Chapter 6 Capacity Building

6.1 Physical Infrastructure

NRHM stipulates creation of new infrastructure/buildings for health centres and strengthening of the existing ones for improving accessibility and quality of healthcare delivery services after assessment of the load on the existing health centres and requirement for creation / upgradation in view of potential increase in the number of patients. However, the Indian Public Health Standards (IPHS), which provided the norms for creation of physical infrastructure, were approved only in 2007-08.

6.1.1 Adequacy of Health Centres

NRHM guidelines provided that one SC is to be set up for a population of 5,000 (3,000 in hilly and tribal areas), one PHC for 30,000 population (20,000 in hilly and tribal areas) and one CHC for 1,00,000 population (80,000 in hilly and tribal areas). For a total population of 2,66,55,528 (33,08,570 in tribal areas) in the State as per Census 2001, 4,344 SCs, 605 PHCs and 94 CHCs were existing (as per RCH-II PIP) before the commencement of NRHM. Hence, there was a requirement for setting up an additional 1,428 SCs, 338 PHCs and 180 CHCs during the Mission period (2005-12) to cover the gap as per the Census population, even without taking into account the increase in population since 2001 and intra-state variations. The status of creation of infrastructure at the end of 2007-08 compared to the requirement is shown below:

Table: 4

Level	No. required to be created during 2005-12	No. required to be created during 2005-08 on prorata basis	No. created and operationalised	Gap (2005-08) Excess (+) / Shortfall (-)
Sub Centres	1,428	612	248	(-) 364
Primary Health Centres	338	145	307	(+) 162
Community Health Centres	180	77	14	(-) 63
Total	**1,946**	**834**	**569**	

Source: - Statistical Handbook of Assam and data obtained from SHS.

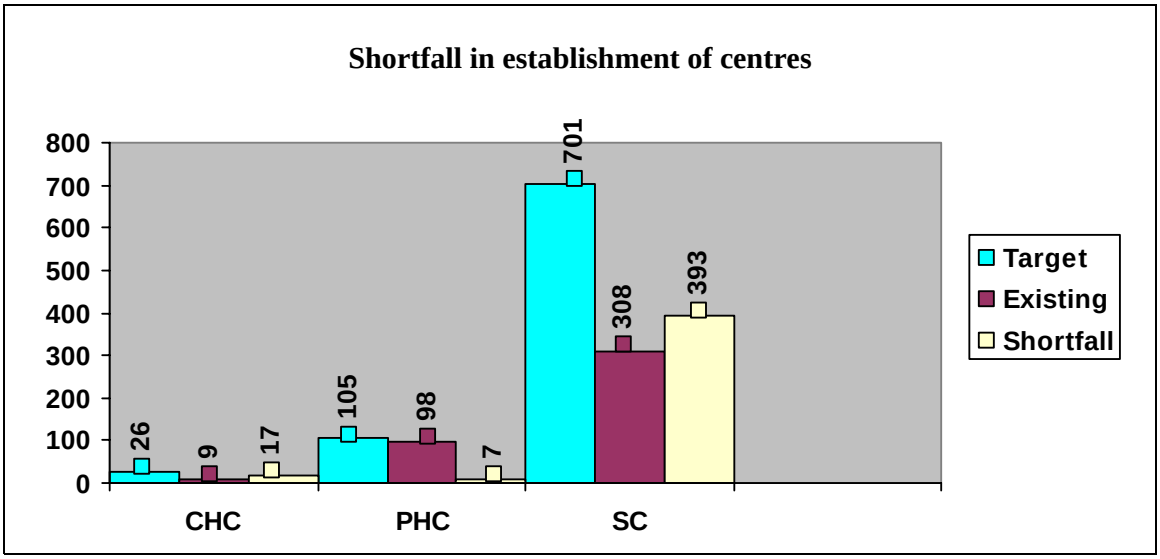
As can be seen from the table above, there was a shortfall of 59 and 82 *per cent* in the SCs and CHCs respectively during 2005-08, while there was an excess of PHCs (112 *per cent*) during the period.

Non-setting up of the required number of health centres as per the population norms resulted in non-achievement of the primary objective of improving accessibility to health facilities in rural areas.

In the tribal areas, health centres are to be set up as per different population norms as mentioned above. In the three districts of N.C. Hills, Karbi-Anglong and Kokrajhar with a total population of 21,01,819 (as per Census 2001) 415 health centres had been established as of March 2008 against the required number of 832.

