Unit (SPMU), Orissa

Note: N/A = Not Applicable

While prominent and flagship programmes under this component have been listed in the table above, other programmes under this component include Annual Maintenance Grant, Equipment Maintenance, Recurring Expenses, Monitoring & Supervision, Mega Swasthya Mela, Mobile Health Unit, Advocacy for NRHM, PIP preparation, Institution strengthening, Data Centre at Secretariat, Hospital Development & MIS, Swasthya Sevika Yojana, Establishment of Orissa SHSRC and Disease control Programme Additionalities.

Over the last three years, it is programmes like ASHA, RKS Fund (including RKS, UF and AMG) and Civil Construction that have clearly demonstrated the immense potential at health improvement offered with the help of NRHM.

Figure 2.1: Sub-Centre Jaswantpur in Keonjhar

Source: MM Field Visit

ASHA, or Accredited Social Health Activist, is a programme that has seen a jump of more than 100% in expenditure during the last three years, with a lot of funds directed to recruitment and training of ASHA. Based on discussions in the field with beneficiaries and community members in the villages, it can be inferred that this programme was able to generate significant improvements in health care in rural parts of Orissa.

The funds budgeted and utilized for Civil Construction are meant for renovation and repair of existing buildings of various facilities in the state, along with construction of new buildings. The benefit of these funds can easily be gauged by the new buildings that have been erected at the sub-centre (SC) level in Orissa. However, it was clear during the field visit that a lot of sub-centres in various districts of Orissa do not still have a separate building, but are functioning from a shack or home of the ANM in charge of the SC, like in SC Jaswantpur (Keonjhar), SC Paudadiha (Balasore), SC Naldikudar (Sundargarh) and SC Dengaguda (Nabarangpur). This clearly brings out the need for an increased budget and timely utilization of funds under this head of NRHM.

AYUSH stands for a compendium of alternate systems of medicine practiced in India, which includes Ayurveda, Yoga, Unani, Siddha and Homeopathy. In 2009-10, expenditure under this head reached INR 1287.6 Lakh from INR 553.8 Lakh in 2008-09, showing its immense popularity among the people of Orissa, especially in the villages.

Rogi Kalyan Samiti, or RKS, is another major programme under NRHM that seeks to bring financial autonomy to the various health facilities in Orissa, thus moving towards decentralization. Financial autonomy is one of the most important aspects of RKS, one that has had a major role in expediting the developmental processes of block and village level health facilities. NRHM, under the head of Mission Flexible Pool, places a certain amount of funds with the health facilities, earmarked for use by these facilities for general use and maintenance purposes. With a specified pool of funds available with the facility, purchases are made for general maintenance and upkeep on a continuous basis. During the field visit, it was observed that in most cases, the CHCs and PHCs had purchased generators/inverters from the RKS Fund. In many cases, construction and repair of boundary walls and building was also carried out through RKS Fund. Another important aspect of RKS is its self-sustaining nature, as the facilities are allowed to levy ‘User Fee’ for the services rendered after adequate consultations with the stakeholders.

Thus, IPD and OPD services, X-Ray charges and other services are offered at a nominal cost to the patients, with the amount going to the RKS Fund

Table 2.20: Expenditure under RKS Fund

Programme	RKS Fund Expenditure (Amount in INR Lakh)			Share in RKS Fund Expenditure (in %)		
	FY 2007-08	FY 2008-09	FY 2009-10	2007-08	2008-09	2009-10
Rogi Kalyan Samiti	226.2	635.9	952.0	56.3%	47.3%	24.8%
Untied Fund	154.9	588.8	2340.0	38.5%	43.8%	60.9%
Annual Maintenance Grant	20.9	120.3	551.3	5.2%	8.9%	14.3%
Total RKS Fund	**402.0**	**1345.0**	**3843.4**	**100.0%**	**100.0%**	**100.0%**

Source: State Programme Management Unit (SPMU), Orissa

In a majority of the facilities visited, it was seen that the funds allocated under RKS, AMG and UF were kept in the same account of RKS Fund. While RKS was the highest contributor to this fund in 2007-08, situations changed by 2009-10, with most of the expenditure made under the head of Untied Fund, due to lack of coordination between RKS executive committee members regarding use of RKS account.

Gaon Kalyan Samiti (GKS) (also known as Village Health and Sanitation Committee) is another programme initiated under NRHM that seeks to improve health conditions in the state using community participation, comprising of representatives of the villages and is envisaged as a facilitating body for all village level developmental programmes. The Samiti takes up the important role of creating awareness among its revenue village about maternal and child health services, family planning and environmental sanitation services. It seeks to manage health-related issues and problems at the local level by planning and implementing health and allied activities at the village level. Looking at the performance of GKS in Orissa, from an expenditure of INR 228.4 Lakh (share of 3.5% in NRHM Initiatives expenditure) in 2007-08, its expenditure jumped to INR 8167.1 Lakh in 2009-10, with a share of 41.6%. This sudden jump in expenditure is attributed to the increasing focus on GKS by NRHM, which has sought to empower the committee so as to become the focal point of all health-related activities in the respective villages, thus creating awareness on health issues at the ground level while simultaneously ensuring community participation. For this purpose, fund availability under NRHM have been re-channelized from other heads like Civil Construction and Procurement of Drugs and Logistics to GKS, in order to give more impetus to the GKS.

2.2.3.3 Immunization

With a really strong growth in expenditure during 2009-10, expenditure reached INR 1015.8 Lakh from INR 0.3 Lakh in 2007-08. It can be observed that expenditure as well as budget utilization has increased by leaps and bounds since 2007-08 till 2009-10. This is primarily due to increased focus and spread of NRHM in terms of Immunization efforts in the state.

Table 2.21: Expenditure under Immunization

Programme	FY 2007-08	FY 2008-09	FY 2009-10
Immunisation (Amount in INR Lakh)	0.3	488.4	1015.8
Total NRHM (Amount in INR Lakh)	**877.2**	20964.3	38127.5
Percent Share	0.03%	2.3%	2.7%
CAGR	N/A	31.2%	108.0%

Source: State Programme Management Unit (SPMU), Orissa

2.2.3.4 Integrated Pulse Polio Immunization (IPPI)

Though there was a high amount of expenditure under IPPI during 2008-09, overall expenditure settled to pre-2008-09 times, with a share of 1.3% of the total NRHM expenditure in 2009-10. This is the direct result of increased awareness and understanding of the NRHM undertakings since 2008-09.

Table 2.22: Expenditure under IPPI

Programme	FY 2007-08	FY 2008-09	FY 2009-10
IPPI (Amount in INR Lakh)	0.5	1098.5	510.8
Total NRHM (Amount in INR Lakh)	877.2	20964.3	38127.5
Percent Share	0.1%	5.2%	1.3%
CAGR	N/A	110.6%	-53.5%

Source: State Programme Management Unit (SPMU), Orissa

2.2.3.5 National Disease Control Programme (NDCP)

National Disease Control Programme (NDCP) is a newly-created component, with expenditure (INR 1906.6 Lakh) recorded only in 2009-10.

Constituting a share of 5% of the total NRHM expenditure of INR 38127.5 Lakh in 2009-10, it is expected that there will be further growth of expenditure under this component in the years to come.

3. Condition Assessment of the Public Health System – Findings from Field Survey

3.1 Human Resource

Lack of adequate staff was a constant refrain at almost all the facilities, in all the districts visited during the study. While a vacancy of ADMO (PH) or ADMO (FW) is somehow taken care of by the CDMO or ADMO (Medical) of that district (like in District Nabarangpur), the problem of staff shortage becomes extremely acute and affects the public directly at facility level. In many cases, it was observed that the post of Medical Officer in Charge at the CHCs visited was lying vacant, due to which fund flow from and to the CHC was not smooth, creating a bottleneck and hindering medical services offered to the public. At almost all the CHCs visited, there was a shortage of medical staff. In some cases, lack of surgeons and/or anaesthetists rendered the O.T useless. Lack of technicians for X-ray is making the X-ray machines redundant. At PHC(N) level, mostly there is a single MBBS doctor sanctioned at the facility, and a vacancy for that post in that facility rendered it almost useless. Another aspect of this staff shortage is the additional burden borne by the staff in-position, especially for Medical Officers in charge at both the CHCs and PHC(N), who in such cases have to balance their administrative as well as medical duties. This causes them to lose their efficiency and productivity, which was evident during the field visit in terms of discharge of their administrative duties involving fund flow, utilization and adequate management of available resources. Especially at PHC(N) level, the doctors reiterated that inadequacy of relevant medical equipment and drugs, along with shortage of doctors causes insufficient care meted out to the patients, due to which the patients go to private facilities for prompt treatment and medical tests despite a high charge associated with these private facilities as compared to public health facilities. A detailed state of staff position in the districts covered during the field visit has been given in **Annexure 7.1.**

3.2 Drugs & Equipment

Drugs are supplied from the SDMU to various districts, from where they are further disseminated to various facilities according to the Annual Indent or Annual Requirement. During the field visit, it was observed that anti-biotic and anti-allergic injectibles were found to be in shortage at many of the facilities. Since the field visit took place at a time when spread of diseases like Malaria was common, it was observed that the demand for anti-malarial medicines was much higher than the supply.

Equipment usage was not found to be good in the various districts that were visited during the study. At many of the facilities, lack of trained operators caused equipment like X-ray machines and Baby Incubators to remain unused, lying idle. It was also observed that many equipments like New Born Care Unit, various furniture, Labour Room equipment and O.T equipment was found to be faulty and non-functional during the field visit, and had not been repaired in the last six months. At some facilities it was reported that the equipment had turned faulty within two weeks of installation, and was never repaired. A detailed state of equipments at the facilities visited during the study has been given in **Annexure 7.2**.

3.3 Services Utilization Pattern (IPD / OPD / Institutional Delivery)

During the field visit, all the district hospitals were visited in the eight districts. Apart from interacting with various medical and administrative officials, data regarding IPD, OPD and Institutional delivery cases were also collected for the last three years wherever available.

Table 3.1: Service Utilization at DHHs - Orissa

District	Facility	FY 2007-08			FY 2008-09			FY 2009-10		
		IPD	OPD	Institutional Delivery	IPD	OPD	Institutional Delivery	IPD	OPD	Institutional Delivery
Balasore	DHH	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Jagatsinghpur	DHH	18350	118757	3467	20732	139659	3751	21380	Not available	3311
Jharsuguda	DHH	32877	175494	1007	41673	178632	1079	48778	192341	2682
Kandhamal	DHH	15700	102766	1245	12150	80127	1238	16560	114830	1852
Keonjhar	DHH	55128	127081	2260	Not available	Not available	2785	27558	123837	2731
Nabarangpur	DHH	10887	70242	2386	14049	51840	3286	14992	54019	3671
Nuapada	DHH	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Sundargarh	DHH	40521	1116373	Not available	61487	931731	Not available	Not available	Not available	Not available
	Total	**173463**	**1710713**	**10365**	**150091**	**1381989**	**12139**	**129268**	**485027**	**14247**

Source: Field Visit

While data regarding IPD, OPD and Institutional Delivery was not available at DHH Balasore and DHH Nuapada at all, at other facilities as well, the data management was found to be ad-hoc. At Nuapada, it was informed to the MM Field Team that the Annual Medical Statement (official document containing details of incidence of diseases, deliveries, IPD and OPD cases etc) for the district and DHH had not been prepared for last many years. Efforts directed towards Statistical Assistants and Pharmacists regarding any records of this information were in vain. In some cases, SA.s were found to be on leave during the period of field visit, thus making access of such medical records impossible. At facilities where these records were available, it was observed that most of these records were prepared by hand and were kept in dusty and unkempt files. While the total number of IPD cases at the eight visited districts has been falling over the last three years, it can be observed that the number of IPD cases has been highest at DHH Keonjhar (31.8% of total IPD cases in 2007-08). On the other hand, in terms of OPD patients visiting the facility, the number has been the highest at DHH Sundargarh (65.3% of total in 2007-08 and 67.4% of total in 2008-09). The number of Institutional Delivery cases has been the highest at DHH Jagatsinghpur and DHH Nabarangpur over the last three years.

Visits to the facilities at the CHC / UGPHC / Block PHC level during the study brought out the glaring inadequacy in timely data management at the level. No data regarding the IPD, OPD and Institutional Delivery cases was available at CHC Rupsa (in Balasore) and UGPHC Ersama (in Jagatsinghpur), the primary reason being lack of preparedness of Annual Medical Statement at these facilities. Efforts to obtain the data from the pharmacists and VS clerks were also in vain, as they could not furnish the relevant data during the time of the field visit. At other facilities the data was found to be kept in an ad-hoc manner, as a result of which there were some gaps in data availability. Different sets of data were found to be kept at

different places. This, over a period of years, had caused the Vital Statistics (VS) clerks to forget the exact location of specific data and had to locate them from various rooms/cabinets/files. The record-keeping of health indicators was mostly done manually, and the documents were found to be frayed, with ink sometimes invisible for records kept since last five years.

