NATIONAL RURAL HEALTH MISSION

4th Common Review Mission

(15th December – 23rd December 2010)

Chandigarh

Ministry of Health & Family Welfare
Government of India

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LIST OF ABBREVIATIONS

ANM	Auxiliary Nurse Midwife
AWW	Anganwadi Worker
AWC	Anganwadi Center
BEMONC	Comprehensive Emergency Obstetric & Neonatal Care
CD	Clinical Dispensary
CEMONC	Comprehensive Emergency Obstetric & Neonatal Care
CGHS	Central Government Health Scheme
CHC	Community Health Center
CRM	Common Review Mission
DHS	District Health Society
DLHS	District Level Household Survey
HR	Human Resource
GMSH	Government Multi-Speciality Hospital
GMCH	Government Medical College and Hospital
LHV	Lady Health Visitor
LSAS	Life Saving Anesthesia Skills
MCR	Micro Cellular Rubber
MO	Medical Officer
NCDP	Non Communicable Disease Programme
NFHS	National Family Health Survey
NLEP	National Leprosy Eradication Programme
NPCB	National Programme for Control of Blindness
PGIMER	Post Graduate Institute of Medical Sciences and Research
PHD	Public Health Department
PIP	Programme Implementation Plan
PRI	Panchayati Raj Institute
RHTC	Rural Health Training Center
RNTCP	Revised National Tuberculosis Control Programme
SACS	State AIDS Control Society
SC	Sub Center
UT	Union Territory

CHAPTER 1. TITLE

List of Places Visited during the CRM with Officials at the site

4th Common Review Mission				
17th December 2010 to 23rd December 2010				
Name of the Union Territory		**Chandigarh**		
Name of the Districts Visited				
S.No.	**Name**	**District HQ**	**Name of DM**	**Name of CMO**
1	Chandigarh	Government Multispeciality Hospital, Sec-16		Dr. M P Vadhera
Health Facilities Visited				
S.NO	**Name**	**Address/Location**	**Level (SC/PHC/CHC/Other)**	**Name of Person In Charge**
1	Sec-22	Sec-22	CHC	Dr. Rajinder Sharma
2	Mani Majra	Mani Majra	CHC	Dr. V. Gagneja
3	Sector-19	Sector-19	CD	Dr. Paramjyoti
4	Phase-2	Phase-2	CD	Dr Ranjana
5	Maloya	Maloya	SC cum CD	Dr. Anshu Shashi
6	Sarangpur	Sarangpur	SC	Ms Khushwant Kaur
7	Khuda Lahora	Khuda Lahora	SC	Ms Jasmeet Kaur
8	Kaimbwala	Kaimbwala	Rural dispensary	Dr. Shweta, MOIC, Ms Sukhvinder Kaur (ANM)
9	Colony-4	Colony-4	AWC	Mrs Meena
10	Mauli Jagran	Mauli Jagran	AWC	Ms Tara Devi

CHAPTER 2: INTRODUCTION TO CHANDIGARH

Geographical Profile

Chandigarh is the first well planned modern city of India designed by the French Architect Le Corbusier. Chandigarh and the area surrounding it were constituted as a Union Territory on 1st November, 1966. It serves as the joint capital of both, Punjab and Haryana States. It is bounded on the North and West by Punjab and East and South by Haryana. Total area of the Union Territory is 114 Sq. Km.

Chandigarh is situated at the foot of the Shivalik range. There is hardly any forest in this Union Territory, except for small tracks of forest developed by acquiring some area on lease from Punjab and Haryana States. There is about 2542 hectares of forest area in Kansal (Leased from Punjab) and Nepali (Leased from Haryana) forest and some area in Raipur Khurd village of Chandigarh Union Territory. Forest Department is also maintaining a Deer Park in Kansal forest and a nursery near Hallo Majra village. Forest Department is also taking adequate steps to promote wild life in Kansal forest and is likely to be converted into a tourist spot. The city was named after the mother goddess of power, Chandi, whose temple Chandimandu is a feature of the new city. Le-Corbusier was assisted by his cousin, Pieree Jeanneret and the English couple E.Mazwell Fry and Jane B. Druel. These three architects are responsible for most of the public and residential buildings raised in Chandigarh between 1950 and 1965. The beautiful city also known as **'city of roses'**, was planned to house the capital to the erstwhile Punjab State. The partition of Punjab, on linguistic basis, the present Union Territory was formed which in addition to the city of Chandigarh included Mani Majra town and some villages of Kharar Tehsil of Ambala District. It is a city which is declared as **Best City** in the country by **ORG-AC Nielson** in the field of health, water sanitation, greenery and water supply.

Chandigarh is considered as one district administratively. It is divided in 3 Sub-divisions namely Central, East and South. A Sub Divisional Magistrate (SDM) heads each Sub-division. This city has a Municipal Corporation with 21 wards. A Mayor heads Municipal Corporation with 3 Deputy Mayors assisting him/her. Each Municipal Corporation ward has an elected representative called Councilor. Municipal Corporation has the post of Medical Officer of Health who looks after public health and environmental sanitation in the city. Urban slums are also under Municipal Corporation. Each slum has a President representing different political parties. Chandigarh has 22 villages (13 around the city and 9 villages are under the municipal limit of Chandigarh). There are 18 colonies in the city. The State has population density of 7,900 per sq. km. (as against the National average of 312). The decadal growth rate of the state is 40.28% (against 21.54% for the country).

Demographic and Socio Economic Profile

The population of Chandigarh is 9,00,635 (Census 2001), out of this 60% resides in the urban areas, 30% in urban slums and 10% in rural areas. Chandigarh has a decadal growth rate of

40.28% (Census 2001). According to Census 2001, there are 56.3% males and rest are females. UT's sex ratio of 773 is a very surprising figure for a city, which has been declared best in terms of health indicators. Overall literacy rate is 82%. Males are more literate (85.65%) as compared to females (76.65%).

Table I. Showing Population of Chandigarh

	2010 Projected*	**2009***	**Census 2001**
Total Population	13,68,000	12,97,000	9,00,635
Urban (including slum)	12,31,200	11,67,000	8,08,515
Rural	1,36,800	1,29,700	92,120
Slum	4,10,400	3,89,100	1,07,125

Source: *www.censusindia.gov.in/Census.../Projected Population/Projected population

Table II. Showing Socio-demographic Profile of Chandigarh

Parameters	**Figures**	
Population	**Female**	**Male**
Urban	358393 (91%)	450122 (88.8%)
Rural	35304 (9%)	56816 (11.2%)
Total population	393697 (43.7%)	506938 (56.3%)
Area (in sq. Km.)	114	
Decadal Population growth	+ 40.33%	
Overall Literacy Rate (%)	81.8	
Literacy Rate (%) among Males	85.6	
Literacy Rate (%) among Females	76.6	
Sex Ratio (Census 2001)	777	
Sex Ratio(0-6yrs)*	882	
Population below Poverty line (%)	5.75	
Schedule Caste population (in million)	0.16	
Schedule Tribe population (in million)	0	

Health Profile

There is one Government Multispeciality Hospital, 1 General Medical College and Hospital , PGIMER, 2 CHCs, 1 Poly Clinic, 46 Civil Dispensaries and 16 SCs cater to the health needs of people residing in Chandigarh. Even Chandigarh caters to the health needs of the people residing in the adjoining districts of Ambala and Punjab as well.

Map of Chandigarh Showing Health facilities.

