


# COMMON REVIEW MISSION REPORT

Punjab - 2010

# Punjab Review Team

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# 1. Infrastructure

- All infrastructure work managed by the Punjab Health Systems Corporation.
- Sub-center work given to panchayats.
- **Expect to complete all gaps by June 2011 at current rate of construction. Working to a plan- with an outlay of 350 crores.**
- Under WB project 332 staff Quarters were completed- at two doctor and two nurse quarters per PHC.
- **Visit shows all facilities to have good infrastructure, very clean and well maintained, with proper drainage.**
- Untied funds have contributed significantly to achieve this. In CHCs and above user fees have also been used extensively for maintenance.

## 2. Human Resources-

- 87 staff nurses added in 30 PHCs (9 of which are mini PHCs) and 10 CHCs –17 PHCs and 4 CHCs ; 2 ANMs in most sub-centers; 2 medical officers in all PHC, one of them AYUSH.
- **All peripheral facilities visited - PHCs and sub-centers have nurses and doctors as per requirement- often above the current case load.**
- District hospitals and civil hospitals have severe nursing shortage- considerably below both norms and the current case loads. 71 nurses against 430 beds in Jalandhar, (excluding trauma unit); 10 nurses for 50 bed dt hospital in Muktsar. And 7 nurses in 50 bedded Nakodar. These hospitals manage large case loads, but no of specialists, doctors, and nurses are less than required.
- Special packages needed for difficult districts- like Muktsar.

# Training

- Training center has only two support staff- but there is space.
- Training pace is slow- only 9 trained in Muktsar- 6 nurses and 3 ANMs. Better pace in Jalandhar- 15 staff nurses and 15 ANMs- but no plans this year.
- Quota- based- and major mis-match between person trained and job expectation. ANMs trained on SBA, but nurses doing deliveries. Those doing maximum delivery are not prioritised.
- Many of the nurses and ANMs met had not undergone SBA training – but even as per statement since less than 20% have been trained, they may have missed in sample.
- Wrong use of oxytocin a problem, protocols on display – but its use is limited. Protocol adaptation to 24\* 7 is needed.

# 4. Facility Development

## **Increase in case loads at all levels.**

- OPDs
  - ▣ Jalandhar: DH 300/day SDH, 500 /day, CHC 100 / 200 day PHC- 30 to 50 per day. Increasing at all levels- with a dip in year 2009.
  - ▣ Muktsar- DH -250/day, CHC 60/day; SDH- Malaut 425, CHC 60/day,
- IPDs- Jalandhar : DH- 62 admission per day. civil hospital- 56, CHC- 8/15 Muktsar- DH 50/day, SDH – CHC- 5/day
- Institutional delivery- Jalandhar: Civil – 54/month CHC 40/month; Muktsar: DH 122 month /CH 54/month/ CHC 54/month
- Large number of trauma cases at DH and CH. Thallemia clinic ++ High dengue load with apheresis, ART and ICTC and functional HIV control programme,
- AYUSH co location effectively put in place and increasing OPDs substantially.

# Drugs and Supplies:



At DH- mainly outside prescription- High Out Of Pocket Expenditure (OOPs )- internal supply very weak.

At SDH- mainly on internal supply based on user fee purchases made locally. Low OOPs.

At CHC- mainly on internal supply based on state delivery of supplies- mixed pattern- but could have substantial OOP expenditures.

Certain RCH drugs like misoprostol, magsulf not available.

Many drugs could go out of stock due to supply driven logistics- eg Copper T, doxycycline.



# Facility Development


- Equipment- seems adequate- no major gaps observed.
- Laboratory services available at all facilities as planned.
- Diet not provided in any facility at any level- even in DH
- Security reported as a major issue at the peripheri.
- Laundry services/ clean linen was adequately managed.
- Good situation in Sanitation and Hygiene at places visited. But financed by on user fee based funds.
- Biomedical waste management systems in place: training of staff could be improved.
- Signages good; Citizens charter prominently displayed.
- Separate and Clean toilets for women. Privacy was good
- No effective assured referral transport services in place. Limited use of available vehicles for transport to higher facilities.