Table 3.2: Service Utilization at Block Level - Orissa

District	Facility	FY 2007-08			FY 2008-09			FY 2009-10		
		IPD	OPD	Institutional Delivery	IPD	OPD	Institutional Delivery	IPD	OPD	Institutional Delivery
Balasore	CHC Rupsa	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Balasore	CHC Soro	9852	46380	2034	10341	56718	3488	11887	74879	3934
Balasore	CHC Simulia	2663	31893	1499	3151	31139	2223	3286	30183	2063
Jagatsinghpur	CHC Manijanga	1945	31378	491	1384	35318	387	1858	36412	691
Jagatsinghpur	UGPHC Ersama	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Jagatsinghpur	PHC Mandasahi	490	43572	101	478	39812	133	583	39489	155
Jharsuguda	CHC Mundrajore	792	9488	206	613	7871	236	645	7751	242
Jharsuguda	CHC Brajrajnagar	0	33312	0	0	32493	0	0	26667	0
Jharsuguda	CHC Lakhanpur	490	10914	338	467	14373	405	Not available	Not available	Not available
Kandhamal	CHC Gumagarh	546	19367	Not available	632	17406	Not available	1057	20582	Not available
Kandhamal	CHC G. Udayagiri	12605	21953	402	11262	24445	419	20972	23003	547
Kandhamal	CHC Daringbadi	Not available	Not available	330	Not available	Not available	521	Not available	65907	841
Keonjhar	CHC Padmapur	1091	36405	493	1261	31071	517	1529	30235	517
Keonjhar	CHC Ghatagaon	4732	52437	1130	4542	47760	1372	8478	57051	1251
Keonjhar	CHC Salania	3271	27409	479	4167	30007	564	5701	31544	726
Nabarangpur	CHC Kosagumuda	1300	13600	449	3329	14967	508	4064	9360	947
Nabarangpur	CHC Papadahandi	10402	12681	848	11142	15512	555	6009	14399	595
Nabarangpur	CHC Jharigam	1273	21917	328	1294	20910	470	1017	20738	556
Nuapada	CHC Khariar Road	1462	27411	439	1190	31658	473	1247	22356	570
Nuapada	CHC Komna	3810	37198	391	2765	39768	448	2766	31769	587
Nuapada	UGPHC Khariar	7595	57597	2668	7925	63467	2632	11991	65538	2632
Sundargarh	CHC Kinjirkela	2457	20859	504	3172	20629	750	590	17589	421
Sundargarh	CHC Bargaon	1443	24659	310	1473	27215	332	1521	30560	344
Sundargarh	CHC Lahunipara	1906	32002	400	2240	33006	540	2450	33078	625
	Total	**70125**	**612432**	**13840**	**72828**	**635545**	**16973**	**87651**	**689090**	**18244**

Source: Field Visit

It can be observed that the number of IPD cases was highest at CHC Soro, UGPHC Khariar and CHC G. Udayagiri during the last three years, among the CHCs / UGPHCs / Block PHCs visited during the study. While the number of OPD cases was quite evenly distributed among those facilities visited, still the observation of highly crowded OPD rooms during field visit at CHC Soro and UGPHC Khariar corroborate the high number of OPD patients visiting these facilities during the last three years. Institutional Delivery cases were the maximum at CHC Soro and UGPHC Khariar during the last three years.

3.4 Bed Utilization

During the study, the District Headquarter Hospitals (DHH) of eight districts were visited and based on the number of patients admitted in the facility and the number of actual beds available, the bed utilization was calculated.

Table 3.3: Bed Utilization at DHH - Orissa (as per Observation on the Date of the Visit)

District	Facility	Number of Approved Beds	Number of Actual Beds	Number of Patients Admitted	Average Duration of Stay	Average bed utilization
Balasore	DHH Balasore	237	330	340	2.7	103.0%
Jagatsinghpur	DHH Jagatsinghpur	106	126	88	5.0	69.8%
Jharsuguda	DHH Jharsugada	135	135	107	NA	79.0%
Kandhamal	DHH Kandhamal	186	173	117	0.7	67.6%
Keonjhar	DHH Keonjhar	160	209	200	3.0	95.7%
Nabarangpur	DHH Nabarangpur	67	71	81	7.0	114.1%
Nuapada	DHH Nuapada	120	116	116	7.0	100.0%
Sundargarh	DHH Sundargarh	197	213	220	2.3	103.3%
Total		**1208**	**1373**	**1269**	**4.0**	**92.4%**

Source: Field Visit

As can be observed, the bed utilization at most of the DHH visited during the study was above 95%. Only at DHH Jagatsinghpur, DHH Jharsuguda and DHH Kandhamal did the bed utilization figures drop below 80%. Medical officials at these facilities reported that these hospitals have a bed strength that is higher than what is needed for that particular district. As a result of this, some of the beds remain unoccupied.

As part of the study, three CHCs/ Block PHCs were also visited in each district during the field visit and details regarding bed utilization were recorded.

Table 3.4: Bed Utilization at CHCs/ Block PHCs Level - Orissa (as per Observation on the Date of the Visit)

District	Facility	Number of Approved Beds	Number of Actual Beds	Number of Patients Admitted	Average Duration of Stay	Average bed utilization
Balasore	CHC Rupsa	16	16	4	2.0	25.0%
Balasore	CHC Soro	30	30	22	2.0	73.3%
Balasore	CHC Simulia	16	16	7	2.0	43.8%
Jagatsinghpur	CHC Manijanga	16	16	15	2.0	93.8%
Jagatsinghpur	UGPHC Ersama	30	28	10	2.8	35.7%
Jagatsinghpur	PHC Mandasahi	6	6	6	2.0	100.0%
Jharsuguda	CHC Brajrajnagar	16	9	0	NA	0.0%

District	Facility	Number of Approved Beds	Number of Actual Beds	Number of Patients Admitted	Average Duration of Stay	Average bed utilization
Jharsuguda	CHC Lakhanpur	20	6	2	NA	33.3%
Jharsuguda	CHC Mundrajore	20	16	6	NA	37.5%
Kandhamal	CHC G. Udayagiri	30	30	45	1.5	150.0%
Kandhamal	CHC Gumagarh	16	16	4	0.3	25.0%
Kandhamal	CHC Daringbadi	16	16	21	1.3	131.3%
Keonjhar	CHC Padmapur	16	9	4	1.7	44.4%
Keonjhar	CHC Ghatagaon	30	34	50	3.0	147.1%
Keonjhar	CHC Salania	16	8	1	2.0	12.5%
Nabarangpur	CHC Kosagumuda	16	14	7	3.0	50.0%
Nabarangpur	CHC Papadahandi	16	12	3	3.0	25.0%
Nabarangpur	CHC Jharigam	16	8	7	2.0	87.5%
Nuapada	CHC Khariar Road	16	13	9	1.0	69.2%
Nuapada	CHC Komna	16	16	11	3.0	68.8%
Nuapada	UGPHC Khariar	16	16	22	7.0	137.5%
Sundargarh	CHC Kinjirkela	16	13	13	2.0	100.0%
Sundargarh	CHC Bargaon	30	18	7	3.0	38.9%
Sundargarh	CHC Lahunipara	16	21	21	2.0	100.0%
Total		**452**	**387**	**297**	**2.3**	**76.7%**

Source: Field Visit

It can be observed that bed utilization does not follow any fixed pattern at the CHC / Block PHC level. While some CHCs had a bed utilization of more than 100% (like CHC G. Udayagiri, CHC Daringbadi and CHC Ghatagaon), on the other hand, some facilities showed a very poor bed utilization of below 25% (like CHC Brajrajnagar and CHC Salania).

3.5 Findings from Observation Chart

3.5.1 District Headquarter Hospitals (DHH)

During the field visit to various District Headquarter Hospitals (DHHs), a general observation that was made was that most of the facilities were found to be not clean or well-maintained. This was especially true of Indoor Patient Wards, primarily at DHH Balasore, DHH Jagatsinghpur and DHH Kandhamal. While there were separate OPD rooms for different specialities, most of these rooms were found to be unkempt. With medicines and used bandages lying on tables and on the ground as well. Only three out of the eight DHHs visited had a functioning emergency room at the premises. The pharmacies at the hospitals were found to be lacking in the space required for storage of medicines. Also, lack of proper ventilation in pharmacy rooms rendered them damp and smelly. Only two hospitals had an ICU facility, out of which only at DHH Nuapada was the ICU functioning with adequate level of cleanliness, while at DHH Keonjhar the ICU was not functioning due to lack of adequate staff and equipments. While some hospitals had a single O.T, some of the hospitals like DHH Balasore, DHH Jharsuguda, DHH Nuapada and DHH Sundargarh had two functional O.T.s. DHH Keonjhar had three functional O.Ts, while at DHH Nabarangpur, the O.T was not in use due to lack of anaesthesia specialists. While all the visited hospitals had a Labour Room, the one at DHH Balasore was found to be quite dirty. Out of eight hospitals visited, only three had a functioning Blood Bank in the premises, two had a semi-functioning Blood Bank while the rest did not have Blood Bank or

Blood Storage facilities. While all the visited hospitals had a provision for X-ray, DHH Nuapada did not have functioning Ultrasound at the premises and only five hospitals had functional ECG facilities. DHH Sundargarh also had a provision for CT Scan. While continuous water supply was available at all the hospitals, most of the hospitals suffered from frequent power outages causing lot of problems to both administrative staff as well as patients. Due to this, all the hospitals had a power back-up facility. A proper Bio-Medical Waste Management System was not found only at DHH Jharsuguda. Food was cooked for Indoor patients at only five hospitals, where a separate kitchen was available. The toilets at all the DHH visited (except DHH Jharsuguda and DHH Sundargarh) were found to be extremely dirty and unusable. A detailed matrix of observations at the eight DHH has been given in **Annexure 7.3.**

3.5.2 CHCs / UGPHCs / Block PHCs

During the field visit, it was observed that only a few of the facilities had a separate registration counter. At UGPHC Khariar in Nuapada district, the waiting area was being used as IPD because of lack of adequate space in the wards. Most of the facilities had ill-maintained IPD wards, with patients often observed to be resting on the ground due to lack of available beds. While some of the facilities had an Emergency room, all the facilities visited had a pharmacy. However, the space available in the pharmacy room was almost always found to be inadequate and with little or no ventilation. While none of the facilities had an ICU, even the O.Ts at some of the facilities were not functional and were being used as storerooms. The reason for this was generally found to be lack of equipment or lack of adequate staff (like anaesthetists) or both. While a Labour Room was found at almost all the facilities visited, some of them were found to be very dirty like at UGPHC Ersama (dogs roaming in the room), CHC Daringbadi and CHC Padmapur. While some of the facilities did have a provision for a Blood Bank or Blood Storage Unit, at none of these places was it found to be functional during the field visit. Only a few of the facilities have functional X-ray facilities, as the other facilities either had a problem of staff availability or of faulty equipment. While none of the facilities had an Ultrasound facility, only at CHC G. Udayagiri were ECG facilities available for patients. Most of the facilities suffered from an erratic water and electricity supply. The problem of power outage was quite acute at CHC Daringbadi and at CHC Soro. While only a few of the facilities had a proper Bio-Medical Waste Management System, the toilets available at almost all the facilities visited were in poor and dirty condition. Detailed observations regarding the CHCs / UGPHCs / Block PHCs visited during the study have been given in **Annexure 7.4.**

3.5.3 PHC(N)

PHC(N) were mostly equipped for out-patient facilities. Electric supply was not continuous in any of the PHC(N) visited. There were frequent and long power outages, causing a lot of difficulty to the Medical Officers in position there to adequately discharge their duties. While all of the facilities had between 1-4 rooms for OPD and a single laboratory and a labour room, hardly any of the facilities had functioning toilets.

3.5.4 Sub-centres (SCs)

Sub-centres are the first point of contact between the public of Orissa and the public health system of Orissa in the villages. While it is not expected for the Sub-centres to have advanced medical facilities, it was however observed that even the basic facilities required at any public health facility were missing at many of the sub-centres. In about 50% of the sub-centres, there were no separate premises, no water or electricity supply.

4. Existing Bottlenecks

4.1 Staff Shortage

- One of the biggest bottlenecks to an efficient public health system in Orissa is the lack of adequate manpower, both in terms of medical as well as non-medical staff. **Shortage of medical staff** at a facility forces the MoIC at CHCs (who is the **DDU** for a particular block) to focus disproportionately more on his/her medical duties rather than administrative responsibilities. As a result, financial management within that block suffers, with inaccurate budgetary requirements sent to the District Programme Managers and Office of the CDMO while simultaneously neglecting requisite purchases and sundry expenses, leading to non-utilization of funds to various degrees. This problem becomes magnified when the vacancy is for the position of MoIC as well.

- Shortage of medical staff also puts a huge burden on the medical officers in position as they have to attend to a patient load sometimes much higher than they can handle. As a result, their lives become extremely stressful with no time available for relaxation, leading to loss in productivity and motivation to work.

- Shortage of specialist medical staff like assistant surgeons, gynaecologists, anaesthetists cause Operation Theatres to remain unused.

- Lack of an adequate number of **AYUSH doctors** in position for a facility has also been hampering the efforts that are being put in for increasing the popularity and trust in other systems of medicine (AYUSH).

- Lack of adequate staff at the pharmacies and/or stores (like helpers, assistant pharmacists) also cause huge burden on the pharmacists, creating bottlenecks at the stage of disbursal of medicines to patients.

- **Unavailability of technicians** for equipment like X-Ray, Ultrasound and ECG cause equipment to lie idle and unused.

4.2 Process-related Issues

- **Salaries** - More than two-thirds of the budget under Health and Family Welfare comprises of salaries component, which generally shows inadequate utilization. This is because of long leaves undertaken by the employees and also due to procedural delays.

- **Diet –** The budget for Diet is often only partially utilized. In many of the districts visited during the study, it was observed that the kitchen at the hospital facility was defunct. This was mainly due to shortage of cooks and general apathy of the administrative authorities towards diet. Interactions with health officials led to the opinion that INR 20 per day per patient of expenditure was too less to attract any contractor, who could undertake cooking and food distribution in the absence of a cook at the facility. As a result, the patients were often forced to make alternate arrangements for their meals from outside, expending money from their pockets.