The details of health centres are shown below:

Chart No.5



Shortfall of nearly 50 *per cent* in health centres in the tribal districts indicates that the areas with high concentration of socially and economically deprived population were not given adequate priority in the plans for creation of new infrastructure under NRHM.

6.1.2 Existence of two centres in the same locality

There were 44 cases of two health centres (CHC and PHC) in the same locality in 18 out of 23 districts. Further, in one[1] out of the five sampled districts, there were two CHCs in close proximity of four km within the same block. This indicates that health centres were set up without considering their actual necessity based on population norms and violates the concept of equity in providing health care in rural areas.

Demow CHC

Demow BPHC

6.1.3 Delay in construction of Sub-Centres

Construction of buildings for 404 existing SCs (rented) was taken up in 2006-07 at an approved cost of Rs.37.50 crore in 9 out of the 23 districts. Not a single building was completed and handed over to the concerned DHS as of March 2008, although an amount of Rs. 9.99 crore was expended on these works. This resulted in delay in providing quality healthcare services to the rural population through fully functional SCs.

[1] Nalbari.

Khanajan SC functioning in a rented house despite having newly constructed building

Newly constructed Khanajan SC yet to be functional due to lack of electrical connection

6.1.4 Status of infrastructure at health centres

The NRHM framework envisaged provision of certain guaranteed services at SCs, PHCs and CHCs as per the norms of IPHS. Physical verification and facility survey by the Audit team in the five sampled districts revealed that the basic facilities were not available in a number of health centres, as detailed below:

Table: 5

Sl. No.	Particulars	Sub Centres	Primary Health Centres	Community Health Centres
1	**Total number of health centres checked**	**58**	**29**	**14**
2	No. of health centres where the building was in a dilapidated condition	11	Nil	Nil
3	No. of health centres where cleanliness was poor	10	5	Nil
4	No. of health centres where required number of vehicles/ambulance were not available	58	19	Nil
5	No. of health centres where Citizen's Charter was not displayed prominently in local language	19	16	6
6	No. of health centres where suggestion/complaint box was not kept prominently	45	17	11
7	No. of health centres where separate utilities for men and women were not available	46	21	7
8	No. of health centres where OPD rooms/cubicles were not available	58	1	Nil
9	No. of health centres where operation theatre/minor operation theatre were not available (where applicable)	58	21	4
10	No. of health centres where labour room was not available (where applicable)	58	11	Nil
11	No. of health centres where labour room was available but not functional (where applicable)	Nil	2	Nil
12	No. of health centres where medical store was not present	58	Nil	Nil
13	No. of health centres where separate ward for male and female patients were not available (where applicable)	58	23	3
14	No. of health centres where waiting rooms for patients were not available/not in good condition	58	29	Nil
15	No. of health centres with no provision of water supply	58	Nil	Nil
16	No. of health centres with no provision for storage of water	58	9	1
17	No. of health centres with no facility of sewerage	58	10	Nil
18	No. of health centres with no facility of medical waste disposal	58	29	11

19	No. of health centres with no electricity connection/power supply	58	1	Nil
20	No. of health centres with no standby power supply/generator	58	15	2
21	No. of health centres with no telephone connection	58	16	9
22	No. of health centres with no computer	58	17	6
23	No. of health centres with no accommodation facilities for attendants of admitted patients	58	29	14
24	No. of health centres where accommodation facilities for staff were not available	58	7	Nil
25	No. of health centres where accommodation facilities for staff were partially available	Nil	2	14
26	No. of health centres where adequate furniture was not available/not in working condition	58	17	Nil

Source: - Data collected from centres test checked.

As can be seen from the above details, basic physical infrastructure was quite inadequate in a large number of PHCs and CHCs and was almost non-existent in the SCs.

The Department did not offer any comments in this regard.

Photographs of working condition of health centres are given below:

Unscientific storage of drugs and medicines in Centre Bazar PHC

Labour bed at Centre Bazar PHC

Radiant warmer remained unutilized at Panigaon SHC

Generator lying idle for two years for want of electrical works at Bokolia CHC

Lack of waste management at Panigaon SHC

Insecure maternal ward at Nowboicha CHC

Conclusion

The number of health centres in the State was far from the norms prescribed, leading to denial of healthcare services to the community in an equitable manner. Also, absence of the required infrastructure at the health centres affected the quality and reliability of health services in the rural areas.