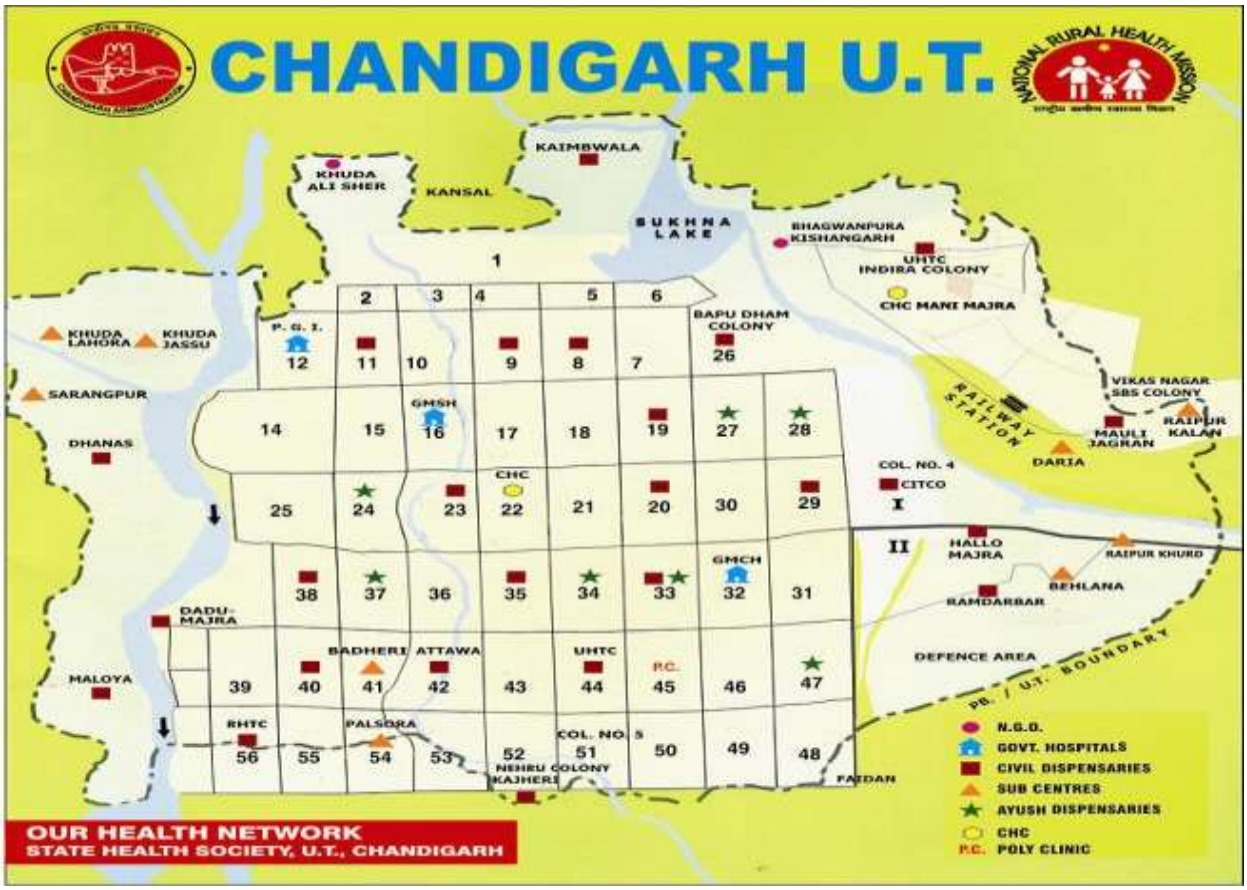

Table III. No of Health Facilities in Chandigarh

Health Institution	Number
Medical College	2
District Hospitals (General Medical Hospital)	1
Community Health Centre	2
Polyclinics	1
Civil Dispensary	46
Sub Centre	16
Ayurvedic Hospitals	1
Ayurvedic Dispensaries	6
Homeopathic Hospitals	1
Homeopathic Dispensary	5
Other private Hospitals/Nursing Homes	-

The health indicators of Chandigarh which are compared with the national figures are provided below in Table IV. Crude Birth Rate of Chandigarh is 16.4 percent while in India its 22.8 percent. Crude Death Rate is 4.4, Infant Mortality Rate is 28 against the National figure of 53. Full immunization coverage is still not ensured since its only 73 in a UT, institutional delivery in Chandigarh is 74 percent only.

Table IV. Health indicators of Chandigarh

S. No.	**Item**	**Chandigarh**	**India**
1	Crude Birth Rate (SRS 2009)	16.4	22.8
2	Crude Death Rate (SRS 2009)	4.4	7.4
3	Total Fertility Rate (SRS 2009)	NA	2.6
4	Infant Mortality Rate (SRS 2009)	28	53
5	Maternal Mortality Ratio (SRS 2004 - 2006)	NA	254
6	Full Immunization (%) DLHS-3	73.0	54.1
7	Institutional Delivery (%) DLHS-3	74.0	47.0
8	Safe Delivery (%) DLHS-3	78.5	52.6
9	Total Unmet Need (%) DLHS-3	8.3	21.5
10	Health contribution to total GDP for the year 2008-09	1.72 %	

Human Resource

Human resource is a constraint for almost all the states and Chandigarh is no more untouched with this constraint. Due to lack of proper referral mechanism, load on the facilities is more and hence there is shortage of manpower in the facilities.

CHAPTER 3. FINDINGS OF THE 4TH COMMON REVIEW MISSION IN CHANDIGARH

Part I: The findings on 11 items as per the Terms of Reference

1. Changes in key aspects of Health Delivery System

a. Infrastructure Up-gradation

There is no Infrastructure Development Wing in the UT of Chandigarh. No new construction has been undertaken under NRHM. However, UT of Chandigarh has undertaken some renovation / upgradation projects viz., upgradation of CHC in Sector 22 for 24x7 emergency services; upgradation of a Polyclinic Centre as CHC, construction of State Health System & Resource Centre (SHSRC), a warehouse and construction of additional block of Civil Dispensary (CD) at Industrial area-CITCO to upgrade it to the level of PHC as per IPHS norms. The construction is still going on. In order to avoid delays in construction there should be time line for completion of the construction work.

Upgradation of CHC Manimajra, through State funding, by way of raising its bed capacity from 50 to 100, is being undertaken. Construction of a 100 bedded Maternity Hospital is also proposed at Maloya through State budget.

Construction work for upgradation of a Polyclinic Centre as CHC could not be taken up as some portion of the Polyclinic is occupied by CGHS. Construction of 2 Sub-centers as approved under PIP for FY 2010-11 could not be completed due to land constraints.

Chandigarh is a small territory spread over a radius of 8 kms. The need for residential accommodation to the health personnel in a facility is not much sought for and where available are in poor state. However, some of the facilities like CHC-Manimajra do have a provision for the Medical Officer as well as support staff.

(See Annexure 1)

b. Human Resources Planning

i. Availability of Human Resources & Gap analysis:

As per inputs / information made available to the team, there is not much shortage of staff vis-à-vis sanctioned strength in CHCs. However, it may be mentioned these posts were sanctioned way back, and having regard to substantial increase in work load due to increased population and new facilities proposed to be provided at CHCs, sanctioned strength of CHCs need to be increased. The upgradation of CHC-22 for making operational on 24X7 basis, outsourcing of Specialists would be required.

ii. Pre-service Training capacity:

There is no training institute as such in Chandigarh UT. Under RCH-II, trainings are given in the auditorium of District Family Welfare Office, mostly by resource persons from Health Deptt., PGIMER / GMC / Private Practitioners and staff. Course material for training is updated from time to time. The Team had interacted with ANMs in Sub-centre at Khudha – Lahora, and Rural Dispensary (RD) at Kaimbwara, It was observed that ANMs are well-versed with work assigned to them. They are doing their work in accordance with the trainings provided to them.

It is learnt that there are constrains in sparing Medical Officers for providing trainings of longer period due to work load.

iii. Recruitment and Cadre Management:

Mostly, medical officers on deputation from Punjab and Haryana manage health services of UT Chandigarh. There are 14 Medical Officers of UT cadre. No new positions have been filled for over a decade in the UT cadre. There are 85 ANMs, 22 MPHWs, 9 LHVs, 3 Consultants, 1 Data Entry Operator, 10 Lab Technicians, 1 Office Assistant, Ward Attendant, Computer Assistant and Statistical Assistant each hired on contractual basis from NRHM funding. These personnel have been hired on contract against the sanctioned posts.

Recruitment of contractual staff is done through written test (if numbers of applicants are more than 100 for 2-3 posts) and interview by a board headed by Mission Director, with Nodal Officer of NRHM , Programme Officer-RCH, and head of the concerned programme, as members. Contractual staffs are paid consolidated salary from NRHM funding.

iv. Plan for Augmentation of Health Human Resources:

The UT has initiated process for hiring Specialists on contract basis. Despite salary of Rs.65, 000 offered for the position, there were no applicants for the post. UT is contemplating higher salaries, if approved in the PIP for 2011-12. To meet the shortage of Specialists, the UT has empanelled some Specialists to be paid on the basis of visit. Some ANMs have been hired on contractual basis.

v. Skill quality of Health Human Resources:

Training to Medical officers and other staff, is given as per annual Comprehensive Training Plan (CTP). Types of training include knowledge and skill based trainings, on job-trainings, induction trainings, in-service trainings and update trainings. Trainings are linked to functionality of the health centers through relevant postings, logistic supply etc. Under RCH-II - Trainings to Trainers (TOTs), 52 personnel were trained. 260 medical officers including 12 SMOs, 638 ANMs, 92 school teachers and 257 AWW have been trained under RCH-II.