# High collection of user fees

	Monthly collection	Staff salary	Drugs	Patients comfort	Maint. Bldg	Maint. Equipt
SDH Nakodar	1683815	74251	753862	369855	225403	145643
SDH Phillaur	831911	56311	394408	126887	125898	137052
SDH Normahal	366576	2360	199287	105479	21459	17108
CHC Kalabakara	378371	0	172166	131148	13360	36750
CHC Shahkot	416076	38260	148867	102659	33097	11500
CHC Bundala	189586	0	81832	65020	34132	13170
CHC Barapind	168831	0	57129	36059	21138	14428
CHC Kartarpur	682477	0	369405	144835	92380	41003
CHC Shankar	113546	0	55233	31481	18505	24266
CHC Lohian Khas	318905	0	169471	99022	12436	0
CHC Apra	141647	0	36380	49015	2993	21383
<b>Total</b>	<b>52,91,741</b>	<b>1,71,182</b>	<b>24,38,040</b>	<b>12,61,460</b>	<b>6,00,801</b>	<b>462303</b>

# User Fees collection and use rules

- **10% to be given to PHSC**
- **Of the remaining**
  - ▣ **45% drugs and supplies**
  - ▣ **25% on patient comforts**
  - ▣ **15% building repairs**
  - ▣ **15% equipment repair.**
- **Amounts collected are considerable- about 2 crores per year in the higher facilities and about 30 to 50 lakhs per year at the CHC level.**

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- **Exemptions given to less than 10%- and in investigations the percentages could be even lower.**
  - **This goes along with substantial OOPs on drugs- co-relate with NSSO data on Punjab having highest OOPs at the public hospital.- rural 9774- urban- 10323, pvt hospital rural 13,044 urban 19035 - % as compared to Rs 1400 national average and less than Rs 800 in Tamilnadu.**
  - **Perception is that removing such higher user fees would be welcome- but without loss of immense operational flexibility that it provides.**
  - **Current RKS grant from NRHM allows a minor flexibility for going beyond the above ceilings on maintenance work.**
  - **Total user fee collection in state over Rs 25 crores.**

## 4. Sub-centers and MMUs


- No deliveries in sub-centers – by order.
- One day per week- sometimes two days goes to immunisation session- both ANMs go for it. Number of session points not increased. In one sub-center- 3 out of 4 sessions in month was in HQ.
- Visits to home for promoting sterilisation- and accompanying them is the main other work reported. Also to manage a sterilisation complication.
- Trained in NCD in Kala Bakra but no work started on the ground.
- Sub-centers with separate building and quarters located in PHC/CHC premises.
- MMUs- 4 units in Muksar, one supported by NRHM and three by Ranbaxy.

## 5. ASHAs

- ASHAs available in all villages/ facilities visited.
- Less than needed for full coverage (80 ASHAs to 1.04 lakh population did not match with fact that in the FGD most ASHAs were seeing a limited 600 to 800 level of population. Are there significant areas with no ASHA? Are we missing out on the small urban township. Especially the below one lakh town should have ASHAs under NRHM.)
- ASHAs functional on promotion of institutional delivery and immunization- and have knowledge related to this. ASHAs not functional on any area of nutrition or on an childhood illness management- ORS supply weak. Payments received Rs 200 for promotion and 350 for accompanying- but number of cases not substantial.
- Major issue- are they missing those with home deliveries- since there is no incentive available for the same- even recognition of marginalisation is an issue.
- Training completed in 1 to 4- not in 5 , planning IYCF, not having any understanding on 6 and 7. No support system in place- but regular monthly meetings help.
- Attrition in Jalandhar less than 2%, but 15% in Muktsar. And then re training plan is weak.

## 6. RCH

- Persistent home deliveries are an issue – about 30 to 40%. Reasons for this ill understood and ill studied.
- High private sector case load- in Jalandhar.
- The notion of sector level review is missing. The mini PHCs and subsidiary health centers each supervise 2 sub-centers and report to block PHC- but they supervise only the services provided at the facility. The health of the population is not supervised. So there is no knowledge at this level of the home deliveries and those who did not come for services.
- ASHAs also constrict their services to those who are likely to become institutional delivery? Is it high cost or is it social barriers to access, or is poor mobilisation that prevents one thirds of patients from seeking any health care.
- One thirds- goes to public , one third to private and one thirds stays at home – despite availability of public services – Why?

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- Nine FRUs – functional in Jalandhar but blood is a huge bottleneck- only available in DH- no storage also elsewhere. But blood on demand supplied from 2 blood banks at SDH and DH. Only one blood bank in Muktsar.
  - Facility based child care has just not arrived- training, facility development – any dimension. Newborn corners present at all levels.
  - Management of complications in both pregnancy and newborn weak, except in DH. Specialists concentration needed at DH. Distributed too thin across 7 CHCs & SDH.