- **Materials, Equipment and Supplies** – Lack of proper utilization under this budget have been due to lack of streamlining of supply of various equipment and materials. In many cases, it was noted

that despite an indent made for equipment like X-ray or Baby Warmer and supplies like OT Table and furniture by various facilities more than a year ago, the supplies had not been received. According to Store Managers at various districts visited during the study, this was primarily due to shortage of equipment and in procedural delays in transportation of equipment. Lack of AMCs for various equipments like X-ray, Ultrasound and OT equipment rendered many services unavailable at facilities in the Blocks like CHCs, UGPHCs and Block PHCs. As a result, the patients were asked to get these services from private diagnostic clinics, which entailed heavy expenditure on the part of the patients.

- **NRHM –** Fund utilization under NRHM was quite poor in 2007-08 as it was still a new concept in Orissa and its programmes were still getting streamlined.

4.3 Budget Allocation and Utilization Issues

- Budget allocation for NRHM at district level is done on the basis of **PIP** – Programme Implementation Plan. The District PIP is based on previous year's achievements along with a commensurate increase in the current years' targets based on estimates taken after discussions with MoICs of the blocks PHCs or CHCs or UGPHCs. However, the Block PIPs that are prepared at the block level are very adhoc, a pattern followed in only some districts. These Block PIPs, seldom in a similar format, are prepared by the Block Accountant cum Data Assistants (BADAs) who are not qualified or competent enough to undertake this scale of activity.

- Budget allocation at PHC level for administrative purposes is also done without much thought to the ground situation in many of these facilities, with informal communication from CHCs to utilize **RKS Fund** for general repair and maintenance. At these facilities, the RKS funds are utilized in a very ad-hoc manner.

- At Sub-Centre (SC) level, funds are allocated and used via **Untied Fund**, which is a Joint Account between the ANM of the SC and the PRI functionary of that village. However, during the field visit, it was reported by ANMs in almost all districts (across blocks) that the PRI functionaries were not supportive in the cause of usage of Untied Fund for development of the SC for better serving the people. Informal interactions with ANMs brought out the fact that PRI functionaries demanded payback for acquiescing for usage of Untied Fund for a particular activity. It is believed that unless steps are taken on the Sub-centre level for taking the PRI functionaries into confidence, development at SCs will not progress at a pace that is envisioned by the government.

4.4 General Apathy and Fear of Financial Matters

- While procedural delays and improper budget allocation remains a part of the reason for inadequate utilization of available resources, it was also reported during the field visit that at some facilities, the MoICs at PHC level and the ANMs at Sub-centre level were wary of undertaking any financial transactions, either unwilling to take responsibility or uncaring in their approach.

4.5 Law and order

- In western districts of Orissa close to Chattisgarh (like Kandhamal and Nabarangpur), many blocks were found to be adversely affected by Maoist violence due to which health administration as well as fund utilization for development activities in the block was consequently poor.

5. Findings from ASHA and Beneficiaries (IPD, OPD, JSY)

5.1 ASHA

5.1.1 Profile of ASHA

The median age of ASHA in Orissa varied from 27 years in Nuapada to 39 years in Jagatsinghpur. Majority of ASHA are educated upto upper primary level. Findings related to the current place of working of ASHA suggested that all ASHA in Jharsuguda, Keonjhar and Sundargarh are serving a village different from her place of residence. Average number of months worked by ASHA varies from 33 months in Nabarangpur to 45 months in Sundargarh. Unlike the ASHAs in other districts, very few ASHA in Jharsuguda have received training on Module I, II, III, IV and V. All ASHA in Balasore, Jagatsinghpur and Keonjhar have been issued an identity card. ASHA kits are available with all ASHA in Jagatsinghpur, Jharsuguda, Kandhamal and Keonjhar. ASHA in almost all the surveyed districts of Orissa have received monetary incentives for attending training related to ASHA. The most common mode of transfer used for the incentive is electronic transfer.

5.1.2 Key Findings from ASHA

5.1.2.1 Perception about JSY

ASHA in almost all the districts are aware of the stipulated rates under JSY scheme. All ASHA in Balasore, Jagatsinghpur, Keonjhar, Nuapada and Sundergarh are involved with at least 1 JSY in the last one year. The average number of times ASHA was involved with the JSY beneficiary varied from 8 in Jharsuguda to 23 in Balasore. Likewise, the average payment received per activity by ASHA varied from INR 314 in Nabarangpur to INR 350 in Balasore, Jagatsinghpur, Keonjhar and Sundergarh. District wise variations were also marked in the case of average time taken to receive the payment, ranging from 15 days in Sundargarh to 2 month and 13 days in Nabarangpur.

Table 5.1: Perception about JSY

Particulars	Balasore	Jagatsingh pur	Jharsuguda	Kandhamal	Keonjhar	Nabarangp ur	Nuapada	Sundergarh
Whether Aware of Stipulated Rates	100%	100%	95%	100%	100%	100%	100%	100%
Whether Involved with any in last 1 year?	100%	100%	75%	95%	100%	85%	100%	100%
Average number of times involved	23	18	8	12	17	11	11	15
Average Payment Received / Activity (INR)	350	350	331	319	350	314	330	350
Authority Responsible for making payment								
Medical Officer	100%	100%	94%	90%	100%	41%	100%	100%
ANM	-	-	6%	10%	-	18%	-	-

Particulars	Balasore	Jagatsinghpur	Jharsuguda	Kandhamal	Keonjhar	Nabarangpur	Nuapada	Sundergarh
Others (ASHA Coordinator, BPO)	-	-	-	-	-	6%	-	-
Can't say	-	-	-	-	-	35%	-	-
Timelines of Receiving Payments								
On time in general	100%	100%	94%	16%	15%	6%	90%	70%
Sometimes late	-	-	6%	68%	85%	18%	5%	-
Sometimes very late	-	-	-	16%	-	35%	-	30%
Can't say	-	-	-	-	-	41%	5%	-
Average time taken to get paid (No. of months)	1	1	Not Replied	1 month 15 days	1	2 month 13 days	1	15 days

Source: Field Visit

5.1.2.2 Type of facility used by ASHA for delivery

Detailed findings regarding the type of facility generally used by ASHA for delivery revealed that maximum ASHA in Jharsuguda, Keonjhar and Nuapada took the JSY beneficiary to District hospital as against maximum ASHAs in Jagatsinghpur, Kandhamal, Nabarangpur and Sundargarh taking the beneficiary to CHC for delivery.

Table 5.2: Type of facility used by ASHA for delivery

Type of facility used by ASHA for delivery	Balasore	Jagatsinghpur	Jharsuguda	Kandhamal	Keonjhar	Nabarangpur	Nuapada	Sundergarh
DH	5%	30%	50%	25%	50%	30%	55%	40%
CHC	25%	65%	45%	65%	10%	55%	45%	50%
PHC	70%	5%	5%	10%	-	15%	-	5%
Sub Centres	-	-	-	-	40%	-	-	5%
Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

Source: Field Visit

5.2 Beneficiaries

5.2.1 Profile of Beneficiaries

Age distribution of the beneficiaries revealed that majority of the beneficiaries are in their twenties. Maximum were educated up to primary level and are working as agricultural labours. Most of the beneficiaries in Jagatsinghpur and Keonjhar have monthly household income between INR 2000 and INR 5000, while the income scenario in rest of the six districts was even worse as the monthly household income of significant proportion of beneficiaries was below INR 2000. The most common reason cited for seeking treatment from that particular facility includes availability of a particular specialist, no other facility in the area, closest to the dwelling and so on. However, district wise variations have been marked. While majority of the beneficiaries in Balasore, Jagatsinghpur, Keonjhar and Sundargarh pointed out availability of a particular specialist as the most important reason for getting treatment from that facility, maximum

beneficiaries in Jharsuguda, Kandhamal, Nabarangpur and Nuapada mentioned 'no other facility in the area' as the most vital reason for seeking treatment from that facility. Majority of the beneficiaries in almost all the districts reported that they use public transport to reach the facility.

5.2.2 Key Findings from Beneficiaries

5.2.2.1 Out of pocket expenses incurred by In-patient

The out of pocket expenses incurred by the in-patients across all the eight surveyed districts of Orissa is tabulated below. In-patients in Balasore had incurred high transportation charges and diet charges in comparison to other districts. Likewise, the expenditure on medicine and Pathology/ Radiology/Laboratory Test conducted outside the facility was also found to be highest in Balasore as compared to the other surveyed districts of Orissa. On the contrary, the expenditure incurred on conducting the Pathology/ Radiology/Laboratory Test in the facility was found to be highest in Jharsuguda district. Similarly, findings related to attendants expenditure revealed that expenditure incurred on local conveyance was highest in Jharsuguda and lowest in Kandhamal.

Table 5.3: Out of pocket expenses incurred by In patient

			Balasore			Jagatsinghpur			Jharsuguda			Kandhamal			Keonjhar		Nabarangpur			Nuapada			Sundergarh		
Expenses	**S No**	**Particulars**	**%**	**Cost incur in INR (including outlier)**	**Cost incur in INR (excluding outlier)**	**%**	**Cost incur in INR (including outlier)**	**Cost incur in INR (excluding outlier)**	**%**	**Cost incur in INR (including outlier)**	**Cost incur in INR (excluding outlier)**	**%**	**Cost incur in INR (including outlier)**	**Cost incur in INR (excluding outlier)**	**%**	**Cost incur in INR**	**%**	**Cost incur in INR (including outlier)**	**Cost incur in INR (excluding outliers)**	**%**	**Cost incur in INR (including outlier)**	**Cost incur in INR (excluding outlier)**	**%**	**Cost incur in INR (including INR)**	**Cost incur in INR (excluding INR)**
Patient's Expenditure	1	Transport	87	400	400	87	235	235	45	216	216	87	142	48	60	350	97	212	212	97	225	225	73	136	136
	2	Regn.	97	6	6	84	6	6	68	4	4	73	4	4	70	8	84	4	4	100	5	5	47	10	10
	3	Others- maintenance, cleanliness, bed pan etc.	47	126	126	33	105	105	10	653	653	-	-	-	13	168	-	-	-	-	-	-	6	200	200
	4	Diet*	17	505	505	13	600	300	48	428	428	80	114	114	10	168	65	120	120	73	112	112	13	240	240
	5	Pathology/ Radiology/Lab. Test																							
		- At facility	30	87	87	10	33	33	3	500	500	63	53	53	37	52	42	90	90	33	35	35	20	192	192
		- Outside	70	543	370	61	268	268	29	393	217	27	189	189	33	175	19	63	63	20	243	243	30	182	182
	6	Medicine	100	6670	2542	94	1050	587	61	2685	1706	83	1660	1660	97	1183	90	1032	848	80	966	690	83	2443	1748
	Total			**8337**	**4036**		**2297**	**1534**		**4879**	**3724**		**2162**	**2068**		**2104**		**1521**	**1337**		**1586**	**1310**		**3403**	**2708**
Attendant Expenditure	1	Local Transport	27	43	43	45	52	52	55	277	277	37	35	35	7	53	-	-	-	-	-	-	20	77	77
	2	Food	73	88	88	81	113	113	65	176	176	97	89	89	93	85	100	89	89	90	57	57	73	335	77
	3	Accommodation	7	40	40	26	162	162	23	24	24	3	40	40	-	-	-	-	-	-	-	-	23	24	24
	4	Others (mosquito coil etc.)	20	19	19	48	69	69	6	20	20	10	15	15	3	14	6	12	12	3	30	30	-	-	-
	Total			**190**	**190**		**396**	**396**		**497**	497		**179**	**179**		**152**		**101**	**101**		**87**	**87**		**436**	**178**
Gross expenditure incurred by In Patient for the current case of ailment				**8527**	**4226**		**2693**	**1930**		**5376**	**4221**		**2341**	**2247**		**2256**		**1622**	**1438**		**1673**	**1397**		**3839**	**2886**

5.2.2.2 Out of pocket expenses incurred by Out-patient

Transportation charges incurred by the out-patients to reach the facility were found to be highest in Keonjhar district and lowest in Nabarangpur district. Likewise, the expenditure incurred by the out patient on medicine and in conducting the pathology, radiology or laboratory test outside the facility was highest in Balasore.

Table 5.4: Out of pocket expenses incurred by Out patient

		Balasore		Jagatsinghpur		Jharsuguda		Kandhamal		Keonjhar			Nabarangpur		Nuapada		Sundergarh	
S No	Particulars	%	Amount in INR	%	Amount in INR	%	Amount in INR	In %	Amount in INR	%	INR (including [illegible])	INR (excluding [illegible])	%	Amount in INR	%	Amount in INR	%	Amount in INR
1	Transport	94	23	73%	32	20%	40	93%	23	52%	110	110	100%	20	70%	26	45%	37
2	Registration/ Users fee	97%	1	37%	2	53%	2	50%	1	100%	2	2	97%	1	60%	2	3%	2
3	Others (snacks)	3%	36	50%	36	-	-	3%	20	26%	34	34	-	-	-	-	45%	45
4	Medicine	90%	251	87%	239	17%	632	30%	52	74%	218	218	43%	47	87%	138	31%	184
	Pathology/ radiology/ laboratory test-At the facility	-	-	7%	25	-	-	17%	27	35%	50	50	20%	34	13%	30	14%	40
5	Pathology/ radiology/ laboratory test-Outside the facility	26%	101	30%	129	7%	325	20%	51	19%	307	48	-	-	13%	20	14%	53
Total			**412**		**463**		**999**		**174**		**721**	**462**		**102**		**216**		**361**

5.2.2.3 Actual amount received by the JSY beneficiaries

Overwhelmingly, JSY beneficiaries in Keonjhar had received the full amount entitled under the '*Janani Suraksha Yojana*' scheme. However, in other districts the JSY beneficiary had to make certain unofficial payments to Doctors, ASHA, Facility Staff, ANM/Health worker etc. After deducting those unofficial payments, the actual amount received by the beneficiaries under the JSY scheme was highest in Nuapada and lowest in Kandhamal.