None of the Doctors have been trained in LSAS, CEMONC, , BEMONC and IMNCI.

The postings of the MOs is not on need basis rather is based on rotational policy basis. There is no apparent supervisory mechanism to oversee the work of LHVs and ANMs subsequent to trainings.

c. Health Care Service Delivery – Facility Based - Quantity and Quality.

i. Progress since Implementation of NRHM in Chandigarh (2008-09 to Oct. 2010-11)

There has been an increase in ANC, institutional deliveries, use of family planning methods and immunization after the implementation of NRHM in the state in the year 2008-09 ***(See Annexure 2)***. In Chandigarh number of patients treated at AYUSH centres also reflects and increasing trend since 2008-09 ***(See Annexure 3)***.

At both the visited CHCs, the CHC sector 22 and CHC Manimajra, there has been increase in ANC over the years that reflect improvement in health care service delivery. However, at CHC Manimajra the number of deliveries conducted is less than its capacity as most of the pregnant women goes to nearby hospital in Panchkula (Haryana). ***(See Annexure 4)***

ii. AYUSH

AYUSH department in Chandigarh is providing preventive, promotive and curative healthcare to the community. In Chandigarh six Ayurvedic and six Homeopathic Centers are functioning under Directorate of AYUSH. Each of these centres is accompanied with a dispensary or CHC.

CRM visited two AYUSH Centres, one Homeopathic and one Ayurvedic Centre located at each of the two CHCs- CHC Sector 22 and CHC Manimajra.

Both Ayurvedic and Homeopathic Centers are run by a Medical Officer and Pharmacist who work on contractual basis. In each of the centre patients ranging 60-70 are treated every day. Maintaining AYUSH centers not only share the patient load of the allopathic health facilities but they are also preserving the practice of indigenous system of medicine which is heading slowly towards the verge of extinction. Increasing patient load on the centres indicates their growing popularity among the community.

iii. Use of JSY

Use of JSY is a cause of concern. Chandigarh having a population of nearly 4 lakh slum dwellers needs to promote the JSY incentives to increase institutional deliveries in slum population. On account of not having BPL cards the benefits of JSY are not reaching to the needy. In some of the cases MO's by their own discretion proved the eligibility of the poor women as BPL and allowed them to get JSY benefits. However, auditors have made objections on such decision which as informed has been resolved. However, the MOs restrain themselves from certifying the poor eligibility status and JSY benefits thus are not reaching to the needy.

iv. Details of the number of beds and services provided

Each of the two CHCs (CHC sector 22 and CHC Manimazra) are 30 bedded hospital, providing services of OPD, counseling for HIV/AIDS, eye care, orthopedics, radiology, heart care, normal deliveries, cesarean deliveries and diagnostic tests. The complicated cases are referred to the hospital at General Hospital at Sector 16. Services of abortions and family planning, particularly, supplies of OC pills, EC pills, condoms, IUDs, sterilization are also provided during PNC and OPD. For the diagnostic tests facility of laboratories are available. RTI/STI treatment services are not provided at both the visited CHCs as posts of the dermatologist is vacant.

v. Availability of Human resource

At General Hospital Sector 16, and the visited CHCs the availability of adequate human resource is a major constraint. Trained ANMs and Gynecologists are available at the centres. However at sector 22 CHC there are only three Gynecologists who are not able to attend the increasing deliveries load. At CHC 22 following posts are vacant- 2 Physicians, one Eye Surgeon, 1 General Duty Medical Officer, 1Ppharmacist, one OT attendant and one OPD attendant. At CHC Manimajra also many of the post are vacant. In order to function the CHCs as 24X7 hospital more manpower is required. Ensuring availability of the required human resources will immensely help health facilities working at optimal efficiency as all other infrastructure and resources are in place.

Safety and Security of women staff needs to be reviewed.

Quarters for the doctors are available at the premises of the CHCs but doctors do not stay there, in sector 22 CHC they have not been sanctioned to the doctors and in Manimajra the doctors have their residences in nearby areas and thus do not stay in the CHC premises. ANMs stay in the CHC premises and are stationed at the facility. Retiring rooms for night duty lady medical officers and staff nurses are available at the CHCs.

(See Annexure 5,6,7,8 & 9)

vi. Availability of Infrastructure at visited CHCs

Following Infrastructure is available at the visited CHCs:

Operation Theater: OT Table, OT light, Air conditioners, Autoclave, Equipments for Caesarean Section, Laparoscopes, Oxygen supply.

Labour room: Labour table with McIntosh sheet, suction machine, autoclave stabilizer, 24 hour running water supply, attached toilets in the labour room, emergency drugs, oxygen cylinder with face mask, wrench and regulator, normal delivery kit, surgical set of episiotomy, gloves, sterilized cotton gauze, sterilize syringes, sterile dip sets, IV infusion are available.

Facilities of family planning and immunization are available at both the facilities.

At sector 22 CHC the newborn care unit, generator, and blood storage facility is not available. Providing these services will help smooth carrying out of the emergency services.

vii. Functioning of Labs

At both the visited CHCs lab facilities are available and they are reasonably being used. Most of the required diagnostic tests are conducted at these facilities at the reasonable charges. The rate list for the diagnostic test was not displayed at these centers. Prominent display of the rate lists would help maintain transparency. Safety measures for the lab technicians and radiologists are in place.

viii. Quality of MCH services

Labour rooms and operation theaters are available for normal deliveries and C-sections. The OT and labour rooms are maintained at the general hospital as well as CHCs. The labour rooms have arrangements of room heating and sterilizing the instrument and other items. After delivery the women stay only for 24 hrs at the CHC whereas they should stay compulsorily at the hospital for at least 48 hrs.

At CHC 22 owing to vacant post of pediatrician the neonatal unit is dysfunctional. Lack of availability of generator further limits the use of emergency, neonatal and other services. Moreover, the services at General Hospital and CHCs are below the accreditation norms.

ix. Usage and Procurement of drugs

At general hospital the drugs are procured as per the GFR provisions. Most of the basic drugs are provided free of cost but costly medicines such as antibiotics are purchased by the patients from the markets. For poor patients there is a provision of providing medicines free of charge through RKS fund. However, owing to lack of availability of BPL cards and lack of norms for identifying the poor patients the provision of providing drugs free of costs appears to be grossly under used.

All essential drugs are available and there has not been observed any shortage of the drug or vaccine supply at the CHC or Sub centres. To reduce the outpatient expenditure the drugs are provided free of cost. At CHC Manimajra, the RKS members have negotiated with a private medical store to provide medicines (which are not available in government supply) to the patients at subsidized rates.

However, standard treatment guidelines are not available at any of the visited CHC and sub centre. Efforts should be made to know and adhere to these guidelines.

x. Support services

Food is provided to the in-patients at the hospital at the subsidized cost. However, the food is not cooked at the CHCs it is brought from the nearby General Hospital where kitchens are run by the hospital's regular staff.

Waiting area for the patients is clean and seems adequate. At the time of OPD at CHC 22 there is overcrowding in the waiting space. Therefore efforts should be made to expand the waiting area or locating some of the OPDs, such as, AYUSH centres to some other place to disperse the crowd.

Signages are available which help patients to know about the available facilities. A board displaying the available facilities was put in place at the Sub centres, but it needs to be put at prominent place at the CHCs.

Availability of separate toilets for men and women

Separate toilets are available for both men and women, in some of the cases their maintenance needs to be further improved.

Cleanliness and hygiene

Services of cleaning the premises at CHCs have been outsourced to maintain better control on the services. The premises at CHC and visited Sub-centers were clean. There are arrangements of disposal of biomedical waste and sanitation. The infectious biomedical waste is collected from CHCs and disposed off at the General Hospital where biomedical waste disposal system is installed.

Availability of emergency referral transport

The General Hospital and each of the visited CHC has ambulances for the emergency referral. The people need to call them at the given numbers and immediately the ambulances are sent to bring the patients. However, at the general hospital more drivers are required to operate all the ambulances round the clock.

Maintenance of the equipments

For maintaining the equipments annual maintenance contracts have been given to the external agencies that take care of the equipments.