## 7.Nutrition:



- No NRCs existing or planned.
- AWCs giving supplemental food to those as per guidelines.
- No health checks up for 0 to 6.
- Medicine kits- but not aware of using it- and drugs still in the kit.
- SAM identification and referral not taking place.
- New WHO standards not available at any facility visited.

## 8. Disease control

- Case detection rate good at Muktsar, poor at Jalandhar- main problem seems to be inadequate chest symptomatics examined, both from public sector and from private sector.
- Dengue – advanced management available at Jalandhar .
- MDR programme not started.
- HIV facility with ART: well functional on all parameters at DH Jalandhar- ICTC functional in Muktsar.
- Typhoid and hepatitis and measles reported on IDSP- but there is no public health response and no protocols in place or awareness of the same.

# 9. Programme Management.

- Contractual staff in position. Programme officers also aware of the programme. Hospital administrator in DH
- DPMU does not exist with distinct identity- absorbed into CHMO office. Seamless integration is a strength if the new tasks are also managed adequately eg planning, logistics etc.
- RKS meetings – about once in a quarter. Composition has PRI, professionals and NGOs. Minutes maintained. Only the NRHM RKS grant is brought under this purview.

## 9 . Programme Management

- ANM reporting on mobiles – both daily and monthly is a major advance. Use of daily data is questionable and it is causing tensions out of proportion to any possible benefits. Monthly data adequate if well utilised.
- Considerable lack of clarity on pregnancy tracking- and no systems in place yet.
- Primary registers incomplete on many data elements – would make reporting inaccurate.
- Private sector accreditation weak. Only few facilities linked up to, though large number of private facilities are providing RCH services including delivery.

# 10 Financial Management



- ❑ No director- F&A- at state level. But state finance and accounts manager in place.
- ❑ Transfers of funds upto district by e-transfers and below this by cheque. District accounts staff in place.
- ❑ Untied fund utilisation – used for maintenance and minor repairs- not available for other needs. Better in Jalandhar.
- ❑ Over- all absorption of funds weak. Mainly due to poor guidelines and low areas of expenditure slowing down the whole.

# 1 1. Decentralisation

- District Plans of both districts – good in objectives, indicators, and strategies.
- Poor link between physical and financial achievements and between physical achievements and expected outcomes. Clear facility identification and moving resources – as per case loads and needs would help.
- Use of HMIS and IDSP data for district planning not in use.
- Budgets to district not flowing as per plan – but on line items .
- Community Monitoring not in place.

# Recommendations:

1. Creating more posts and recruiting more doctors in facilities which are providing high volume of care.
2. Clearer work allocation for both ANMs
3. There is need to develop demand driven drug supply in the state or develop local channel to met the demand of drugs at lower facility level.
4. State should plan for provision of diet supply to the patient.
5. State should plan to develop a programme for NCDs.
6. Quality Management systems which record patient satisfaction levels, and which ensure basic processes of quality and effectiveness of care should be put in place.
7. User fees to be re-examined in view of high degree of exclusion seen. Would need differential financing to compensate the losses of withdrawing user fees-

# Recommendations

8. High level of home deliveries needs to be studies and addressed .
9. Bring in a special sensitization programme on marginalization- so that ASHAs reach out to the most dispossessed categories
10. Health check-up of children (0-6 years) at least once in 6 months need to be institutionalized and mechanism development. Orientation of AWWs on use of Medicine Kit.
11. Need to initiate on scale the development of facility based newborn and child health care.
12. Home based new born care services needed to reach out to stagnant neonatal mortality over the entire decade. Emphasis to the roll out of module 6 and 7.
13. Special focus on technical protocols of labor rooms, make them more appropriate and effective and support with necessary drugs and supervision.
14. In-service training, particularly skill based training like LSAS, EMOC, SBA, IMNCI, NSSK needs immediate implementation with quality protocols
15. Improve response to disease outbreaks in IDSP and also in analysis and use of IDSP sourced information for public health programmes.



# Recommendations on Improving Management:

- 16. Greater use of HMIS data for state and district level management purposes.
- 17. Improve financing of facilities and districts to make it more responsive to case loads.
- 18. Stabilise and build up the SHSRC.
- 19. Develop a larger faculty team and make the SIHFW empowered and accountable to lead the entire skill training programmes of ANMs, nurses, and doctors in the system.
- 20. Build up an ASHA resource center to manage both the ASHA and the VHSC programmes together.



**Thank You**