Table 5.5: Actual amount received by the JSY beneficiaries (In INR)

Heads	Balasore	Jagatsinghpur	Jharsuguda	Kandhamal	Keonjhar	Nabarangpur	Nuapada	Sundergarh
Amount - JSY beneficiary	**1400**	**1400**	**1400**	**1400**	**1400**	**1400**	**1400**	**1400**
Amount paid to others	-	-	-	-	-	-	-	-
Doctor	225	238		333	-	-	-	150
ASHA	-	-	350	233	-	225		50
Facility Staff	117		250	142	-	162	150	
ANM/Health worker – Female/ Nurse		100		75	-	-	-	50
Others (JE driver, ASHA demanded for doctors etc.)	-	-	-	57	-	-	-	-
AWW	-	-	-	-	-	-	-	100
Total amount paid to others	**342**	**338**	**600**	**840**	**0**	**387**	**150**	**350**
Total actual amount received by beneficiary	**1058**	**1062**	**800**	**560**	**1400**	**1013**	**1250**	**1050**

6. Conclusions and Recommendations

6.1 Findings

BUDGET & EXPENDITURE

- In Orissa, the total Health budget was INR 102223.5 Lakh, INR 177111.0 Lakh and INR 221626.9 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively.

- The total expenditure was INR 76096.8 Lakh and INR 115277.4 Lakh for the years 2007-08 and 2008-09 respectively. The expenditure for the year 2009-10 has not been published for any of the Departments in Orissa.

- The Health and Family Welfare Department (H & FW) is the primary source of funds and expenditure, contributing 94% of the total expenditure in 2007-08. Of late, the NRHM expenditure has shown a progressive increase- its share in total health and health-related budget has reached from 1.2% in 2007-08 to 25.5% in 2009-10.

- The total budget for H & FW was INR 83331.0 Lakh, INR 118630.7 Lakh and INR 159943.9 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively while the total expenditure was INR 71531.1 Lakh and INR 89912.4 Lakh for the years 2007-08 and 2008-09 respectively.

- Under various accounting heads, it was observed that Medical and Public Health comprises more than 80% of the budget and expenditure during 2007-08 and 2008-09.

- The expenditure under H & FW has been further divided into major heads. It was observed that more than 60% of expenditure is on Urban and Rural Health Services.

- In terms of minor-heads, more than 67% of the budget and expenditure over the last three years was under the Salary component, showing budget utilization of 88.5% in 2007-08 and 77.3% in 2008-09.

- The total budget relating to health care allocated to “Other Departments” was INR 4830.7 Lakh, INR 4916.8 Lakh and INR 5200.5 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively while the total expenditure was INR 3688.5 Lakh and INR 4400.8 Lakh for the years 2007-08 and 2008-09 respectively.

- Maximum expenditure was under the heads of Medical and Public Health as well as under Capital Outlay on Medical and Public Health in the Works Department.

- Overall, the budget utilization has increased from 76.4% in 2007-08 to 89.5% in 2008-09.

- The total budget for NRHM was INR 14061.8 Lakh, INR 53563.4 Lakh and INR 56482.6 Lakh in the financial years 2007-08, 2008-09 and 2009-10 respectively while the total expenditure was INR 877.2 Lakh, INR 20964.3 Lakh and INR 38127.5 Lakh for the years 2007-08, 2008-09 and 2009-10 respectively. Though NRHM was considered a new concept among various health facilities during 2007-08, the fund utilization has increased to 39.1% in 2008-09 and to 67.5% in 2009-10.

STAFF, DRUGS & INFRASTRUCTURE

- Most facilities covered under the primary survey are plagued with lack of adequate staff. In some CHCs visited, the post of Medical Officer in Charge is vacant.
- It was observed that antibiotic and antiallergic injectibles was in short supply in many of the facilities.
- In some of the facilities, due to the lack of trained operators equipments like X-ray machines and Baby Incubators are lying unused.
- It was also observed that many types of equipment like New Born Care Unit, various furniture, Labour Room equipment and OT equipments were faulty and non-functional and had not been repaired in the last six months.

SERVICES UTILISATION

- The number of IPD cases is highest at DHH Keonjhar (31.8% of total IPD cases in 2007-08)
- In terms of OPD patients visiting the facility, the number has been the highest at DHH Sundargarh (65.3% of total in 2007-08 and 67.4% of total in 2008-09).
- The number of Institutional Delivery cases has been the highest at DHH Jagatsinghpur and DHH Nabarangpur over the last three years.
- Among the CHCs/ UGPHCs/ Block PHCs visited during the study, the number of IPD cases was highest at CHC Soro, UGPHC Khariar and CHC G. Udayagiri during the last three years. While the number of OPD cases was quite evenly distributed among the CHC/PHC facilities visited, Institutional Delivery cases were the maximum at CHC Soro and UGPHC Khariar during the last three years.
- The bed utilization at most of the DHH visited was above 95% during the study period except at DHH Jagatsinghpur, DHH Jharsuguda and DHH Kandhamal which was below 80%. However, bed utilization does not follow any fixed pattern at the CHC / Block PHC level.

CONDITION OF FACILITIES

- The general observation of the District Headquarter Hospitals (DHHs) is that most of the facilities are neither clean nor well-maintained. This is especially true of Indoor Patient Wards at DHH Balasore, DHH Jagatsinghpur and DHH Kandhamal.
- The pharmacies at the hospitals lack in space and ventilation required for storage of medicines.
- Only two hospitals had ICU facility.
- Of the eight hospitals visited, only three had functional Blood Bank in the premises.
- The toilets at all the DHH visited (except DHH Jharsuguda and DHH Sundargarh) were found to be extremely dirty and in some cases unusable.
- The CHCs/UGPHCs/ Block PHCs have ill-maintained IPD wards, with patients often observed to be resting on the ground due to lack of available beds.

- A Labour Room was found at almost all the facilities visited but some of them were very dirty like at UGPHC Ersama (dogs roaming in the room), CHC Daringbadi and CHC Padmapur.
- None of the visited facilities of Block level had a functional Blood Bank or Blood Storage Unit.
- Most of the facilities have erratic water and electricity supply.
- The toilets available at almost all the CHCs/UGPHC/Block PHCs are in extremely poor and dirty condition.
- The PHC(N) visited are equipped for only out-patient facilities. None of the PHC(N) have constant supply of electricity.
- In many of the sub-centres visited, there were no separate premises, no water or electricity supply.

ASHA

- FGDs with 160 ASHAs were conducted in the districts that were covered during the field visit.
- The median age of ASHA in Orissa varies between 27 years in Nuapada to 39 years in Jagatsinghpur.
- Majority of ASHA are educated up to upper primary level.
- ASHA in almost all the surveyed districts of Orissa have received monetary incentives for attending training related to ASHA.
- The average payment received per activity by ASHA varies between INR 314 in Nabarangpur to INR 350 in Balasore, Jagatsinghpur, Keonjhar and Sundargarh. District wise variations were also marked in the case of average time taken to receive the payment, ranging from 15 days in Sundargarh to 2 month and 13 days in Nabarangpur.
- The most common mode of transfer used for the incentive was electronic transfer.
- ASHA in almost all the districts were aware of the stipulated rates under JSY scheme
- Most of the ASHA in Jharsuguda, Keonjhar and Nuapada took the JSY beneficiaries to District hospital as against those in Jagatsinghpur, Kandhamal, Nabarangpur and Sundargarh took the beneficiary to CHC for delivery.

BENEFICIARIES

- Field Surveys were conducted with 243 IPDs, 241 OPDs, 162 JSY beneficiaries.
- Age distribution of the beneficiaries show that majority of the beneficiaries are in their twenties.
- Maximum are educated up to primary level and work as agricultural labourers.
- Most of the beneficiaries in Jagatsinghpur and Keonjhar have monthly household income between INR 2000 and INR 5000, while the monthly household income of significant proportion of beneficiaries in rest of the six districts is below INR 2000.

- The most common reason cited for coming to seek treatment from that particular facility was availability of a particular specialist.

- Majority of the beneficiaries reported that they use public transport to reach the facility. In-patients in Balasore incurred high transportation charges and diet charges in comparison to other districts. Likewise, the expenditure on medicine and Pathology/ Radiology/Laboratory Test conducted outside the facility was also found to be highest in Balasore as compared to the other surveyed districts of Orissa. On the contrary, the expenditure incurred on conducting the Pathology/ Radiology/Laboratory Test inside the facility was found to be highest in Jharsuguda district.

- Findings related to Attendants expenditure reveal that expenditure incurred on local conveyance is highest in Jharsuguda and lowest in Kandhamal.

- The Out-of-pocket expenses incurred by the In-Patients at public health facilities was highest in Balasore (INR 4226, excluding outliers) among the districts covered during the field visit.

- Transportation charges incurred by the out-patients to reach the facility were found to be highest in Keonjhar district and lowest in Nabarangpur district.

- The expenditure incurred by the out patient on medicine and in conducting the pathology, radiology or laboratory test outside the facility was highest in Balasore.

- The Out-of-pocket expenses incurred by the Out-Patients at public health facilities was highest in Jharsuguda (INR 999)

- JSY beneficiaries in Keonjhar had received the full amount entitled under the 'Janani Suraksha Yojana' scheme. In other districts, the JSY beneficiary had to make certain unofficial payments to Doctors, ASHA, Facility Staff, ANM/Health worker etc. After deducting those unofficial payments, the actual amount received by the beneficiary under the JSY scheme was highest in Nuapada and lowest in Kandhamal.

6.2 Recommendations

Reduce Delay in disbursal of funds under *State budget* at Block levels – Incidence of delay should be minimized by streamlining the fund disbursal processes. This may be effectively achieved by computerizing the processes. Fund disbursal process at facility levels (DDUs of CHC and Block PHC) should be made online. Timely release of funds, which comprise mostly of Salaries, will effectively mean salary disbursal to employees on time, which will motivate them to continue working at higher productivity. This will also lead to better utilization of State Budget & Expenditure.

Fund Flow under NRHM – The District Account Managers of the districts informed that NRHM funds are released for the district generally in the month of June for that financial year which ultimately reaches the Block sometimes by July (delay by a full quarter for that financial year) and thereafter the funds meant for utilization over one year need to be spent in nine months in order to *show* effective utilization. The PIP preparation should be preponed and the Block level NRHM officials (BPOs and BADAs) should receive the funds on time for proper utilization over a period of designated twelve months.

Fund Allocation for Diet facilities to In-Patients – Medical Officers in Charge at CHCs informed that INR 20 is allocated for diet facilities per day for In-patients, which is certainly very less. In some facilities, only a bottle of milk along with a banana was provided as 'diet facility per day', while in other facilities no diet was

provided causing a lapse of the entire budget for diet for the facility. It is recommended that the diet budget per patient per day be increased by 100% for effective provision of such facilities.

Financial Management at PHC(N) and SC Level – It was observed that Medical officers in charge in some PHC(N) and ANMs of some SCs were not comfortable with handling of accounts. As a result, in some cases, expenditure for development of the premises (repair and maintenance) was not undertaken to avoid the 'hassle'. It is suggested that capacity building training programmes are conducted to orient staff at PHC(N) and SC level in documenting and utilizing the funds allotted to the facilities.

Non-utilization of Untied Funds at the Sub-centre – Since the ANM and PRI functionary hold a Joint Account for Untied Funds, without the PRI functionary's consent these funds cannot be utilized. Many ANMs at the SCs (across the districts visited) complained of lack of cooperation from the PRI functionaries for utilization of these funds for development purposes. This fact was corroborated by the BPOs of some of the blocks as well. It is suggested that workshops be organized under NRHM sensitising the PRI functionaries the need of effective and efficient utilisation of untied funds.

Staff Shortage – Medical Officers at many facilities visited during the study complained of heavy workload due to lack of adequate staff at their facility, both medical as well as non-medical. It is suggested that more number of medical, para-medical and support staff are recruited to work in the Public Health System in Orissa, especially at block level (CHCs, PHCs, SCs). Strong efforts should be made to fill the staff vacancies at various facilities, as lack of adequate staff at a facility ultimately inconveniences the patients/beneficiaries.

Infrastructure – While infrastructure at District Hospitals and CHCs was found to be adequate, the same could not be said for PHCs, PHC(N) and Sub-centres. It should be the endeavour that all Sub-centres operate from designated government premises in the villages, as the SC is the first point of contact for the rural population. Electricity and regular water supply should be provided to all facilities at PHC(N) and SC level. The pharmacies at Block PHC / CHC level should be designed keeping in view the importance of ventilation and insulation from extreme weather conditions. More efforts should be directed towards cleanliness of the facilities, especially for IPD rooms and toilets, which were found to be quite dirty in almost all the facilities visited during the field visit.

Data Management – During the field visit, it was observed that Annual Medical Statement (official document comprising Statement A-H for recording various health, infrastructure and staff indicators for the facility) for many facilities had not been prepared for year 2009-10 and sometimes for previous years as well. Also, the record-keeping of such documents was done manually, causing the documents to get frayed over a period of time, with ink disappearing in some areas. It is suggested that administration should be strict on timely completion of Annual Medical Statements of all the relevant facilities and the process of computerization of such records should also be undertaken.