Display of Citizens charter and User charges

Citizens'/ Patients' charters, displaying the rights of the patients and availability of services, need to be displayed at the general hospital, CHCs and sub centres. This helps in making the facilities accountable to the community.

Rates charged for each of the services provided by the hospital also need to be displayed at each of the unit. The user charges from the CHCs are sent to the directorate, however, as per the NRHM provisions the amount of user charges can be kept at the facilities and may be used for its improvement.

Grievance redressal mechanism

Grievance redressal mechanism also needs to be put in place with the person name and contact number who could be contacted in case of a compliant.

In order to avoid the bias in decisions a grievance redressal committee can also be formed. Sexual harassment prevention mechanism also needs to be put in place.

xi. Formation of Rogi Kalyan Samiti (RKS)

The General Hospital and each of the CHCs has formed the RKS. At General Hospital the RKS has been constituted under the chairmanship of the Deputy Commissioner of UT Chandigarh. The other members of RKS include mayor of city, medical officers and prominent citizen. The RKS of general hospital meets regularly at each quarter. The funds of RKs are used for the purchase of benches, patient trolleys, appointment of part time radiologist, putting in signage, water purifiers and so on.

In the RKS at CHCs, SDM of the area has been designated as the Chairman and SMO as the member secretary. The members have been selected from the community, however, representation from the marginalized sections of the society is lacking. In the meetings members of the community rarely participate. The funds allocated to the RKS have been highly helpful to the CHCs, in Manimajra. Through RKS funds water coolers for drinking water to the patients have been installed and generator of the CHC has been repaired.

The RKS needs to be further strengthened by increasing active participation of civil society groups. In order to realize the RKS's purpose of increasing the involvement of the communities in decision making and bringing-in the ownership of the communities in the hospital matters, they need to be strengthened and nurtured by sensitising their members and making the RKS true representative of all sections of the community.

xii. Project foundation

It is an innovative program of Chandigarh health department under which each program adopts each of the village for two months which helps carrying out survey of each of the villages for a particular disease and its treatment over a period in phased manner.

d. Outreach Services

Outreach services are provided through Sub-centres, medical mobile units and by ANMs in their areas. Below is a brief description of the outreach services.

i. Sub Centres

There are 16 Sub centres in Chandigarh; some of the SCs are merged with Civil Dispensaries. Deliveries are not conducted at the sub centre, the cases are referred either

to the CHC or General Medical Hospital, and some of the cases are sent to the PGI, Hospital.

Maloya Sub center cum Civil Dispensary:
Sub center Maloya caters to the Population of 22514. 17134 people in the colony and 5580 resides in the village. This sub center is in the Panchayat building. There is 1 Medical officer, 3 ANMs (one is regular and other two are contractual), 1 MPW, 1 trained dai, 1 ward servant and 1 sweeper. Deliveries are not conducted at the SC. General OPD services are provided at the center, including ANC check up, Immunization and Family planning (FP) services (like Copper T insertions, Condoms and Contraceptive pills) are provided to the residents. Pregnant females are provided IFA tablets and vitamin supplements. According to the ANM they have not got any fund since 2008-09, they have a balance of Rs.1087/-. Outreach programmes include Post natal care, family planning and immunization. VHNDs are conducted on last Friday of every month.

Sub Center, Sarangpur
There is one ANM in the Sub centre; she provides services like ANC, PNC, and immunization and for other minor medical ailments like fever, cough, diarrhea etc. She refers people to the GMH-16 or RHTC. People of the community provide full support to the ANM; they have provided their public library for the set up of SC.

Sub centre Khuda Lahora
There are two ANMs at the Khuda Lahora sub centre. As regard the VHSC meetings; they are held at the MOs office and hence the minutes are not available at the centre or with the VHSC members, some of whom were met by the CRM Team at the Sub centre.

Outreach camps by ANMs
ANMs conduct outreach camps in slums and villages at every month to provide immunization services, and identify pregnant women for ANC checkups. The outreach camps are organized at anganwadi centres in coordination with the AWWs.

ii. Mobile Medical Units (MMUs)
Two mobile medical units, run by NGOs, are used for providing OPD services in the rural peripheral areas and slum clusters. In each unit two medical officers (including one lady medical officer), 1 staff nurse, 1 pharmacists provide the services. These units work 5 days in a week in two shifts. One of the units works in two shifts from 9.00 AM to 12.00 PM and 12.00PM to 3.00 PM.

Two MMUs were visited at the locations: 1) in Vikasnagar resettled colony and 2) Colony No. 5.

During the visits it was observed that the functioning of MMUs can be further improved by changing their timings to morning and evening for making them suitable to the

working population. Modified timings can help increasing accessibility of the poor to these services as they can avail the services without losing their wages. Immunization services can also be provided from these medical units. This will help the communities which are distantly located from the sub centers.

iii. Immunisation

Union Territory, Chandigarh is now eligible for introducing Hepatitis 'B' and introducing Measles II vaccination.

In evaluation done in 2006 and 2009, % of fully immunized children increased from 51.6% to 65.3% however measles immunization dropped from 75.4% to 68.3%.

Table V. Status of immunization coverage in 12-23 months children in Chandigarh

Indicators	**Baseline -2006 (%)**	**Midline-2009(%)**
BCG	92	93.2
DPT/Polio (3 doses)	82	88.2
Measles	76.4	68.3
DPT booster and OPV Booster	58.4	65.3
Overall dropout rate between measles and BCG	16.9	22.9
% of fully immunized children at 1 year of age	**51.6**	**65.3**
Children not received any vaccination	**-**	**2.7**

There is 28.7% increase in number of fully immunized children in slums; still slums have the lowest immunization coverage in the UT at 58.7%, with rural areas not far better at 61%. There is a big urban-rural/slums disparity with urban complete immunization coverage at 75.5%. There is high dropout rate in rural and slum areas (32.4% and 29.3% respectively). The coverage evaluation indicates that the dropout and incomplete immunization may not be totally attributed to population in transit or migration. Efforts should be intensified to ensure complete immunization in slums and rural areas which comprises about 40% of the total population of the UT.

Table VI. Immunization status of children 12-23 month-Area wise

Indicators	**Total (%)**		**Urban (%)**		**Rural (%)**		**Slum (%)**	
	2009**	**2006***	**2009****	**2006***	**2009****	**2006***	**2009****	**2006***
Immunization status of children 12-23 month								
Fully immunized	65.3	51.6	75.5	74	61	62.5	58.7	30
Unimmunized	**2.7**	**8**	**1.9**	**2**	0	0	**4**	**16**
BCG vaccination	93.2	91.7	94.4	100	94.4	100	92	82.1
3 doses of DPT	84.4	82	87	100	88.9	93.4	81.3	57
3 doses of OPV	84.4	82	87	100	88.9	93.4	81.3	57

Measles	68	76.4	77.8	100	62	86.7	62.7	46.4
At least one dose of vitamin A supplementation	64.6	36.6	74.1	61.8	55.6	45.3	60	13.6

**Midline RCH survey *Baseline RCH survey

Table VII. Area wise immunization coverage in 12-23 months old children (Midline 2009)

Indicators	**Urban N(%)**	**Rural N (%)**	**Slum N(%)**	**Total N (%)**
Total no. of under five children	176	70	235	481
Vaccine coverage/ Immunization status(12-23 months)				
Number of 12-23 months old	54 (36.7)	18 (12.2)	75 (51)	147
Presence of Immunization card among children	44(81.5)	16(88.9)	59(78.7)	119(81)
B.C.G.	51(94.4)	17(94.4)	169(92)	137(93.2)
D.P.T. & OPV 1st	50(92.6)	18(100)	67(89.3)	135(91.8)
D.P.T. & OPV 2nd	48(88.9)	17(94.4)	165(86.7)	130(88.4)
D.P.T. & OPV 3rd	47(87)	16(88.9)	61(81.3)	124(84.4)
Measles	45(77.8)	12(62)	48(62.7)	105(68)
% of children fully immunized at one year of age	42(75.5)	11(61)	47(58.7)	100(65.3)
% of children partially immunized at one year of age	53(98.1)	18(100)	72(96)	143(97.3)
% of children with no vaccination at all at one year of age	1(1.9)	0(0)	3(4)	4(2.7)
D.P.T. & OPV Booster	41(75.9)	10(55.6)	45(60)	96(65.3)
Vitamin-A at 9 mo	40(74.1)	10(55.6)	45(60)	95(64.6)
Vitamin-A at 15 to 18 months	21(38.9)	6(33.3)	16(21.3)	43(29.3)

e. ASHA Programme

The UT of Chandigarh has sought and received approvals for using AWWs as the link workers for the NRHM program. There is a plan to train the AWWs of the UT as per the prescribed ASHA modules. 1st batch of trainings of the AWWs with first 3 modules of the ASHA training began on 21st December with trainers from PGI Chandigarh.