Recommendation

There is an urgent need to create new health centres and to strengthen the existing ones. The State Heath Society needs to map and rationalize the available health facilities and other infrastructure at the health centres through extensive surveys and initiate measures to gear up the pace of construction of health centres. Support infrastructure like electricity, generators, telephone etc. also need to be provided to ensure improvement in the quality of health services.

6.2 Facilities at health centres

The gaps in facilities were particularly critical in the following areas:

6.2.1 In-patient services

The NRHM guidelines provide for six and thirty bed in-patient service at the PHC and CHC respectively. Out of the 29 test checked PHCs, only 11 were functioning with in-patient services with two to ten beds and 18 were functioning without in-patient service. In 16 PHCs, two to ten beds were available, while in 13 PHCs, no bed was available. In 5 PHCs, beds were available but in-patient services were not operational due to the absence of the required (i) medical specialists, (ii) infrastructure facilities like operation theatre etc. All the 14 test checked CHCs had in-patient services. While in 9 CHCs, the full compliment of 30 beds was available, in 5 CHCs, 10 to 25 beds were available and in 2 CHCs, beds were available but in-patient services were not operational due to the absence of the required (i) specialists (ii) infrastructural facilities and (iii) operation theatre.

Available beds at Manja PHC without in-patient services

In one out of 29 PHCs and 14 CHCs, the patient bed ratio was optimum (90 to 110 *per cent*) in 2007-08. In one CHC and five PHCs the patient bed ratio was between 50 and 90 *per cent* in 2007-08 while in 11 CHCs and 3 PHCs, it was below 50 *per cent*. This indicated under utilization of in-patient services in rural health centres, possibly due to lack of manpower and infrastructure facilities.

The lower patient bed ratio in rural hospitals affected the goal of providing reliable and quality health services in rural areas, while there was an overload on services in semi-urban and urban health centres, as well as in private hospitals.

Audit scrutiny revealed that 5,000 steel beds procured out of NRHM funds were shifted to the National Games Village at Guwahati, of which, 4,265 beds were transferred subsequently to various health centres in the districts without assessing the actual requirement for in-patient services, as was evident from the failure to fix the beds in the health centres due to non-availability of space. A test check of distribution of 2,711 beds revealed that as many as 177 beds could not be installed for want of space in four[2] centres (out of 126 centres). Only 11 out of 29 PHCs and 12 out of 14 CHCs sampled were functioning with in-patient services and the patient bed ratio was optimum (0.9 to 1.1) in only 1 PHC out of 14 CHCs and 29 PHCs. Further, out of the 2,711 beds distributed, 1,250 (46 *per cent*) beds were distributed to 14 District Hospitals. The whereabouts of the remaining 735 beds costing Rs. 52.94 lakh were not available on record. The Department confirmed that the beds procured out of NRHM funds were utilized in the Games Village with the approval of the State Government.

Unutilised beds in Dekhoumukh MPHC for want of manpower

Thus, the objective of providing in-patient services in rural health centres and to reduce the patient load in district hospitals remained unfulfilled.

6.2.2 Operation theatre

As per NRHM norms, every CHC is to have one operation theatre. However, out of the 14 CHCs checked, a functional operation theatre was available only in 5 CHCs. Four CHCs had no operation theatre, while 5 CHCs had a non-working/ defunct operation theatre. In 10 cases, the operation theatre was

Non-functional operation theatre at Bokolia CHC

Operation theatre at Bokolia CHC converted as in-patient ward

[2] Bongaigaon, Lakhimpur, Dhemaji Civil Hospitals and Lahorighat PHC.

not adequately equipped. The details of various equipments in the operation theatres of CHCs are shown below:

Table: 6

	Number of CHCs where equipment was available and functional	Number of CHCs where equipment was available but not functional	Number of CHCs where equipment was not available
Boyales apparatus	4	-	10
Cardiac Monitor for OT	4	1	9
Ventilator for OT	2	-	12
Vertical High Pressure Sterilizer 2/3 drum capacity	1	1	12
Shadowless lamp pedestal for minor OT	3	1	10
Gloves and dusting machines	3	1	10
Nitrous oxide cylinder 1780 ltrs 8 for one Boyales Apparatus	3	1	10
EMO Machine	-	-	14
Defribillator for OT	-	-	14
Horizontal High Pressure Sterilizer	1	-	13
Shadowless lamp ceiling trak mounted	2	-	12
OT care / fumigation apparatus	1	-	13
Oxygen cylinder 660 ltrs 10 cylinder for one Boyales apparatus	4	1	9
Hydraulic operation table	5	1	8

Source: - Data collected from centres test checked.