Utilization of Equipments – During the field visit, it was observed that equipment usage was quite poor in some of the facilities. It was also seen that equipments at many facilities was either non-functional due to faulty machinery or lying idle due to lack of technical staff availability. In some CHCs, the OT equipment was found lying idle as there were no operations taking place due to lack of anaesthetists or surgeons. In some other facilities, it was reported by staff that such equipment was not required but had been supplied to the facility. It is suggested that the supply chain management of equipments be strengthened and Annual Maintenance Contracts signed for all the facilities which have equipments. Technical staff, who are proficient in use of specialized equipment should be recruited on a regular basis so that new equipment does not remain idle, inconveniencing the patients.

7. Annexure

7.1 Staff Position at Sample Districts

Sl.N	District	All categories of Doctors			LHV			Health Worker (Male)			Health Worker (Female)			MPHS(male)		
		S	P	V	S	P	V	S	P	V	S	P	V	S	P	V
1	Balasore	178	153	25	47	45	2	225	163	62	348	329	19	70	37	33
2	Jagatsinpur	109	73	36	34	33	1	117	117	0	240	234	6	36	17	19
3	Jharsuguda	65	45	20	14	9	5	76	76	0	81	80	1	18	5	13
4	Kandhamal	139	76	63	29	18	11	142	142	0	185	185	0	45	18	27
5	Keonjhar	198	98	100	57	40	17	221	221	0	376	360	16	70	39	31
6	NawaraPur	112	43	69	35	15	20	144	137	7	307	307	0	40	32	8
7	Nuapada	70	36	34	18	12	6	75	75	0	116	116	0	16	12	4
8	Sundargarh	191	152	39	57	51	6	241	241	0	458	408	50	90	48	42
	Total	**1062**	**676**	**386**	**291**	**223**	**68**	**1241**	**1172**	**69**	**2111**	**2019**	**92**	**385**	**208**	**177**
Source: Department of Health and Family Welfare																

Sl. No	District	Laboratory Technicians			Pharmacists	Radiographers		
		S	P	V	V	S	P	V
1	Balasore	40	35	5	12	7	6	1
2	Jagatsingpur	21	19	2	3	5	3	2
3	Jharsuguda	16	14	2	1	3	1	2
4	Keonjhar	57	51	6	1	8	2	6
5	Kandhmal	39	28	11	0	6	6	0
6	Nabarangpur	28	18	10	0	2	2	0
7	Nuapara	17	14	3	1	4	4	0
8	Sundargarh	62	53	9	2	9	7	2
	Total	280	232	48	20	44	31	13
Source: Department of Health and Family Welfare								

***Key: S**: Sanctioned; **P**: In-Position; **V**: Vacant*

7.2 Status of Equipments at Facilities covered during Field Visit

A.1.1. Equipment Status at Sample District Hospitals

District	'Shortage' of equipment(s)		'Non-functioning' equipment			Idle 'New' equipment		
	Equipments	Period since unavailable	Equipments	Period since 'Non-functioning'	Reasons of 'Not functional'	Equipments	Period since 'Lying Idle'	Reasons for 'Lying Idle'
Jagatsinghapur	Delivery Table	>6 months	N/A	N/A	N/A	N/A	N/A	N/A
Balasore	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Keonjhar	N/A	N/A	OT light	2 yrs	No AMC/ After-sales service	Treadmill	4 yrs	No operating manual
	N/A	N/A	ICU equipment	2 yrs	No AMC/ After-sales service	Autoclave	5yrs	No service technician for repair
	N/A	N/A	Generater	2 yrs	No AMC/ After-sales service	N/A	N/A	N/A
Sundargarh	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Jharsuguda	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Kandhamal	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nabarangpur	Ultrasound machine	New machine needed	Dental equipment	>6 months	No equipment operator	Cystoscope	>6 months	Lack of trained staff
	N/A	N/A	ENT equipment	>6 months	No equipment operator	Physiotherapy unit	> 6 months	No equipment operator
	N/A	N/A	Ultrasound machine	>6 months	No service technician	N/A	N/A	N/A
Nuapada	N/A	N/A	OT lights	>6 months	No AMC/ After-sales service	N/A	N/A	N/A
	N/A	N/A	Baby Warmer	1-3 months	No AMC/ After-sales service	N/A	N/A	N/A
Source: MM Field Visit								

A.1.2. Equipment Status at Sample CHCs

Name of District	CHC	'Shortage' of equipment(s)		'Non-functioning' equipment(s)			Idle 'New' equipment(s)		
		Equipments	Period since unavailable	Equipments	Period since 'Non-functioning'	Reasons for 'Not functional'	Equipments	Period since 'Lying Idle'	Reasons for 'Lying Idle'
Jagatsinghapur	Manijanga	N/A	N/A	X-ray machine	>6 months	Lack of AMC/ After sales services	N/A	N/A	N/A
	Ersama	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Mandasahi	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Balasore	Simulia	X-ray	Never available	Baby Incubator	>6 months	Lack of AMC/ After sales services	X-ray view box	>6 months	Lack of trained staff
		Ultrasound	Never available	Type writer	N/A	N/A	N/A	N/A	N/A
	Soro	OT	N/A	Boyle's apparatus	N/A	N/A	N/A	N/A	N/A
		OT Monitor	N/A	Auto clave	N/A	N/A	N/A	N/A	N/A
		N/A	N/A	Photo Therapy unit	N/A	N/A	N/A	N/A	N/A
	Rupsa	X-ray	> 6 months	Boyle's apparatus	>6 months	Lack of service technician (for repair)	OT light	>6 months	Support equipment not available
		Ultrasound	Never available	Incubator	>6 months	Lack of service technician (for repair)	Air conditioner	>6 months	Lack of operating manual
Keonjhar	Padmapur	N/A	N/A	N/A	N/A	N/A	Baby Incubator	>6 months	Lack of information about use
	Gatagaon	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Salania	Nebulizer	Never available	Body Warmer	4 months	Lack of service technician (for repair)	N/A	N/A	N/A
		Phototherpy	Never available	N/A	N/A	N/A	N/A	N/A	N/A

		'Shortage' of equipment(s)		'Non-functioning' equipment(s)			Idle 'New' equipment(s)		
		Unit							
Sundargarh	Kinjirkela	N/A	N/A	N/A	N/A	N/A	Operation Table	>6 months	No anaesthia trained person
		N/A	N/A	N/A	N/A	N/A	OT lights	>6 months	No anaesthia trained person
	Lahunipara	N/A	N/A	OT lights	3 yrs	Lack of AMC/ After sales services	Electric Cantery	2 yrs	Particular equipment is of no use here
	Baragaon	N/A	N/A	OT lights	4 yrs	Lack of service technician (for repair)	N/A	N/A	N/A
		N/A	N/A	Baby Warmer	2 yrs	Decision cannot be taken at facility level	N/A	N/A	N/A
		N/A	N/A	Blood storage unit	2 yrs	Lack of service technician (for repair)	N/A	N/A	N/A
Jharsuguda	Mundrajore	Baby care Equipment	Never available	N/A	N/A	N/A	Body Enck	10 yrs	Lack of information about use
		N/A	N/A	N/A	N/A	N/A	Eather mac	5 yrs	No anaesthia trained person
		N/A	N/A	N/A	N/A	N/A	Sterilizer	6 yrs	N/A
	Lakhanpur	X-ray	3 months	X-ray	3 months	Lack of service technician (for repair)	N/A	N/A	N/A
	Brajrajnagar	N/A	N/A	N/A	N/A	N/A	Operation Equipment	2 yrs	Particular equipment is of no use here
Kandhamal	Daringbadi	No equipment available except sterilization and dispensing equipment					X Ray machine	5 yrs	Support equipment not available
	G. Udayagiri	N/A	N/A	Baby Warmer	> 6 months	Lack of service technician (for repair)	X Ray machine	5 yrs	Support equipment not available
		N/A	N/A	Weighing machine	10 yrs	Old- Beyond repair	N/A	N/A	N/A
	Gumagarh	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nabarangpur	Kosagumuda	N/A	N/A	Sedulous	1 yr	Lack of AMC/	N/A	N/A	N/A

		'Shortage' of equipment(s)		'Non-functioning' equipment(s)			Idle 'New' equipment(s)		
				lamps		After sales services			
	Papadahandi	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Jharigaon	Paediatric AMBU bag	Never available	OT Lamps(2)	6 months	Lack of service technician (for repair)	Electric Sterilizer	1 yr	Lack of trained staff
		Baby warmer	Never available	Blood Storage Unit	2 yrs	Lack of service technician (for repair)	N/A	N/A	N/A
		X ray machine	Never available	N/A	N/A	N/A	N/A	N/A	N/A
Nuapada	Khariar Road	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Komna	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
	Khariar	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Source: MM Field Visit									

A.1.3. Equipment Status at Sample PHC / PHC(N)

Name of District	Block Name	PHC(N) Name	'Shortage' of equipment(s) on day of visit	'Non-functioning' equipment(s) on day of visit	Idle 'New' equipment(s) on day of visit	Adequacy of Storage Place in Facility
Jagatsinghapur	Tirtol	Kolar	Yes	Yes	No	Adequate
	Ersama	Balikuda	Yes	Yes	No	Inadequate
	Jagatsinghpu	Kaduapada	No	Yes	No	Adequate
Balasore	Remuna	Remuna	Yes	No	No	Inadequate
	Ishwarpur	Ishwarpur	Yes	No	No	Inadequate
	Bahanagar	Gopalpur	Yes	No	Yes	Adequate
Keonjhar	Padmapur	Baradapal	No	No	No	Adequate
	Ghatagaon	Jharbeda	No	No	No	Adequate
	Hatadih	Tukuna	No	No	No	Inadequate
Sundargarh	Balisankara	Balisankara	Yes	No	No	Adequate
	Lahunipura	Khuntagaon	No	No	No	Adequate
	Baragaon	Barangakachhar	No	No	No	Adequate

Name of District	Block Name	PHC(N) Name	'Shortage' of equipment(s) on day of visit	'Non-functioning' equipment(s) on day of visit	Idle 'New' equipment(s) on day of visit	Adequacy of Storage Place in Facility
Jharsuguda	Lalikera	Sahaspur	Yes	Yes	Yes	Inadequate
	Brajrajnagar	Sripura	No	No	Yes	Inadequate
	Lakhanpur	Kumarbandha	Yes	No	No	Adequate
Kandhamal	Daringbadi	Simanabadi	Yes	No	No	Adequate
	G.Udayagiri	Gressingia	Yes	Yes	Yes	Adequate
	Gumagarh	Bisipada	No	Yes	Yes	Inadequate
Nabarangpur	Kosagumuda	Asanga	No	No	No	Adequate
	papadahandi	Biriguda	No	No	No	Adequate
	Jharigaon	Ichhapur	No	No	No	Adequate
Nuapada	Khariar Road	Darlimunda	No	Yes	No	Inadequate
	Komna	Tarbod	No	No	No	Adequate
	Khariar	Duajhar	Yes	No	No	Inadequate
Source: MM Field Visit						

7.3 Observation Chart of District Headquarter Hospitals

Facility	DHH Balasore	DHH Jagatsinghpur	DHH Jharsuguda	DHH Kandhamal	DHH Keonjhar	DHH Nabarangpur	DHH Nuapada	DHH Sundargarh
Registration Counter	The DHH at Balasore had a separate counter for registration of patients.	There was no separate registration counter at the DHH.	There is a single registration counter available at the Jharsuguda District Hospital, and the level of cleanliness at the counter is adequate.	The DHH had a registration counter area, with an adequate level of cleanliness. This counter was also functioning as the RKS User Fee Collection Counter.	The District Hospital at Keonjhar had a separate registration counter for patients.	The hospital had a single registration counter and was found to be quite crowded during the field visit.	A separate area was reserved for the purpose of registration of patients.	Two clean rooms were found to be available as Registration Counters.
Seating / Waiting Area	There was a waiting/seating area for the attendants outside each ward, with an average level of cleanliness overall.	A separate seating area was available for patients and attendants.	There are two rooms which serve as seating/waiting area for patients and attendants at the hospital, with adequate level of cleanliness.	The Kandhamal District Hospital had a waiting area for patients and attendants with adequate number of chairs/benches. The area was found to be clean and tidy during the field visit.	There was a separate seating/waiting area at the hospital for the convenience of the patients and attendants.	The seating area was found to be kept clean during the time of the field visit.	There was a separate seating/waiting area at the hospital for the convenience of the patients and attendants, with adequate level of cleanliness.	The hospital had a clean seating area for waiting patients and attendants.
Out Patient Dept (OPD)	Different rooms were allotted as OPD for different specializations at the hospital.	The hospital had separate OPD wards for different departments.	There are six rooms at the hospital which serve as OPDs, based on the functioning departments. Taking an overall view, the cleanliness of the OPDs is considered adequate in general.	There were a total of four designated OPDs functioning at the DHH, including a Female OPD. The OPD rooms were found to have an average level of cleanliness.	Separate OPDs were available for different specialties. The rooms had an average level of cleanliness.	There were different OPD rooms for different specialists, with an average level of cleanliness.	Separate OPDs were available for different specialties. The rooms had an average level of cleanliness.	The hospital had separate OPDs for separate specialists, which were found to be neat and clean.
Wards	There were eight rooms that functioned as wards for Indoor patients at the hospital. Due to a high number of patients, the wards were crowded and slightly dirty.	There were different wards for accommodating the Indoor patients who were at the facility. The wards were found to be dirty during the field visit.	There are six wards at the District Hospital at Jharsuguda, one for each department – Paediatrics, Medicine, Surgery, O & G, Eye, and Orthopaedics. In general, the level of cleanliness in the wards is considered adequate.	There were a total of twelve wards at the District Hospital. Most of the wards were found to be crowded and were not found to be clean during the field visit. Indoor patients were also seen lying on the floors of the wards due to lack of adequate number of beds.	Different wards had been demarcated for different types of specialist treatment.	A total of 10 wards were available for Indoor patients, which were found to be somewhat dirty during the time of field visit.	Different wards had been demarcated for different types of specialist treatment, with an altogether average level of cleanliness.	Separate wards were assigned for separate types of specialist treatment required.