f. RCH II

i. Status of name-based tracking of pregnant women and children

Name based tracking is not fully operational in the UT. An Orientation of "eMamta" Software has been done for Nodal Officer MCH, Manager IT & HMIS, Statisticians and Data Entry Operators for the said software by NIC Chandigarh. The customization in the

"eMamta" Software is required as per the setup of UT Chandigarh. The coordination in this regard is on with NIC, Chandigarh. The data collection of the pregnant women and children has been initiated at all sub-centers, civil dispensaries and CHCs w.e.f. July 1st 2010 onwards. ANMs/LHVs/ and MOs have been sensitized on name based tracking mother and child. Master data set finalized with NIC for online application 'eMamta' software and uploaded on the eMamta software of NIC. UT Chandigarh is not involved in any type of Sensitization/Training of MCTS by GOI. The tracking of pregnant women and children is a big challenge due to floating and migratory population.

ii. Linkages between service delivery and demand generation activities:

The UT has a plan to use AWWs as the link workers for the MH, CH and FP services. The training of AWWs as per the guidelines for trainings of ASHA began on 21st December, 2010. The IEC cells in RCH II, RNTCP and the NRHM SPMU are also engaged actively in demand generation activities.

iii. JSY functioning:

Only 0.96% (186) of the 19369 deliveries conducted in the public hospitals were given JSY cash transfers in 2009-10 and only 0.91% (120) of the 13165 deliveries conducted in the public hospitals were given JSY cash transfers. For 9 out of the only 20 deliveries conducted in the accredited private health institutions were eligible for JSY cash transfers.

iv. Services for management of malnourished children:

Grade 3 malnourished children are put on supplementary diet; the AWWs are able to plot the growth of the enrolled children and identify the severely malnourished children. These children then examined and certified for supplementary diet by the ICDS supervisors and the PHD medical teams. Vitamin A and IFA is being provided at the anganwadis by the ICDS medical officers. There are Nutritional Rehabilitation Centers at Medical College and the PGI but majority of the slum pockets where the children are more likely to be malnourished are distant from these facilities.

v. Plan for MCH centers to cover whole state:

MCH services are being provided through the network of public health facilities like Sub centers / CDs / Polyclinics / CHCs and the District hospitals but there are no designated MCH centers in the state.

vi. Systems for Maternal Death Review:

Nodal persons identified for MDR at 5 institutions CHCs/DH/GMC&H/PGI. Orientation of all officers has been undertaken on MDR. PGI conducts MDR and IDR and share a monthly report with the UT NRHM. Members from PHD / NRHM are not part of this process that is undertaken by PGI.

g. Nutrition

i. Nutrition services for mothers, children and adolescents:

Team visited many anganwadi centers and found good ICDS services being provided through these centers. There is good coordination between PHD and ICDS. The AWWs are plotting growth charts of the children in the anganwadi centers. Grade 3 malnourished children are being screened by the ICDS supervisors and medical officers from the health department and are being put on supplementary diet.

Screening and counseling of the pregnant mothers is being done by the team of ICDS medical officers. Iron and Folic acid is being given to the mother, children and adolescents.

The UT is also providing nutritional counseling the children, adolescents and mothers through the school health program and the non-communicable disease programs. The school health program provides screening and counseling services to school going children and their parents through its 10 teams that have medical officer, dentist, refractionist and a dietician.

The non-communicable disease program provides screening and dietary counseling through its diet clinics at the CHCs and the DH in the UT.

ii. IEC on nutrition and the VHNDs:

There is extensive and visible IEC on nutrition. The IEC cell has prepared 'Discharge card holders' for pregnant mothers and 'booklets' for anganwadi workers that have IEC material on nutrition. Stickers for school books of children have been designed with picture messages on importance of nutritional diet. AWWs and the ICDS supervisors along with the ICDS medical officers from PHD participate in the VHNDs.

iii. Functioning of Aanganwadi Centers (AWC):

5 Anganwadi centers were visited – anganwadi worker and helpers were present in all the anganwadi's. Good coordination with ICDS and the health department is visible. Every anganwadi is being screened by the medical team every 4 to 5 months and they are maintaining 'Summary Medical Check Up to Improve Monitorable Indicators' with details of medical team's evaluation of the children. Anganwadi's also issue a 'Anganwari Card' to every child with summary of immunization status, oro-dental hygiene and physical examination. The card also takes status of birth registration and duration of residence of the family in Chandigarh. The children who do not have complete immunization or whose birth has not been registered are identified and their parents counseled and possible remaining immunization completed and birth registered.

h. National Disease Control Programme

i. RNTCP

RNTCP has been achieving the expected levels of new smear positive case detection and treatment rates over the years.

Table VIII.Comparison of 2009 and 2010 achievement of the state on important indicators

	Year 2009	Year 2010 (up to 3rd Qtr. 2010)
TB suspect examination rate (Expected 180/lakh/year)	1346/ per lac	1573/ per lac
New Smear Positive Case Detection Rate (Expected – at least 70%)	81 %	76%
Treatment Success Rate in New Smear Positive cases (Expected – at least 85%)	88%	85%
Treatment Success Rate in Retreatment Cases (Expected – at least 85%)	80%	80%
Default Rate in New Smear Positive Cases (Expected – less than 5%)	3%	4%
Default Rate in Retreatment Cases (Expected – less than 5%)	6%	8%

All sanctioned positions of the cell are filled up. STO and Lab Technicians are regular staff and remaining on contractual basis. Positions of Deputy STO, Assistant Epidemiologist and Microbiologist for Intermediate Reference Laboratory are not there in Chandigarh. The IRL for Chandigarh is in Patiala.

In Chandigarh State TB Society maintains its own separate account. STO is a signatory of the TB account and funds are released after the approval of Mission Director and the State TB Officer. RNTCP develops its annual action plan and it is later included in the state NRHM PIP.

RNTCP has effectively involved the medical college in its activities. They frequently interact in TB control activities. Medical College (PGI Chandigarh) has a Task Force on TB Control, in which STO act as its member secretary. Cost of treatment of TB patients at PGI/medical College is born by the State TB Cell. Under RNTCP sensitization of the doctors of medical colleges is done by the state TB cell. Medical college has also been involved in carrying out the operational researches on the TB issues.

The state TB Cell has involved NGOs in the TB implementation activities. Five NGOs manage DOT Centers. NGOs have also been assigned the responsibility of sputum collection from slum areas. The NGOs also organize community meetings and generate awareness.

TB-HIV state coordination committee is in place but the coordination among the two programs can be further strengthened.

ii. NIDDCP:

The present prevalence rate of Goitre is 14.2% according to survey carried out in 2006. The next re-survey is due in 2011. Prevalence rate of Goitre in a household survey of 2466 households in 2010 is 5.54%

The samples of salt and urine being lifted and tested by NIDDCP have been steadily increasing and are above the expected number since 2006-2007, when the program started its own lab. Samples failing the tests have dropped for the salt samples from 8% in 2009 to 3% till November in 2010 and from 2% in 2009 to 1% till November in 2010 for the urine samples.

The budget for the program is sufficient but the budget is being released in two installments and the release of 2nd installment by March leads to lack of utilization and reduction in subsequent financial year. In the current year the budget had to be diverted from IEC head to the salary head and this lead to decrease in IEC. Posts of Statistical Assistant is vacant.

iii. NLEP:

The program in the State functions through 3 reporting and treatment centers. The program cell has all posts filled as per GOI norms.

The state has a Prevalence Rate of 0.31/10000 but the Prevalence Rate of population from outside state 'Others' is 1.82/10000. The UT NLEP also conducted house to house survey under Project Foundation in 2 slum areas with a population of 35000 where 6 cases were identified and put on treatment.