Further, in four[3] cases, the operation theatre was available and well equipped, but surgeries were not carried out due to non-provisioning of generator for the operation theatre/dilapidated condition of building of the operation theatre/absence of specialist/required number of beds.

The absence/non-functioning of the operation theatre and its poor quality were impediments in developing the CHCs as the First Referral Units (FRUs). This deprived the public of quality and affordable surgical treatment in the rural areas and increased the patient load on district hospitals.

6.2.3 Labour room

Under NRHM, every PHC and CHC is to have a labour room for safe delivery. However, out of 29 PHCs and 14 CHCs sampled, while labour room was available in all 14 CHCs, only 10 PHCs had this facility. In 4 PHCs, the labour room was available but not functioning mainly due to the absence of a specialist. In 12 PHCs, deliveries were carried out outside the labour room in a non-dedicated facility due to the absence of other infrastructural facilities.

[3] Dhakuakhana, Nowboicha, Bokajan, Kakaya.

The absence/non-functioning of labour room at PHCs hampered the goal of increasing the number of institutional deliveries and affected the aim of providing quality healthcare services.

6.2.4 Diagnostic services

The Mission provides for essential laboratory services at the PHCs and the CHCs. At the PHC level, the services should include routine urine, stool and blood tests, blood grouping, bleeding time, clotting time, diagnosis of RTI/STI, sputum testing for tuberculosis, blood smear examination for malaria parasites, rapid tests for pregnancy/malaria etc. Out of 29 PHCs test checked, 4 had no laboratory services. At the CHCs, besides the laboratory services, microscopic facilities for tuberculosis, diagnostic facilities for complicated cases of malaria, fileria, dengue, Japanese Encephalitis, Kala azar and leprosy were to be provided. However, out of the sampled 14 CHCs, only 3 CHCs had full diagnostic services. In 11 CHCs and 25 PHCs, equipment for diagnostic services was available only partially. In the absence of the prescribed diagnostic services at CHCs and PHCs, the quality and reliability of health care services in the rural areas is open to doubt.

Laboratory services at Azad State Dispensary

6.2.5 Radiological/X-ray facilities

The Mission provides for X-Ray services at all the CHCs. Out of the 14 sampled CHCs, X-ray facilities were available only at 7 CHCs. At 3 CHCs, X-ray machines were available but were out of order, and at 2 CHCs, X-ray machines were in working condition but not used due to the absence of radiographer and the required electrical facility. In one CHC, the X-ray machine remained uninstalled due to lack of electrical connection. In all the CHCs, charges for X-ray were levied as per the rates prescribed by the Government.

X-ray machine out of order at Bokolia CHC

6.2.6 Blood storage facilities and emergency services

NRHM envisages blood storage facilities at every CHC. Scrutiny however, revealed that out of 14 CHCs, blood storage facilities were available only at two[4] CHCs. The absence of the facility was due to lack of equipment and specialist. There was no blood bank in any of the CHCs test checked.

The NRHM guidelines provide for 24 hours emergency services by posting three staff nurses at PHCs for management of injuries and accidents, stabilization of patients before referral, dog / snake bite cases etc. Scrutiny however, revealed that out of 29 PHCs, only 15 PHCs were providing emergency services. The lack of emergency services was due to non-availability of staff / required facilities.

[4]Kampur and Kawaimari CHCs

6.2.7 AYUSH services

The Mission seeks to revitalise local health traditions and mainstream Ayurvedic, Yoga, Unani, Siddha and Homoeopathy (AYUSH) infrastructure, including manpower, and drugs, to strengthen the public health system at all levels including an AYUSH doctor at every PHC and by establishing AYUSH clinics at CHCs. Out of the 29 PHCs sampled, AYUSH doctor was not provided in 20, either through regular posting or through contractual appointment. This affected the aim of mainstreaming of AYUSH services as per NRHM framework.