Casualty	The hospital had a casualty ward, however, it was not maintained and was quite dirty.	The hospital had a separate Casualty, but was not being used as such.	There is no separate facility for Casualty in the hospital	The hospital had a casualty room, but was functioning as a mortuary. It had an average level of cleanliness	The District Hospital at Keonjhar did not have any casualty.	There was no casualty at the hospital.	The District Hospital at Nuapada did not have any casualty.	The hospital did not have a casualty.
Emergency Room	A separate emergency room is maintained inside the hospital premises, with an adequate level of cleanliness.	An emergency room was available at the hospital having an average level of cleanliness.	There is no provision for an Emergency Room at the hospital.	The hospital had a functional Emergency Room and was found to be clean.	There was no emergency room at the District Hospital.	There were no emergency services available at the hospital.	There was no emergency room at the District Hospital.	There was no working Emergency Room at the hospital.
Injection Room	A separate Injection Room was available at the hospital, and had an average level of cleanliness.	The DHH had an Injection Room with average level of cleanliness.	There is a separate Injection Room at the hospital. During field visit, the level of cleanliness was found to be good and things were in proper order.	The hospital had an Injection Room in the premises, with an average level of cleanliness	There was no separate Injection Room at the District Hospital. Makeshift arrangements were made in the Dressing Room.	There was no separate Injection Room at the hospital.	There was no separate Injection Room at the District Hospital. Makeshift arrangements were made in the Dressing Room.	There was no separate Injection Room at the hospital.
Dressing Room	There were no separate trays in the Dressing Room, and due to continuous movement of patients, the room was not tidy.	Though there was a Dressing Room at the hospital, it did not have any trays for medicines, and the room was not clean during field visit.	There was a single Dressing Room available at the hospital. During field visit, the premises were found to be quite clean and tidy	The District Hospital had two Dressing Rooms, one for general OPD and one for Surgery. They were found to be small and cramped rooms, but were generally found to be clean.	There was a separate Dressing Room at the hospital with average level of cleanliness, which was also being used as Injection Room.	A Dressing Room was in use in the hospital, with an average level of cleanliness.	There was a separate Dressing Room at the hospital with average level of cleanliness, which was also being used as Injection Room.	There was separate Dressing Room at the hospital.
Pharmacy	There was a separate pharmacy at the hospital where the drugs were stored. However, there was a shortage of space in the pharmacy.	There was a pharmacy at the hospital premises for storage of drugs.	The Jharsuguda District Hospital has a single pharmacy, having a single room. At the time of field visit, the level of cleanliness at the pharmacy was considered adequate.	The Pharmacy at the District Hospital was found to be damp and without proper ventilation. Packets of drugs were stacked together haphazardly, indicating lack of adequate space.	There was a separate pharmacy at the hospital, but there was lack of sufficient air circulation in the room which made it damp and smelly.	A separate pharmacy was available at the hospital. However, during the time of the field visit, it was being moved to another room.	There was a separate pharmacy at the hospital, but there was lack of sufficient air circulation in the room which made it damp and smelly.	The hospital had a pharmacy which was kept clean during the field visit.
Intensive Care Unit (ICU)	The DHH at Balasore did not have an ICU in the premises.	The hospital did not have an ICU.	There is no Intensive Care Unit available at the District Hospital at Jharsuguda.	The District Hospital did not have any ICU facility.	Though the DHH had a provision for an ICU, it was not functioning due to lack of adequate staff and equipment.	There were no ICU services available at the hospital.	The DHH had a functioning ICU with a high level of cleanliness as befits the ward.	There was no operational ICU at the hospital during the time of the field visit.

Operation Theatre (OT)	There were two O.T.s at the district hospital which were seen to have an adequate level of cleanliness. Another O.T. had just been constructed but was not in use as yet.	The O.T. at the hospital was found to be functional and clean.	The Jharsuguda District Hospital has two Operating Theatres (OTs) in the premises. Both the OTs were found to be functional and in working condition	The District Hospital had a single Operation Theatre in its premises, and was found to be very clean	The hospital had three O.T. - one each for Surgery, Gynaecology and Ophthalmology. All the O.T.s were found to be adequately clean.	While there was a separate Operation Theatre (O.T.) along with a Minor O.T., it was not in use due to lack of an Anaesthesia Specialist.	The hospital had two O.T.s in a separate building, with an average level of cleanliness.	There were 2 separate O.T.s at the hospital.
Labour Room	The Labour Room at the hospital was found to be quite unclean, which can cause mothers and new-born babies to catch infection.	There was a separate Labour Room at the hospital.	There was a single Labour Room available at the Jharsuguda DHH, with an adequate level of cleanliness	The Labour Room at the District Hospital was found to have an average level of cleanliness	The hospital had a separate room as a Labour Room, but the premises were not quite clean during the field visit.	There was a single Labour Room at the hospital with an adequate level of cleanliness.	The hospital had a separate room as a Labour Room, having an average level of cleanliness.	The three Labour Rooms available at the hospital were found to be kept clean.
New Born Care Unit	A separate New-Born Care Unit was available at the hospital.	There was no New Born Care Unit at the hospital.	Though there was a single New Born Care Unit available at the Jharsuguda DHH, it was found to be non-functional during the time of the field visit.	The District Hospital has a New Born Care Unit; however, it was reported to be seldom used because of lack of adequate staff.	There was a separate New Born Care Unit at the DHH.	The hospital did not have any New Born Care Units.	There was no separate New Born Care Unit at the DHH.	There a single New Born Care Unit available at the hospital.
Heat Stroke Care Unit	The hospital had a separate Heat Stroke Care Unit.	There was a designated Heat Stroke Care Unit at the hospital, but was being used as a general ward as the season for Heat Stroke was now over.	There was one Heat Stroke Care Unit that was available at the hospital. However, since the field visit took place after the summer season, there was no patient suffering from heat stroke, due to which the room was being used for other purposes	The Heat Stroke Care Unit was found to be locked off. This was because the summer season was over and there were no patients of heat stroke at the District Hospital during the time of the field visit.	Though there was a designated Heat Stroke Care Unit at the DHH, it was not in use during the time of the field visit, as there were no patients during this time of the year.	The Heat Stroke Care Unit was available at the hospital, but was not functional as there had been no patients for its services	Though there was a designated Heat Stroke Care Unit at the DHH, it was not in use during the time of the field visit, as there were no patients during this time of the year.	A separate Heat Stroke Care Unit was available, but was not used during the time of the field visit.

Blood Bank/ Blood Storage Unit	The Blood Storage Unit was reported to function intermittently, and was maintained by the Red Cross Society.	The Blood Bank at the DHH was found to be semi-functional. While the staff was available for the Blood Bank, the storage unit was not functional. The Blood Bank was being run by the Red Cross Society.	There is no Blood Bank or Blood Storage Unit available	The District Hospital had a functioning Blood Bank having power back-up facilities like inverter and generator.	The hospital had a Blood Bank for the convenience of the patients.	The District Hospital had a Blood Bank with an adequate level of cleanliness, as observed during the field visit.	The hospital did not have a Blood Bank on the premises.	There was no Blood Bank or Blood Storage Unit at the hospital.
Laboratory	The hospital had a separate Laboratory for testing of diseases. It had an average level of cleanliness.	The hospital had a single Laboratory at the facility, which was found to be quite clean during the field visit.	There was a single laboratory found operational in the district hospital, and the level of cleanliness was found to be adequate.	The District Hospital had two laboratories, one general laboratory and one pathology laboratory. While the Pathology Laboratory was found to be clean, the general laboratory had medium level of cleanliness.	There were four separate laboratories in the DHH, one each for Malaria, PPC, T.B and for general purpose.	The hospital had two laboratories in its premises.	There were two laboratories in the DHH having an overall average level of cleanliness.	The hospital had 4 separate rooms for the Laboratory, where Bio-Chemical and Pathological tests were conducted as well.
X Ray	X-Ray facilities were available at the hospital.	The hospital had X-Ray facilities within its premises.	X-Ray facilities were found to be available at the District Hospital. There were two X-Ray units operational, and the premises were found to have a fair level of cleanliness	The District Hospital had X-Ray facilities for its patients, and the X-Ray room was found to be quite clean during the field visit.	There were three X-Ray units at the DHH.	The X-Ray facilities were available, though only till 3 P.M everyday.	X-Ray facilities were available at the DHH.	The hospital had 9 X-Ray units for the purposes of the patients.
Ultrasound	Ultrasound facilities were also available at the hospital.	The hospital had Ultrasound facilities within its premises.	There is also a provision for ultrasound facilities available at the district hospital. There was one unit for ultrasound found operational at the hospital, with a fair level of cleanliness.	The hospital also had Ultrasound facilities for its patients. The room for Ultrasound had a moderate level of cleanliness.	The hospital also had a provision for Ultrasound.	The hospital also had Ultrasound facility.	The hospital did not have a provision for Ultrasound.	There were 2 Ultrasound units available at the hospital.

ECG	The hospital had ECG facilities within its premises.	There were no ECG services within its premises.	ECG facilities were also found to be available at the hospital.	While the District Hospital did have an ECG machine, it was not in use during the time of the field visit because of lack of availability of trained operator.	ECG facilities were available at the hospital, though there was no separate room for the purpose of ECG.	The hospital also had E.C.G. facility.	The hospital did not have a provision for ECG.	ECG facilities were also available at the hospital.
Water Supply	The District Hospital had a separate bore-well because of which the hospital had continuous water supply.	The hospital used bore well water that was present in the premises, and the water was stored in a tank.	Continuous water supply was found to be available at the Jharsuguda District Hospital.	The District Hospital had continuous water supply at the facility. The arrangement had been kept in a separate building.	The hospital was recently able to procure facility for continuous water supply.	The District Hospital had continuous water supply available in the premises.	The hospital had a facility for continuous water supply.	Continuous water supply was available at the hospital.
Electricity	The District Hospital had a separate transformer for electric supply, due to which power outages were not frequent.	Since the hospital had a separate transformer, electricity supply was mostly uninterrupted and power outages were rare.	Electricity was available at the District Hospital in Jharsuguda, though the supply was found to be erratic.	The District Hospital had provision for electricity, and the area where the electricity poles were located had been cordoned off for safety reasons. However, the supply of electricity was erratic at the hospital.	While electricity was available at the hospital, it was extremely erratic causing lot of inconvenience to the patients and staff of the hospital.	The hospital has continuous electricity supply.	While electricity was available at the hospital, it was extremely erratic causing lot of inconvenience to the patients and staff of the hospital.	Electricity supply was available at the hospital, but the supply was observed to be slightly erratic.
Power Backup (Generator, Inverter, etc.)	While two generators were available in the hospital, only one was reported to be functional during the time of the field visit.	There were two generators available at the facility, but only one was functional during the time of the field visit.	A 7.5 kVa Generator was found to be available at the Jharsuguda DHH, which provided power back-up during times of electricity outage	The District Hospital had a generator and also an inverter for power back-up during electricity outage. The generator was used to supply electricity in wards, pharmacy, OPD and other hospital areas (corridors etc.), while the inverter was used for electricity supply in offices.	Due to the erratic nature of electricity supply at the hospital, inverters and generators were available at the hospital, especially for O.T.s, Labour Room and Blood Bank.	There are two generators that cater to power back-up needs of the hospital.	Due to the erratic nature of electricity supply at the hospital, inverters and generators were available at the hospital, especially for O.T.s.	The hospital had a 25 kVA generator for the facility.

Sewage/Drainage	A sewage/drainage system was available at the hospital, but was not maintained properly.	A proper sewage system was in place at the hospital.	Sewage and Drainage facilities were available at the hospital, though the cleaning and maintenance of the drains was found to be irregular	The District Hospital had sewage/drainage facility in its premises.	The Drainage system at the hospital was reported to be faulty at the hospital, and needed repair.	The hospital has a proper sewage/drainage system.	There was no proper sewage and drainage system at the DHH.	A proper sewage system was observed at the hospital.
Biomedical Waste Disposal	A proper system of Bio-Medical Waste Disposal is followed.	The hospital has a proper Bio-Medical Waste Management system, with anatomical waste buried in pits in a separate containment area.	There was no provision for any Biomedical Waste Disposal at the Jharsuguda District Hospital.	Though the District Hospital had a proper system for Biomedical Waste Disposal in its premises, the containment area was locked off on a general basis. While the pits were used for disposal, the area around the pits was not found to be much clean and had a pungent odour.	A proper system of Bio-Medical Waste Management was maintained at the hospital.	The hospital has a proper system of Bio-Medical Waste Disposal. The containment area was found to have an average level of cleanliness.	A proper system of Bio-Medical Waste Management was maintained at the hospital.	A proper system of Bio-Medical Waste Disposal was found to be existing at the hospital.
Kitchen	A separate kitchen is available at the hospital, with an average level of cleanliness.	The hospital has a separate kitchen within its premises. However, it was found to be poorly-maintained during the field visit.	There was no kitchen available at the Jharsuguda District Hospital, thus there was no provision for cooked food for patients.	The District Hospital had a kitchen where food was cooked. There was no LPG connection here, instead, food was cooked in a chulha. The entire kitchen had vegetables strewn across the floor during the time of the field visit.	A separate kitchen was available at the DHH for provision of food to the Indoor patients of the hospital.	There was a kitchen available inside the hospital premises.	There was no kitchen at the hospital premises.	The hospital had a separate kitchen at its premises.
Laundry	A separate provision for laundry was available at the hospital.	There was no laundry system at the hospital.	There were no laundry facilities available at the Jharsuguda District Hospital	The District Hospital at Kandhamal did not have any laundry facilities	A separate Laundry unit was also available at the DHH.	Though a designated Laundry Room was available at the hospital, it was instead being used as a Post-Natal Room during the time of the field visit.	A separate Laundry unit was not available at the DHH.	The hospital also had Laundry facilities arrangement.