The treatment completion rate is 100% and the UT conducted 6 reconstructive surgeries of patients with grade 2 deformities. MCR footwear is also being procured and provided routinely to the patients with grade 3 deformities.

iv. NVBDCP:

The position of Anti Malaria Officer is vacant and the funds are being released in two installments which led to decreased activities and underutilization in the last quarter of the year. The program is achieving Annual Blood Examination Rate between 7.6 to 9.0 in the last 5 years, with 92202 slides collected till November this year. With 347 slides positive, the SPR is 0.4. The number of Dengue positive cases in the UT increased from 25 in 2009 to 202 in 2010 but no deaths were reported due to dengue. Program cell conducted special drives in motor and scooter markets in the city in the months of June and July.

v. IDSP:

IDSP Epidemiologist yet to be recruited. Data Manager, Data Entry Operator and Microbiologist are in position but only Microbiologist has been trained.

The number of private reporting sites has remained steady at only 10 since the beginning of the program. There is no integration of disease surveillance data from different programs in the UT. There is no evidence of epidemiological analysis and action. Completeness and timeliness indicators are not being monitored routinely. Utilization of funds under IDSP is on track.

i. Institutional mechanisms and Programme Management

UT Chandigarh being a small city, State Health Missions meetings are held at UT level. During 2009, 11 meetings were held under State Health Society (SHS), NRHM. These meetings include meetings regarding Monitoring & Evaluation and reg. Monthly Review and Action Taken (under the Chairmanship of the Mission Director), Executive Committee meeting (under the Chairmanship of the Health Secretary, UT Chandigarh), and meeting of Governing Body (under the Chairmanship of Adviser to Administrator, UT Chandigarh). In 2010, 89 such meetings were held. Meetings of Governing Body were attended, inter-alia, by the Mayor, Municipal Corporation; Heath Secretary; Finance Secretary; Secretary, Indian Red Cross Society, UT; Mission Director; Chief Engineer UT; and PA to Chairman, Zila Parishad. Meetings of the Executive Committee were attended by the Mission Director; Regional Director, ROHFW; and various Programme Officers. It would be observed from the above that at least one meeting per month is being conducted by the State Health Society.

Rogi Kalyan Samiti funds are received at Government Multi-Speciality Hospital at Sector-16, and at two CHCs at Sector-22 and Manimajra. This fund is mostly used for supply of free drugs to the poor patient. Prior approval of RKS is taken for use of this fund. In deserving cases, ex-post facto approval is taken.

Two to three members of Panchayts including sarpanch, are members of the Village Health Sanitation Committee (VHSC), and participate in VHSC meetings at Civil Dispensaries in villages.

The State Programme Monitoring Unit (SPMU) coordinate and supervise activities of District level hospital at 16 Sector, and CHCs at Manimajra and Sector-22, and Poly-clinic at Sector 45. There is sufficient infrastructure and equipment for health services. However, there is lack of sufficient manpower for operating health services to the desired extent.

The procurement and logistic system in the UT is in place with dedicated personnel located in the SPMU for processing the needs of the health facilities across the UT. The procurement processes involve assessing the need of inventory items and then constituting the Purchase Committee for verifying the items and other modalities before submitting the proposal to higher office for due diligence. The procurement teams constitute an Inspection Team, which approves the specification and quality of the products before accepting the supplies as received. The orders received including

equipments are stored in a warehouse available adjacent to the State Health Society Office, however, a new warehouse/renovation and expansion of the facility is underway. The purchase of the needed supplies is staggered with availability of the space, though due care is taken to ensure space for priority items like Kit A and Kit B which are voluminous and require larger space. The received supplies are distributed to the facilities as per the requisition sent by them. It is also learnt that the supplies are distributed to all the 52 facilities across levels in a round trip asking for requirement and delivering on spot if taken in by the concerned facility incharge. The transportation is in a immunization van provided by Government of India, which is used for transporting other consumables. The UT had an instance of stock out in the year 2007 for DPT vaccines since GoI could not provide the same. The above arrangement is only for GOI supply for RCH services and all other requisition is through the Department of Health Services (DHS), Chandigarh and as understood is not in tandem and is independent to each other though Administrative approvals are as per the procedure through DHS. The scope of integrated/central procurement may be assessed by the DHS, Chandigarh. Simultaneously implementing the use of PROMIS to strengthen procurement and logistic system in the UT may be considered.

To monitor the progress of activities undertaken by various programme divisions, monthly review meetings, monitoring and evaluation meetings on quarterly basis, are held at State Health Society. Based on deliberations in these meetings, feedback is sent back to the programme divisions for follow-up / corrective action. For strengthening / monitoring HMIS and Mother and Children tracking system under NRHM, monthly field visits are undertaken as per pre-decided schedule.

18 NGOs have been enrolled for supplementing the efforts in the fields of maternal health and family planning.

While preparing health plan for the UT, participation / consultation of all stakeholders, including at the level of sub-cetre should be ensured. There should be smooth coordination of various programme divisions with SPMU, so that their requirements are properly covered in the PIP of the UT. Inputs from District hospital should also be given due consideration as to how to utilize its services under NRHM.

j. Financial Management

i. Status of Humans Resource:

The post of Director of Finance is lying vacant and rest all posts are in place at State/UT level i.e. State Finance Manager, State Accounts Manager, Finance Consultant, Accountants and Junior Accountant. At CHC level the post of Accountant is lying vacant.

ii. Status of Maintenance of Books of Accounts:

Books of Accounts are not properly maintained as per Finance and Accounts Manual at UT Level. They are maintaining books of account on Tally software and manual but in Tally, the accounts are updated till July 2010. So our observations related to the maintenance of books of accounts are based on manual accounts as follows:-

Cash Book

- Cash book is maintained in Tally which is updated till July, 2010 but manual cash book is updated till 30th November, 2010.
- Printout of cash book has not been taken by the UT.

Bank Book

- There are two accounts (ICICI Bank and Bank of Baroda) for RCH/RI and NRHM activity payments.
- Books are maintained in tally as well as manual but these are updated till July 2010 and November 2010 in tally and manual respectively.
- Bank reconciliation had reconciled till November 2010.

Advance Register

- UT has not maintained Advance Register under any programme as they are treating all releases to CHC/SC as expenditure.

Vouchers

The vouchers of cash/bank and journal are not properly maintained at State, and CHC level. Vouchers are not serially numbered at SHS and CHC.

Journal

- UT did not pass journal entries for the Statement of Expenditure received from CHC.
- No Journal entries are passed in the books in the case of bill received form outside agencies (Guru Granth Sahib Society). UT has given all releases/advances to CHC/outside agencies are being treated as expenditure.
- Supporting documents of journal entries are maintained at CHC / SHC level where the actual expenses are incurred.

iii. Status of Banking and e-transfer:

UT Health Society maintains bank accounts with two banks i.e. ICICI Bank and Bank of Baroda. All the funds from Govt. of India are received in ICICI Bank. Now, UT has opened recently new account with Bank of Baroda for future transaction after receiving letter from GoI. However, the lead bank in PSU and Private sector are State Bank of India and ICICI Bank respectively. There is no e-transfer of funds so for at SHS to down level i.e. CHC to Sub-Center. Funds from SHS to CHC to Sub-center are releasing through cheque or demand draft only.

iv. Status of Tally ERP9:

Tally ERP9 has been procured and customized for NRHM but for RCH it is yet to procured at State level.

Computerization of books of accounts has been done for NRHM at State level and they have not any issue related to usage of Tally ERP9. As for as RCH programme is concern, they have not yet procured Tally ERP9 at State office.

v. Low/Nil Expenditure:

- Low expenditure has been reported under Untied Fund (14.70%)
- Low expenditure has been reported under Training (5.87%) and IEC/BCC (5.55%).
- UT has not reported any expenditure under Hospital Strengthening.
- Low expenditure has reported under Mainstreaming of AYUSH (0.05%)

vi. Diversion of Funds:

It has been observed that UT has diverted a sum of Rs. 4, 50,000/- under Mission Flexi Pool to RNTCP during the month of June 2010. In the case of other programme there is no such diversion.

vii. Concurrent Audits and Internal Control:

UT is a small Sate despite that Auditors have completed audit for SHS. The Concurrent Audit has been completed till September 2010 but October and November 2010 is still pending to submit to UT by the Concurrent Auditor. UT has sent the action taken report to respective programme divisions against queries of Concurrent Audit Report.

viii. Integration between NRHM and NDCPs:

There is integration between NRHM and NDC Programmes in term of audit as the auditor has covered NDC programmes during the audit of 2009-10. In term of release of funds, it has been noticed that there is no integration between the same, as IDSP, RNTCP and NLEP are not receiving funds through NRHM.

ix. Delegation of Financial Power:

As per discussion with the State Finance Manager, they have not issued any Govt. Order for delegation of financial power down the level.