6.2.8 Mobile Medical Units (MMU)

A mobile medical unit was to be provided in every district to enable outreach services. These are particularly relevant in hilly areas like Assam. For procurement of MMUs for all 23 districts in the State, approval was accorded by the GOI in November 2006 for Rs.16.67 crore @ Rs.72.46 lakh per MMU and the entire amount was released in 2006-07. The SHS, however, after a delay of twelve months, could procure and distribute only 10 MMUs in November 2007 to ten districts. The other constituents of those MMUs were, however, sent to the concerned districts during the period from November 2007 to February 2008. The MMUs in complete form were thus received by the districts only in February 2008.

Thus, delay in procurement of MMUs as well as idling of MMUs have affected the NRHM's aim of providing specialized health care facilities to underserved areas.

Conclusion

Basic services like in-patient services, diagnostic facilities, X-ray services etc. were not fully functional at all the CHCs and PHCs. CHCs being the first referral units did not have fully functional operation theatre, blood storage facilities, etc. Similarly, the PHCs had insufficient in-patient services, labour room etc. The diagnostic services at health centres were inadequate with the possibility of patients suffering from poor quality treatment.

Recommendation

Essential services guaranteed under the NRHM at the CHCs and PHCs need to be provided on priority. Adequate diagnostic and radiological services need to be provided at all the health centres. Operation theatres and well-equipped labour rooms should be made functional at all the stipulated centres to ensure improvement in the quality of health care delivery system in rural areas at an affordable cost.

6.3 Human Infrastructure

NRHM aims to provide adequate medical and other manpower at different health centres through filling up of the sanctioned regular posts and appointment of contractual staff on a priority basis for the delivery of healthcare services to rural population.

The status with regard to the availability of manpower at various health centres sampled, is given below:

Table: 7

Sl. No.	Particulars	Number of cases	Cases as percentage of total number audited
SUB-CENTRES (TOTAL NUMBER AUDITED 58)			
1	Sub Centres without two ANMs	30	52
2	Sub Centres without one MPW	52	90
PRIMARY HEALTH CENTRES (TOTAL NUMBER AUDITED 29)			
3	PHCs without an AYUSH Medical Officer	18	62
4	PHCs without three Staff Nurses	17	59
5	PHCs without even one Staff Nurse	1	3
6	PHCs without a Lab Technician	3	10
7	PHCs without a pharmacist	3	10
8	PHCs without a Lady Health Visitor	20	69
COMMUNITY HEALTH CENTRES (TOTAL NUMBER AUDITED 14)			
9	CHCs without a General Physician	6	43
10	CHCs without a General Surgeon	12	86
11	CHCs without an Obstetrics and Gynecologist	10	71
12	CHCs without a Paediatrician	13	93
13	CHCs without an Anaesthetist	12	86
14	CHCs without nine Staff Nurses (two of them may be ANMs)	9	64
15	CHCs without five Staff Nurses	1	7
16	CHCs without one Staff Nurse	1	7
17	CHCs without a radiologist	6	43
18	CHCs without a Pharmacist	1	7
19	CHCs without a Lab Technician	3	21

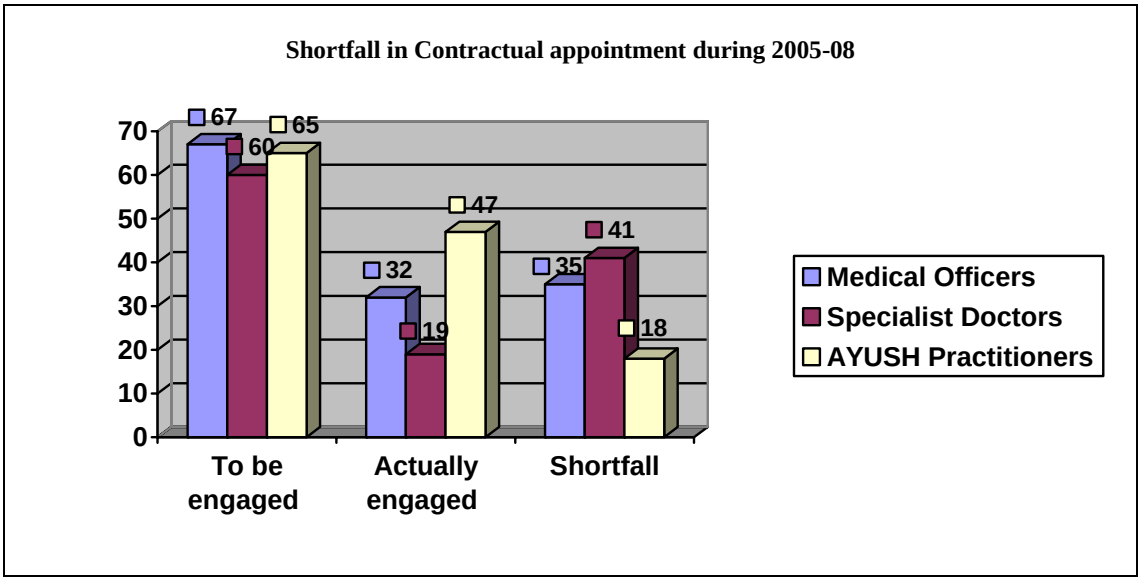
Source: - Data collected from centres test checked.