Toilets	The toilets at the hospital were found to be extremely dirty during the field visit.	While there were many toilets available at the hospital, most of them were found to be unusable due to lack of cleanliness.	There were four toilets found to be available for patients at the Jharsuguda District Hospital, two for males and two for females. All the toilets were found to be in good condition.	There were a total of 60 toilets at the District Hospital premises, located at many places in the hospital. Out of these, 30 toilets were for males, which were found to be extremely dirty. There were also 30 toilets for females, which were in slightly better condition than the male toilets.	The DHH had a total of seven toilets in the premises for the patients, and almost all of them were in poor condition.	The hospital had only eight functional toilets which were in usable condition during the time of the field visit.	The DHH had a total of twelve toilets in the premises for the patients, and almost all of them were in poor condition.	Every ward was found to have 2 toilets at the hospital, most of which were found to be clean and well-maintained.

7.4 Observation Chart of CHCs / UGPHCs / Block PHCs

District	Balasore	Jagatsinghpur	Jharsuguda	Kandhamal	Keonjhar	Nabarangpur	Nuapada	Sundargarh
Facility	**CHCs**	**CHC/UGPHC/Block PHC**	**CHCs**	**CHCs**	**CHCs**	**CHCs**	**CHCs**	**CHCs**
Registration Counter	None of the CHCs visited had a separate registration counter. Registration was being done at the OPD room at the CHCs.	While there was no registration counter at CHC Manijanga and UGPHC Ersama, a clean registration counter was found in PHC Mandasahi.	None of the CHCs visited in the Jharsuguda district had any separate registration counter. Patients visiting the facility had to directly go to the General OPD room for any queries or assistance.	While there was no separate registration counter at CHC Gumagarh and at CHC G. Udayagiri, the CHC at Daringbadi did have a registration counter for patients. At CHC Gumagarh, registration was being done at OPD.	All the CHCs visited had a single counter for registration and collection of user fees.	There was a separate room for registration only at CHC Kosagumuda.	While a registration area was available at CHC Komna kept quite neat during field visit, the one at UGPHC Khariar was ill-maintained. CHC Khariar Road did not have any designated provision for registration of patients.	None of the CHCs had a separate registration counter.
Seating / Waiting Area	A small area was kept as a waiting area in all the CHCs visited, with an average level of cleanliness.	All the facilities visited had a seating/waiting area for patients and attendants. While at PHC Mandasahi this area was found to be quite clean with drinking water facility, the one at UGPHC	All of the CHCs have a waiting area for patients waiting for their turn at the OPD or for attendants of patients. The waiting area is equivalent to the	While CHC Daringbadi did not have a waiting area, the waiting area at CHC Gumagarh and at CHC G. Udayagiri was quite clean.	While there was no designated waiting area at CHC Salania, there were two separate rooms at CHC Padmapur for the purpose. At CHC Ghatagaon,	A separate waiting area for patients and attendants was available only at CHC Jharigam.	While a separate area was being used as seating / waiting area at all the facilities visited, the one at UGPHC Khariar was also being used as an IPD with patients resting	While all the CHCs had a seating area, none of them had a separate room for the purpose.

		Ersama was quite dirty with dogs roaming in the area.	size of a single room, and was found to have an average level of cleanliness in all three of the CHCs visited.		while there was no separate room, a separate area was marked for the purpose.		on chairs as they weren't assigned any beds.	
Out Patient Dept (OPD)	The facilities had separate OPDs for different specialists, having an average level of cleanliness.	While there were four OPD rooms at CHC Manijanga and UGPHC Ersama, only one OPD room was found at PHC Mandasahi. The OPD at all these facilities were found to have an average level of cleanliness.	While CHC Brajrajnagar and CHC Mundrajore had 2 rooms for OPD, CHC Lakhanpur had 3 rooms especially for OPD facilities, out of which one OPD was especially for Paediatrics	All the three CHCs visited had an average level of cleanliness in the OPDs. While CHC G. Udayagiri had four rooms for OPD, CHC Daringbadi had three rooms. Though CHC Gumagarh had only two rooms for OPD, it was observed that the OPD was extremely busy. This indicates a shortage of space for OPD at present at CHC Gumagarh.	While there was just a single OPD room at CHC Padmapur, there were two such rooms at CHC Ghatagaon and three at CHC Salania. While the OPD room at CHC Padmapur was extremely dirty, the ones at CHC Ghatagaon were maintained quite nicely.	The CHCs had 1-2 room set aside as OPD, and were found to be kept quite clean during the field visit.	While there was just a single OPD room at CHC Komna, there were two such rooms at CHC Khariar Road and four at UGPHC Khariar. The OPD rooms at all the facilities had an average level of cleanliness.	The CHCs had an average of two OPD rooms, with a general level of cleanliness maintained.
Wards	The wards were mostly separate for males and females, having an average level of cleanliness.	While there were three and four rooms as IPD at CHC Manijanga and UGPHC Ersama respectively with average level of cleanliness, there was just a single room for IPD at PHC Mandasahi which was kept quite clean.	There were two wards seen at CHC Mundrajore (male and female). However, it was noted that this CHC does not offer IPD facilities to patients any longer. In CHC Lakhanpur, there were three wards – Gynaecology, Paediatrics and General. Out of these, the General	CHC Gumagarh had only two wards at the facility, while CHC G. Udayagiri had five wards. CHC Daringbadi had three wards at the facility.	Different rooms had been assigned at each of the CHCs as IPD for patients. Though on general these wards had an average level of cleanlliness, the wards at CHC Padmapur were found to be quite dirty.	There were 1-2 rooms used as wards for Indoor patients. These rooms were found to be quite dirty.	While there were three wards at CHC Khariar Road and UGPHC Khariar, only two wards were assigned for IPD at CHC Komna. It was observed during field visit that IPD patients were scattered at all places inside hospital premises instead of just the wards.	On an average, the CHCs had two-three rooms in the premises which were used as In-Patient Wards.

			Ward was still under construction. Beds were available only in the Gynaecology Ward (six in number), with two patients admitted.					
Casualty	A separate casualty was maintained only at CHC Simulia.	Apart from CHC Manijanga, both the other facilities had a separate casualty.	None of the CHCs visited had a Casualty in their premises.	It was observed that there was no casualty at any of the CHCs visited.	None of the CHCs had any separate Casualty section.	There was no separate Casualty Room at any of the CHCs visited.	None of the CHCs had any separate Casualty section.	None of the CHCs had a casualty.
Emergency Room	There was an emergency room in all the CHCs visited, except at CHC Rupsa.	None of the facilities visited had an emergency room.	Emergency facilities were not available in any of the three CHCs visited during the field visit. Patients in need of emergency medical care are given first-aid and then rushed to the Distrcit Headquarter Hospital.	Out of the three CHCs visited, only CHC Daringbadi had an emergency room, which had an average level of cleanliness.	An emergency room was available only at CHC Padmapur, and was not kept clean.	There was no separate Emergency Room at any of the CHCs visited.	Only UGPHC Khariar out of the facilities visited had an Emergency Room, however, it was found as being used as a Blood Storage unit during the field visit and not as emergency room.	Only CHC Bargaon had a separate emergency room.
Injection Room	A separate Injection Room was available only at CHC Simulia.	An Injection room was available at all the facilities visited, with an average level of cleanliness.	Out of the three CHCs visited, CHC Brajrajnagar and CHC Mundrajore had a single injection room with moderate level of cleanliness. CHC Lakhanpur did not have any separate injection room within its premises.	Only CHC G. Udayagiri had an Injection Room with average level of cleanliness. The other two CHCs visited during the field visit did not have any Injection Room. However, at CHC Gumagarh, there is a small area which is being used as Injection Room and a Staff	A separate Injection Room was available at CHC Padmapur and CHC Salania, but was not there at CHC Ghatagaon. This room was extremely dirty at CHC Padmapur.	There was no separate Injection Room at any of the CHCs visited.	None of the facilities had a separate Injection Room on the premises.	None of the CHCs had a separate Injection Room.

				Nurse was seen working in that small area also during the field visit.				
Dressing Room	While there were separate Dressing Rooms at CHC Simulia and CHC Soro, only a designated space for this purpose was found at CHC Rupsa, which was also found to be quite dirty during the field visit.	A single Dressing Room was available at all the facilities visited.	All three CHCs visited had a single Dressing Room, with moderate level of cleanliness. However, bandages and medicines were seen strewn across the table which gave the Dressing Room a slightly messy and unkempt look.	All the three CHCs visited had a Dressing Room with average level of cleanliness, except for CHC G. Udayagiri which had a very clean Dressing Room.	While CHC Padmapur had a clean Dressing Room, there was no such provision at CHC Ghatagaon. The one at CHC Salania had an average level of cleanliness.	There was no separate Dressing Room at any of the CHCs visited.	While the Dressing Room at CHC Khariar Road was well-maintained, the one at UGPHC Khariar had average level of cleanliness. CHC Komna did not have a separate Dressing Room.	Only CHC Bargaon had a separate, though very small Dressing Room.
Pharmacy	All the CHCs had a separate pharmacy within the premises.	A single room for pharmacy was available at all the facilities visited having an average level of cleanliness.	All the three CHCs visited had a single pharmacy, taken care of by the pharmacist. The pharmacy was a single room with average level of cleanliness. However, lack of proper ventilation in the pharmacy made the atmosphere damp inside the room.	All the three CHCs visited had a single pharmacy. Except CHC G. Udayagiri which had a comparatively cleaner pharmacy, the other two CHCs had a moderately clean pharmacy.	All the CHCs visited had a single pharmacy at the premises with an average level of cleanliness.	A single separate pharmacy was functioning in all the CHCs visited, having an average level of cleanliness.	All the facilities visited had a single pharmacy, with an average level of cleanliness.	While all the CHCs had a pharmacy, CHC Bargaon had its pharmacy in open space.
Intensive Care Unit (ICU)	None of the CHCs visited had an ICU.	None of the facilities visited had an ICU.	Intensive Care facilities were not found to be available in any of the CHCs visited.	None of the CHCs visited had an ICU in the facility.	None of the CHCs had an ICU on the premises.	None of the CHCs visited had ICU facilities.	None of the CHCs/UGPHC had an ICU on the premises.	None of the CHCs had an ICU within its premises.

Operation Theatre (OT)	During the field visit, it was seen that the O.T. at CHC Rupsa was used only for sterilization (occasionally), and was otherwise used as a store-room.	Only CHC Manijanga had an operational O.T in the premises. While UGPHC did not have an O.T, the one at PHC Mandasahi was not functional with its floor, door and windows damaged.	All the CHCs visited had a single-room Operation Theatre within its premises. While CHC Mundrajore and CHC Lakhanpur had a clean and functional Operation Theatre, the O.T at CHC Brajrajnagar was being used as a storeroom	The Operation Theatre (O.T.) at CHC Gumagarh was found to be used only during family sterilization cases, as a result of which the O.T. premises were found to be very clean. On the other hand, it was observed that the O.T. at CHC G. Udayagiri still needed some repairs before it could be used optimally. The O.T. at CHC Daringbari was found to be operation as well.	While all the CHCs visited had an O.T., only the one at CHC Ghatagaon was being used. While the one at CHC Padmapur was being used as a store-room, the one at CHC Salania was non-functional due to lack of surgeons and was used as an OPD.	While all the CHCs visited had an O.T., it was not in use at CHC Papadahandi. The O.T.s at other two CHCs were well-maintained.	While the O.T. at CHC Khariar Road and UGPHC Khariar were not functional due to lack of surgeon, the O.T at CHC Komna was situated in a separate building and kept quite clean.	All the CHCs visited had an O.T. within its premises, but was not in use in any of these facilities
Labour Room	All the visited CHCs had a separate Labour Room.	All the facilities visited had a Labour Room in its premises. While the one at PHC Mandasahi was superbly maintained and quite clean, the labour room at UGPHC Ersama was found to be quite dirty, with dogs roaming in the area.	While there is a Labour Room available and functioning at CHC Mundrajore and CHC Lakhanpur, the designated Labour Room at CHC Brajrajnagar on the other hand has been converted into Block Programme Management Unit (B.P.M.U.).	All the three CHCs had a Labour Room in their premises. However, while the Labour Room at CHCs Gumagarh and G. Udayagiri were found to be clean, the Labour Room at CHC Daringbari was found to be extremely dirty.	All the CHCs visited had a single Labour Room at the premises. While the one at CHC Padmapur was found to be quite dirty during the field visit, the others had an average level of cleanliness.	All the CHCs visited had a single Labour Room with adequate level of cleanliness.	While the Labour Room at CHC Khariar Road and CHC Komna were found to be well-maintained (with the one at CHC Komna in a separate building), the one at UGPHC Khariar had an average level of cleanliness.	All the CHCs had 1-2 Labour rooms with an average level of cleanliness.
New Born Care Unit	Only CHC Simulia had a separate New Born Care Unit within the premises.	None of the facilities visited had a New Born Care Unit.	While there is no New Born Care Unit at present in either of the CHCs visited, there is one New Born Care Unit being constructed at	CHC Daringbari did not have any New Born Care Unit in its premises. Though the other two CHCs visited had a New Born Care	None of the CHCs visited had a New Born Care Unit inside the premises.	There was no specific room for New Born Care Units, instead, it was merged with the Labour Room.	None of the CHCs visited had a New Born Care Unit inside the premises.	None of the CHCs had a New Born Care Unit.