x. Monitoring and Evaluation:

It has been observed that UT is not analysing any Statement of Expenditure Report or Financial Monitoring Report i.e. budget Vs expenditure of district/CHC whereas action taken report against queries of Concurrent Auditor has been sent to CHC or other programme divisions.

xi. Expenditure out of Interest Earned:

It has been observed that UT has spent Rs. 13, 29,998/- during the month of September 2010, out of Interest Earned under RCH Flexi Pool.

xii. Pending Utilization Certificates:

The pending Utilization Certificate for RCH Flexi Pool and NRHM Flexi Pool. The detail of pending UCs has been given below:

Programme	Amount in Crores
RCH-II	1.19
Mission flexi-pool	2.39
Programme	**Amount in Crores**
RCH Flexi Pool	
2009-10	1.19
Mission Flexi Pool	
2007-08	0.16
2008-09	0.04
2009-10	2.19

xiii. Income Tax Issues:

It has been observed that UT has not followed rules of Income Tax under tax deduction at sources. Tax deduction of Source has been deducted by 1% instead of 10% in the case of salary to Consultant or Technical Professionals.

xiv. State Share Contribution:

The UT share is due of Rs. 2.90 Crores to be credited to SHS Account from 2007-08 to 2009-10. The break up for the same has been given below:

Year	Amounts required on basis of releases (Rs. in Crore)	Amount Credited in SHS Bank A/C (Rs. in Crore)	Short/ (Excess) (Rs. In Crore)
2007-08	1.14	0.00	1.14
2008-09	0.94	0.00	0.94
2009-10	1.67	0.85	0.82
2010-11	1.98	0.00	0.00
Total	5.73	0.85	2.90

xv. AMG/RKS and Untied Funds:

Rogi Kalyan Samiti has been registered under the Society Act. The details of release and expenditure from 2006-07 to 2010-11 has been given below:

	2006-07		2007-08		2008-09		2009-10		2010-11	
Particulars	Allocation	Exps.	Allocation	Exps.	Allocation	Exps.	Allocation	Exps.	Allocation	Exps.
AMG/RKS										
Multispecialty Hospital	0	0	0	0	500000	3000	500000	147994	500000	183609
CHC-22	0	0	0	0	150000	150000	200000	200000	100000	100000
SC- Kuda Lahora										
Untied Funds	10000	9533	10000	9000	10000	0	10000	5594	10000	0

Based on the table above and records available the observations are as under:-

- Multispeciality Hospital has reported low expenditure under RKS during the year 2008-09, 2009-10 and 2010-11. The reasons of low utilization may be clarified.

- Sub-Centre has not reported any expenditure during the year 2008-09 and 2010-11 (up to 30th November, 2010) and under Untied Funds. The reason may be clarified.

k. Decentralized Local Health Action

Chandigarh administration has made efforts to decentralize their health services by constituting VHSCs at Sub centre level and RKS at hospitals. It has also tried to involve village panchayats in the functioning of sub-centres in rural areas. However, these efforts need to be intensified to strengthen the RKS and VHSCs. Health Plans, a key aspect of decentralization, also need to be strengthened.

An account of the decentralization activities is mentioned below:

i. Health Plans

In Chandigarh health plan is prepared at UT on the basis of feedback from the different units of the health departments. However it needs to be developed at all level of health facilities.

District Health Plans

In Chandigarh as such District Hospitals are not there. A General Hospital at sector 16 works as the district level hospital which is headed by the Medical Superintendent. Under NRHM, it has been provided funds for Rogi Kalyan Samiti. The Rogi Kalyan Samiti meets quarterly and decides about the utilization of allocated funds for RKS. The General Hospital seems to work as an independent unit in isolation with the NRHM.

For developing a realistic health plan the general hospital, which caters to maximum patient load of the state, should develop its plan to strengthen the institution by involving the Rogi Kalyan Samiti and other stakeholders including communities' health needs based on exit interview and other methodologies.

Block Health Plans/ CHC level Health Plans

At present the health plans are not being developed at CHCs. Under NRHM emphasis should be laid on developing the CHC level health plans. The RKS has been formed at the CHCs which should be activated and motivated to provide the feedback on the community health needs for reflecting in the health plans. CHC level health plans should be based on the health plans of lower level health facilities and needs and resource assessment of different sections of the population.

Health Plans at dispensaries/ primary level health facilities and Sub centers

There is need of developing health plans at dispensary and sub centers, which can guide them for carrying out their activities and provide feedback to the CHCs health plans.

Sarangpur Sub centre is an example of such multi stakeholder coordination where panchayat has been actively involved in Swasthya Manch/ VHSC activities. Panchayat has provided infrastructure support (tables, chairs, *cupboards) to the sub centre. In such forums resources and opportunities are available but they need to be some times guided to plan and implement the health activities.*

ii. ***Village Health and Sanitation committees (VHSC)***

Three sub-centers, namely Maloya, Sarangpur and Khuda Lahora, were visited, at all these sub centres VHSCs have been formed and maintain their accounts. The funds have been disbursed to their accounts in previous years but in current year none of them has received the funds.

VHSCs have been formed at the sub centres. Maloya VHSC comprises of 2 ANMs, 1 retired school teacher, 2 AWW, 2 Social workers and 2 local worker (Housewives). Sarangpur VHSC comprises of ANM, 4 members of Panchayat, two AWW, one trained Dai and a Sarpanch (Female). VHSCs meetings held on last Friday of every month with the VHNDs and Swasthya Manch. The proceedings of the meetings have been documented only at Sarangpur, others VHSCs needs to be oriented to document the proceedings. In the meetings they discuss about their health problems, issues of cleanliness and promotion of nutrition and child feeding practices. These committees are not active functional and the members do not have clear understanding of the committee's roles and utilisation of fund.

iii. Community monitoring

Community monitoring is not being done. It needs to be initiated for brining in the transparency and effectiveness in the program implementation.

Part II: Status on the progress of State against Specific Objectives and Expected Outcomes of NRHM (PIP/ROP FY 10-11)

Part A: RCH Flexi pool

Maternal Health

- Referral transport:
  - Extensive IEC has been done regarding availability of the referral Transport funds. ANMs have been sensitized in the Monthly Meeting for the need of the women in labor. Efforts have been made to educate the pregnant woman to claim the referral transportation money. Only 10% approved money utilized.
- JSY:
  - Home deliveries: No beneficiaries have been identified till date (proposal were for 100 deliveries)
  - Institutional deliveries: 200 beneficiaries have been identified till 3rd quarter (proposal were for 1200)

Child Health

- Facility based new born care: To assess the demand a committee was constituted. The committee did not recommend any Infrastructure for CHC-22 & CHC-Manimajra. The committee, however, recommended some equipment for GMSH-16.

Family planning

- Dissemination of manuals on sterilization standards & quality assurance of sterilization services: Manuals printed
- Compensation for female sterilization: Out of the 1200 proposed sterilizations about 45% achieved
- Male sterilization: Out of proposed 66 sterilizations about 20% achieved as of date
- IUD services at health facilities/ Compensation: OT lights provided for small facilities, sterilizers yet to be purchased (numbers?)
- Contraceptive seminars: Yet to be held, proposed for January

ARSH

- Adolescent services at health facilities: No activity
- Other strategies/activities (procurement of sanitary pads): No activity

Innovations / PPP / NGO:

- Staff for PNDT enforcement: all approved staff recruited

Infrastructure / HR:

- ANMs / MPHWs / LHVs: All recruitments done and staff in place
- Laboratory technicians: All recruitments done and staff in place.

Operationalise Infection Management & Environment Plan at health facilities:

- Purchase of Autoclaves: No activity

Institutional strengthening:

- Monitoring & Evaluation / HMIS: No activity, plans to utilize 3.75 lakhs by year end

Trainings:

- Following approved trainings have not been done: EmOC, SBA, Contraceptive update, IMNCI, Care of sick children and severe malnutrition, LSAS (items not identified – no takers for this trainings is the remark)
- Except for ARSH (69%) expenditure in other trainings as of date is less that 30% of the approved.

IEC / BCC:

- The expenditure against IEC / BCC in CH and FP have been reported as nil although UT also reports some activities.
- IEC / BCC activities in ARSH and MH are less than 12% against approved.