As is evident from the above table, there was a severe shortage of key health care personnel ranging from 7 to 93 *per cent.* The shortage of manpower had wide inter-health centre variations. In the absence of medical officers and specialists, especially in the CHCs, the aim of NRHM of providing adequate medical and specialist services remained unfulfilled.

6.3.1 Appointment of contractual staff

To meet the additional requirement of manpower as per NRHM norms, the implementation framework provides for engagement of medical and paramedical staff on contractual basis. Review of the status in the five sampled districts revealed shortfall in appointment in different categories vis-à-vis requirements as per norms as shown in the bar chart below:

Chart No.6



The reason for shortfall against the requirement was mainly due to the non-filling up of the regular sanctioned posts. The State Government did not indicate any specific timeframe to fill up the vacancies/posts.

6.3.1.1 Engagement of ASHA

One of the core strategies of NRHM was to promote access to improved healthcare at household level through a trained female community health worker called Accredited Social Health Activist (ASHA) to be provided in every village in the ratio of one per 1,000 people. The ASHA was expected to act as an interface between the community and the public health system. The status of engagement of ASHAs as of March 2008 is given below:

Table: 8

Name of the district selected	Total rural population (2001)	Number of ASHAs required	Number of ASHAs engaged (March 2008)	Gap Excess (+) Shortfall (-)
Sivasagar	9,54,557	955	955	Nil
Nalbari	11,21,338	1,121	693	(-) 428
Nagaon	20,36,342	2,036	2,038	(+) 2
Lakhimpur	8,23,857	824	825	(+) 1
Karbi-Anglong	7,21,381	721	813	(+) 92
Total	**56,57,475**	**5,657**	**5,324**	**(-) 333**
Total for the State	**2,32,16,288**	**23,216**	**26,235**	**(+) 3,019**

Source: - Statistical Handbook of Assam and data obtained from SHS

It would be evident from the above data that there were excess ASHAs in the State over the required number based on Census 2001 data. The excess may be attributed to lack of planning for engagement of ASHAs with reference to the rural population. Considering that there was a shortfall of 333 ASHAs in the five sampled districts despite an overall excess in the State, it is possible that the deployment of ASHAs may be skewed in various districts/villages. The Department stated that ASHAs were engaged as per the projected population. The reply of the Department is not justified as ASHAs were to be engaged

either on the basis of Census 2001 data, or as per the actual population based on latest survey.

6.3.2 Training

6.3.2.1 Shortfall in training

The NRHM envisaged capacity building of human resources through skill development of the medical and other support staff by imparting training periodically. Scrutiny revealed shortfall in imparting training as shown below:

Table: 9

Post	Target/Achievement	2005-06	2006-07	2007-08	Total
ASHA	T	NA	26,235	26,235	52,470
	A	Nil	26,225	Nil	26,225
ANM	T	5,972	NA	135	6,107
	A	4,065	NA	NA	4,065
Staff Nurse	T	1,090	NA	255	1,345
	A	291	NA	NA	291
Medical Officer	T	2,198	2,198	2,198	6,594
	A	495	24	14	533
Programme Manager	T	NA	NA	NA	NA
	A	NA	28	Nil	28
Total	**T**	**9,260**	**28,433**	**28,823**	**66,516**
	A	**4,851**	**26,277**	**14**	**31,142**

Source: - Data obtained from SHS

As can be seen from the table above, there was a shortfall of 57 *per cent* in providing training to important medical personnel/support staff. The shortfall was highest during 2007-08 (almost 99.87 *per cent*) and 48 *per cent* in 2005-06. The high shortfall is attributed to inadequate training infrastructure. In the five audited districts, it was noticed that action plan for training was not prepared by the DHS. In the absence of a plan for training, the requirement of training to various medical and support staff could not be determined. The status of training of the staff in the sampled districts is shown below:

Table: 10

Post	Total staff strength	No. of staff trained during 2007-08	Shortfall
RMP / TBA	No training conducted		
ANM	520	30	490
Public Health Nurse	No training conducted		
Staff Nurse	227	36	191
Medical Officer	23	9	14
Programme Manager	No training conducted		
Total	**770**	**75**	**695**

Source: - Data obtained from SHS

Non-achievement of targets set for training and non-determination of desirability for training through actions plans at the district level affected the human resource management under the Mission.

6.3.2.2 Training of IEC personnel

The NRHM provides for training of Information, Education and Communication (IEC) personnel at the State, district and block levels to create awareness among the masses about preventive and curative aspects of health. However, no training was imparted to IEC personnel at any level i.e. State, district and block during 2005-08. Status of IEC training imparted to other personnel like ASHA/Health Educator/Block Extension Educator during 2007-08 at only district level was quite good, as can be seen below:

Table: 11

Type of training	No. of districts	No. of personnel targeted to be trained	No. of personnel actually trained	Shortfall
BEE / HE	6	127	111	16
ASHA (with basic response to outbreak)	1	1,000	1,000	Nil

Source: - Data obtained from SHS

6.3.2.3 Training to ASHAs

The NRHM guidelines provide for training of ASHAs to equip them with necessary knowledge and skills. The guidelines provide for induction training as well as periodic trainings for skills enhancement. Scrutiny revealed that all the ASHAs in the sampled districts were provided with training in four out of the prescribed five modules as of March 2008. Required training of five modules, which was to have been completed by October 2006, was, however, not provided as of December 2008.

The shortfall in training provided to the ASHAs was due to non-preparation of plan for phasing the training modules by the SHS as well as inadequate training infrastructure. Lack of adequate training to ASHAs resulted in participation of ASHAs in health care activities in an *ad hoc* manner.

6.3.3 Involvement of NGOs

As per NRHM framework, Non-Governmental Organisations (NGOs) were to be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services and developing innovative approaches to health care delivery in underserved areas in collaboration with community organizations and PRIs. Rupees 1.53 crore, against Rs.2.43 crore released by the GOI, was released to twelve Mother Non-Governmental Organisations (MNGO) out of a total of eighteen MNGOs selected for twenty districts (as of May 2008). Of these twelve, two MNGOs in 4 districts were funded Rs.47 lakh and Rs.45 lakh each, against the admissible allotment of Rs.5 to 15 lakh per district.

Scrutiny revealed that, out of the total grants-in-aid to the tune of Rs.1.53 crore released to the MNGOs during the period 2005-08, Rs.12 lakh was utilized by the MNGOs and the remaining amount was lying with the latter as of May 2008. Although the MNGOs are required to submit UCs for the complete project before the end of the financial year, these were not submitted by them. Out of 12 MNGOs to which grants were released during 2005-08, only 1 MNGO submitted audited accounts. The unspent balance of Rs.1.41 crore

lying with the MNGOs shows that grants-in-aid was being released to the MNGOs in a routine manner without actually assessing their potential for performance.

The Department did not furnish any comments in this respect (March 2009).

Conclusion

There was a shortage of medical and other support staff at the health centres due to non-filling up of regular sanctioned posts. In the absence of the required staff at the health centres, the goal of providing reliable health care services was affected.

Due to lack of adequate infrastructure for training, the targeted training to medical and support staff could not be achieved, thereby affecting the quality of medical services through skilled manpower in tandem with new innovations in medical services.

The involvement of NGOs in building capacity in healthcare delivery system was at a primitive stage and funds were being released to MNGOs in a routine manner without assessing the actual potential.

Recommendations

- ***Vacant regular sanctioned posts of medical and paramedical staff should be filled up urgently. In addition, contractual staff should be engaged as per NRHM requirement.***
- ***Training infrastructure may be improved to cope with the requirement of training.***
- ***Necessary steps need to be taken for optimum utilization of the services of ASHAs, particularly the ASHAs appointed in excess of norms.***
- ***The State Health Society should take effective measures to involve NGOs at all levels of health care delivery system and ensure regular feedback and monitoring of activities performed by NGOs as envisaged in the NRHM framework.***