			CHC Lakhanpur.	Unit, the one at CHC Gumagarh was inside the Labour Room itself.				
Heat Stroke Care Unit	While all the visited CHCs had a Heat Stroke Care Unit, none of them were active during the rainy season.	Except UGPHC Ersama, the other two facilities had a Heat Stroke Care Unit.	All of the CHCs visited had a Heat Stroke Care Unit for heat stroke patients.	While all the CHCs visited had a Heat Stroke Care Unit, none of them were being used as such during the time of field visit, as the summer season was over. The rooms were found to be locked up.	While the Heat Stroke Care Unit was available at CHC Ghatagaon and CHC Salania, it was not used for the purpose as the summer season had gone past and there were no patients for heat stroke coming to the facility.	While all the CHCs had Heat Stroke Care facilities, they were only used during the summer season.	While the Heat Stroke Care Unit was available at all the facilities visited, it was not used for the purpose as the summer season had gone past and there were no patients for heat stroke coming to the facility.	All the CHCs had a separate Heat Stroke Care Unit, but were not in use during the time of field visit.
Blood Bank/ Blood Storage Unit	None of the CHCs had any provision for a Blood Bank or Blood Storage Unit.	None of the facilities visited had a Blood Bank or Blood Storage Unit within the premises.	None of the CHCs visited had facilities for either a Blood Bank or Blood Stroage Unit, though construction was being carried out at CHC Lakhanpur for the same.	There was no Blood Bank / Blood Storage Unit at CHC Gumagarh and CHC Daringbari. Though CHC G. Udayagiri had a Blood Storage Unit within its premises, it was not functional yet as it was waiting for clearances.	None of the CHCs visited had a Blood Bank or Blood Storage Unit at the facility.	At all the CHCs visited, Blood Storage Units were available, but not yet functional.	Only UGPHC Khariar had a provision for a Blood Storage Unit, but was reported to have functioned only for the first few weeks after installation, and was not repaired ever since.	Only CHC Bargaon had a separate Blood Storage Unit, but it was not in use during time of field visit.
Laboratory	While all the visited CHCs had a laboratory, the one at CHC Rupsa was found to be quite clean.	All the facilities had a single laboratory inside the facility, which had moderate level of cleanliness.	While CHC Lakhanpur did not have any Laboratory, CHC Mundrajore and CHC Brajrajnagar had a single room laboratory within its premises with average level of cleanliness.	Whiel both CHC Gumagarh and CHC Daringbari had two clean rooms for its Laboratory; CHC G. Udayagiri had a single room which had an average level of cleanliness.	Both CHC Padmapur and CHC Ghatagaon had a laboratory with an average level of cleanliness. CHC Salania did not have a laboratory in the premises.	The Laboratories at the CHCs were used only for T.B. and Malaria tests, and had an adequate level of cleanliness.	While CHC Komna and UGPHC Khariar had a two-room Laboratory with average level of cleanliness, the one at CHC Khariar Road had a single room and was used only for sputum and Malaria Tests.	CHC Kinjirkela did not have a Laboratory. At CHC Lahunipara Laboratory, only malaria and sputum tests were conducted.

X Ray	None of the CHCs visited had X-Ray facilities.	While there was no X-ray facility at PHC Mandasahi, it was available but not functional at CHC Manijanga and UGPHC Ersama due to absence of technician.	Only CHC Lakhanpur had X-Ray facilities out of the three CHCs visited. However, even here the X-Ray facilities were not functional for the last six months. A requisition had already been sent to the Office of the CDMO and SDMU for the same.	There were no X-Ray facilities at CHC Gumagarh. The other two CHCs did have an X-Ray machine and a separate room, however, the one at CHC Daringbari was not being used because of lack of trained operator	Only CHC Ghatagaon had X-Ray facilities among the CHCs visited.	None of the CHCs visited had X-Ray facilities.	Only UGPHC Khariar, out of the three facilities visited, had X-Ray facilities in the premises.	While CHC Kinjirkela did not have X-Ray facilities, the other CHCs had an X-Ray technician who reported to the CHC only once a week.
Ultrasound	None of the visited CHCs had any provision for Ultrasound.	None of the facilities visited had Ultrasound at the premises.	None of the three CHCs had any provision for ultrasound within their premises.	None of the CHCs visited during the field visit had Ultrasound facilities	None of the CHCs had Ultrasound facilities at the premises.	None of the CHCs visited had Ultrasound facilities.	None of the facilities had a provision for Ultrasound.	None of the CHCs had Ultrasound facilities.
ECG	None of the visited CHCs had any provision for ECG.	None of the facilities visited had ECG at the premises.	None of the three CHCs had any provision for ECG within their premises	Only CHC G. Udayagiri had ECG facilities within its premises out of the three CHCs visited.	None of the CHCs had ECG facilities at the premises.	None of the CHCs visited had ECG facilities.	None of the facilities had a provision for ECG.	None of the CHCs had ECG facilities.
Water Supply	Water supply at all the CHCs was not regular, and there was a requirement of an overhead tank for the facility.	All the facilities had continuous water supply due to presence of borewell.	Water supply was available by means of a borewell, at all times, in all the three CHCs visited.	While CHC Daringbari had no water supply at the facility, the other two facilities did have it, with CHC Gumagarh having a borewell for regular water supply.	While all the CHCs had water supply at the premises, the supply was quite erratic.	While water supply was available at all the CHCs visited, it was not a continuous supply at CHC Kosagumuda.	All the facilities visited had a borewell for continuous supply of water, but some problems regarding the supply were reported at CHC Khariar Road.	While CHC Kinjirkela had no water supply at the facility, CHC Lahunipara had intermittent water supply. Only CHC Bargaon was reported to have 24*7 water supply.
Electricity	At none of the CHCs visited was electric supply regular. Especially at CHC Soro, the problem was very acute due to some	Electricity was available at all the facilities, but was found to be erratic which caused inconvenience to staff as well as patients.	While electricity was available at the CHCs visited, frequent outage caused a lot of inconvenience to the patients.	In all the CHCs visited, electricity supply, though available, was extremely erratic, disrupting day-to-day medical and	Electricity, though available at the CHCs, was quite erratic in supply.	Electricity supply was available at the CHCs but extremely erratic.	Electricity supply was found to be erratic in all the facilities visited because of lack of a separate transformer for the facilities.	While all the CHCs had electricity supply, it was extremely erratic in all the facilities.

	wiring problem which was not rectified for a long time.			administrative functions of the facility to a very large extent. At CHC Daringbari, it was observed during field visit that power outages sometimes extended for more than 10 hours.				
Power Backup (Generator, Inverter, etc.)	At all the CHCs visited there were generators and inverters installed for power back-up.	While PHC Mandasahi had a generator and two inverters for power back up, the other two facilities had only a generator.	In order to combat frequent electricity outages, all the CHCs visited had purchased generators. While CHC Lakhanpur and CHC Mundrajore had a 5 kVA generator, CHC Brajrajnagar had a 2 kVA generator for its purpose.	Since power outages were extremely common at CHC Daringbari, there were two invertors installed at the facility which provided temporary relief. Both CHC Gumagarh and CHC G. Udayagiri also had power back-up, but the inverter at CHC Gumagarh was not working during the field visit.	Because of frequent power outages at the CHCs, there were generators and inverters installed at all the facilities. While CHC Padmapur and CHC Salania had a generator, CHC Ghatagaon was using inverters for power back-up.	While the inverter catered to the Labour Room and O.T., the generator was used for power back-up in other parts of the facility.	Power back-up, in the form of an inverter, was available only for the Labour Room at CHC Khariar Road. While two functional inverters were installed at CHC Komna, the one at UGPHC Khariar was not found to be functional during the time of the field visit.	Owing to poor electricity supply, all the CHCs had power back-up facilities. However, the generator at CHC Kinjirkela was out of order during the field visit. Similar was the case at CHC Lahunipara, where 2 invertors had been purchased using RKS Fund.
Sewage/Drainage	Sewage/Drainage facilities were available only at CHC Simulia.	All the facilities visited except for CHC Manijanga had a sewage system.	There were no sewage/drainage facilities at CHC Mundrajore. CHC Brajrajnagar and CHC Lakhanpur had sewage facilities. CHC Lakhanpur also had a soak pit for the purpose.	While CHC G. Udayagiri and CHC Daringbari did not have sewage/drainage facilities, work in this regard had started at CHC Gumagarh facility and was in progress.	Only CHC Ghatagaon had a proper sewage/drainage system among the CHCs visited.	There was no system of sewage/drainage at the facilities visited.	None of the facilities visited had any sewage/drainage facility.	None of the CHCs had any sewage/drainage facilities.
Biomedical Waste Disposal	There was a proper system of Bio-Medical Waste Disposal at the CHCs visited.	Except UGPHC Ersama, the other two facilities had a Bio-Medical Waste Management System.	A system for Biomedical Waste Disposal was in place in all of the CHCs visited	Though a system of biomedical waste disposal was present in all the CHCs visited,	While all the CHCs had a waste disposal system, the system was not	A system of Bio-Medical Waste Disposal was in place at the CHCs, but there	While there was no proper system of Bio-Medical Waste disposal at CHC Komna, the one at	Except CHC Lahunipara, all the other CHCs visited had a system of Bio-

			during the field visit. There were separate pits for biomedical waste disposal, but the area was not kept clean	it was not being used at CHC Daringbari during the field visit.	maintained properly at CHC Ghatagaon.	was no fencing around the containment area.	UGPHC Khariar, though functioning, was not maintained properly. A properly maintained system was observed at CHC Khariar Road.	Medical Waste Disposal.
Kitchen	Except CHC Rupsa, all the other CHCs visited had a separate kitchen in the premises.	A kitchen was available only at UGPHC Ersama and was found to be extremely dirty.	There was no kitchen in any of the CHCs visited in the Jharsuguda district.	Though there were no kitchen available at CHC Gumagarh and CHC Daringbari, only dry items were being served to patients and there was no cooking involved. On the other hand, a kitchen was functioning on the premises at CHC G. Udayagiri and had a moderate level of cleanliness. At CHC Gumagarh, the food was kept in the canteen.	None of the CHCs visited had a kitchen at the facility.	There was no kitchen in any of the facilities visited.	Only CHC Khariar Road, out of the three facilities visited, had a provision for kitchen. However, this kitchen was found to be damaged during the field visit, and was reported to be no longer used. As a result, the patients at CHC Khariar Road were only provided with bread and milk during their stay in the IPD.	None of the CHCs visited had a separate kitchen for the facility.
Laundry	Only CHC Soro, among the CHCs visited, had a provision for laundry.	None of the facilities had laundry facility.	Laundry facilities were not available in any of the CHCs visited during the field visit.	There were no Laundry facilities available at any of the CHCs visited during the field visit.	There was a provision for laundry only at CHC Ghatagaon among the CHCs visited.	There was no laundry facility in any of the CHCs visited.	Laundry facilities were not available in any of the facilities visited.	None of the CHCs had Laundry facilities.
Toilets	While CHC Soro did not have any toilets, there were just two toilets at CHC Rupsa having an average level of cleanliness. However, all the four toilets at CHC Simulia were in poor condition.	The toilets at all the facilities were found to be extremely dirty.	All the CHCs visited had a total of two toilets. However, there were no separate toilets for males and females in any of the facilities. The level of cleanliness was also quite poor,	It was observed that while CHC Daringbari had a total of four toilets for males and females, only one toilet for males and one toilet for females was found to be functional. Even	While CHC Padmapur and CHC Salania only had one and two toilets respectively, CHC Ghatagaon had a total of nine toilets. While others had an average level of	While there were 5 toilets available at CHC Jharigam, there were 3 toilets at CHC Kosagumuda and 2 toilets at CHC Papadahandi. It was observed that all the toilets were kept in poor	While CHC Khariar Road and CHC Komna had six toilets for patients with average level of cleanliness, UGPHC Khariar had only a single functional toilet which was found to be very dirty during the field visit.	At all the CHCs visited, there were common toilet facilities for males and females. While at CHC Kinjirkela, there were 3 toilets, CHC Bargaon had 6 toilets and CHC Lahunipara had

			especially the toilets at CHC Lakhanpur were found to be very dirty	the ones functional were in very bad condition. At CHC Gumagarh, there was a single toilet for males and three toilets for females. The condition of the toilets was slightly better at CHC Gumagarh. There were five toilets at CHC G. Udayagiri, out of which three were for males and the other two toilets were for females. The male toilets were found to be extremely dirty during the field visit.	cleanliness, the toilet at CHC Padmapur was found to be quite dirty during the field visit.	shape.		10 toilets within its premises. However, at none of the CHCs were the toilets clean and hygienically maintained.