Procurement:

- MH procurement: Delivery kits for Sub centers yet to be purchased
- CH procurement: All approved procurements complete

Program Management:

- Human resource: all approved staff recruited

Part B: Mission Flexi Pool

- ASHA/Link workers:
  - Chandigarh UT has sought approval for using AWWs as the link workers. Training for Aanganwadi workers/ Link workers has been planned for December from 21st to 23rd December, 2010. In this phase of training first 3 ASHA modules will be covered for a batch size of 30 AWWs. The UT is yet to finalize the training plan for all 469 AWWs. From the approved budget of Rs. 2.5 lakhs, Rs. 0.159 has been utilized till date.
  - Kits will be purchased after training of the link workers

- Infrastructure:
  - The new baby corner has been established in two CHCs and one at Poly Clinic is being established.
  - Medical Books to the tune of Rs Eighty Six Thousand have been purchased by School of Nursing. Further teleconferencing system at Nursing School has been set up at GMSH, Sector-16.
  - A warehouse is under construction at CHC-22 and further funds shall be released on demand of further funds from Engineering department.
  - Letter has been sent to DFWO for status of Sub centers.
  - Two CHCs have been shortlisted for up gradation to the level of PHC as per IPH Standard. Chief Engineer and Architect department has been requested for the needful.

- Human Resource:
  - Staff nurses have been recruited for Emergency CHC-22, CHC Manimajra and RHTC Palsora.

- Training:
  - SHSRC is under construction at CHC-22 as deposit work and further funds shall be released on receipt of demand from UT Engineering department.

- Untied Funds / RKS
  - Funds to the tune of Rs 160000/- (Rs One Lakh Sixty Thousand only) have been released in the month of December, 2010 to 16 VHSCs @ Rs 10000/- each VHSC.
  - Funds to the tune of Rs 160000/- (Rs One One Lakh Sixty Thousand only) have been released in the month of December, 2010 to 16 sub centers @ Rs 10000/- each sub centre.
  - There is no PHC at UT Chandigarh.
  - Funds to the tune of Rs 50000/- each have been released to 2 CHCs. Further funds shall be released @ RS 50000/- each to Two CHCs shortly.
  - Funds to the tune of Rs. 250000/- have been released to RKS of District Hospital and Funds to the tune of Rs. 50000/- to each CHC.

- Program Management:
  - District Action Plan for the financial year 2010-11 has been initiated.
  - SPMU has already been strengthened with the recruitment of Receptionist (28/4/2010), Manager IT (30/4/2010), Consultant IEC (26/6/2010), Computer Assistant (Trainings)(10/11/2010) and Helper (8/11/2010). Besides manpower,

institutional capacity improved with the provision of utilities like furniture, stationery, internet, telephone etc. Travel head includes travelling expenses and field visits by the SPMU staff/ officers etc.

- Internal Monitoring: - The internal monitoring of all the programs under NRHM is being carried out regularly on monthly basis to review the predefined targets of the respective programmes. Till now five monthly review meetings and two quarterly review meetings have been held.
- External Monitoring: - Foundation for Developmental Research has been engaged for external monitoring. However external monitoring is also being carried out by PGIMER on oral health and measuring patient satisfaction projects.
- HMIS: Training has recently been imparted to approx 160 health workers on tracking of pregnant women and children. A training of MO, SMO and HOD of GMCH-32, PGIMER shall also be organized shortly. HMIS has also been divided in 4 zones i.e. CHC-22, CHC-Manimajra, GMSH-16 and PC-45. Broadband connections have been provided under HMIS at various health facilities.
- State level workshops on community monitoring of VHSC members have recently been organized.

- Mobile Medical Units:
  - Two MMUs are being run successfully covering villages and slum areas/ colonies. Inclusion of homoeopathy wing in MMU is under way. Approx 22 camps are being organized every month in both MMUs.

- Mainstreaming of AYUSH:
  - Manpower like 1 AMO, 1 Ayurvedic pharmacist, 1 HMO, 1 Homoeopathic pharmacist, 1 Unani Medical Officer, 1 Unani dispenser under AYUSH have been recruited to make the mainstreaming of AYUSH functional.

- Mela:
  - One health mela has been organized on 24/6/2010 at Tin colony, Sector 52 Chandigarh. Another Health Mela has been organised on 28/9/2010 at Khuda Alisher. All specialists services are made available in the melas for diagnostic and treatment of the patients. Besides two AYUSH Health Melas have been organized at village Badheri and Khuda Jassu. More such Health Melas have been planned for the FY 2010-11

- Additional activities:
  - Project Foundation (Adoption of villages): All the National health programmes including SACS adopts two villages for 6 months in UT Chandigarh under project foundation and do all the needful activities to raise the health indicators of the villages pertaining to their programmes to the ideal status. After 6 months the villages are changed. First round has been completed..
  - Swasthya Manch (Inter sectoral convergence): Nutrition day is being celebrated on the last Friday of every month in all the 22 villages of UT Chandigarh. The site for celebrating the day was decided depending upon the gathering of the villagers.

- Reimbursement for communication: CUG has already been introduced and is an ongoing process. There are 223 connections.
- Outsourcing of services of specialists: One Radiologist has been recruited while EMO are being recruited. 7 Anesthetists and 2 Paediatricians are also being called for performing surgeries at CHC-22 and they are being paid @ Rs 1000/- per visit.
- School Health Scheme: School Health Programme has been strengthened by recruitment of manpower. The dental material has also been procured.
- Revised National Tuberculosis Control Programme: Recruitments for RNTCP has been completed – 5 LTs, 5 TBHVs, 10 HVs
- Honorarium to programme officers: As Programme officers are doing activities besides their clinical timings. Also they have to travel to SPMU and field from their posting sites to get the work done. As the programme officers don't have the travel and communication allowance so the same is being paid in the form of honorarium. Honorarium is being paid from 1/4/2010 and is performance based. Establishment of IEC cell: One IEC consultant ((26/6/2010), and helper (8/11/2010) has been recruited under NRHM and IEC activities are being undertaken.
- Training by State Health System and Resource Centre: Training being undertaken for Safai Karamchari and Ward Servants in the month of December, 2010 and January, 2011.
- Child protection unit: Clarification sought from Govt of India still awaited

Part C: Immunization

- Trainings:
    - LHV/ANM/MPHW: 6 batches of trainings held
    - Training of MOs: None this year

- Cold chain maintenance:
    - ILR / DF repairs being undertaken as per requirement

- Program Management:
    - Computer assistant recruited for support of RI reporting
    - 2 quarterly review meetings held
    - Alternate vaccine delivery: Rs. 50 are being paid to LHVs / ANMs for holding outreach sessions
    - Printing of MCP cards under progress

Part D: NDCP

- **RNTCP**: The expenditure against the ROP approvals for honorarium, equipment maintenance and trainings are above 50%. Expenditure under rest of the activities is below 50%, with very low expenditures under the heads of IEC, contractual services and research and studies.

- **NIDDCP:**
    - The NIDDCP cell and monitoring laboratory cell staff salary is been utilized
    - 50% of the approved IEC expenditure has been utilized

- **NVBDCP:** Expenditure under all heads is on track except for training, where no expense made against the approved amount of Rs.1 lakh.

- **IDSP:** All expenses on track with total expense of Rs. 20.63 against Rs. 25.57 lakhs

- **NPPCD:** Grants not received since 2 years, however expenditure against manpower and screening camps being made

- **NLEP:** Activities and expenditure in all heads on track except trainings where only 20% utilization of the approved amount done.

Part E: Inter-sectoral convergence

- Swasthya Manch (Inter sectoral convergence): Nutrition day is being celebrated on the last Friday of every month in all the 22 villages of UT Chandigarh. The site for celebrating the day was decided depending upon the gathering of the villagers. This activity is being funded under Mission Flexi pool.

CHAPTER 4. RECOMMENDATIONS

Infrastructure Up-gradation

A number of upgradation of health facilities is undergoing. To ensure timely completion of civil works, time should be fixed in consultation with the concerned Deptt./agency for each activity.

Human Resources Planning

If we cannot hire specialists on contractual basis, it is good idea to empanel the specialists to be remunerated on the basis of per visit.

Health Care Service Delivery – Facility Based - Quantity and Quality

- *Upgrade the dispensaries to PHC and rationalize the manpower to reduce overburdening of the hospitals*

  The general hospital and CHCs, particularly CHC sector 22, are overburdened. In order to reduce the patient load some of the dispensaries may be upgraded and considered for carrying out deliveries and elementary inpatient care.

  The patient load at Manimajara should be assessed and reasons of its low service utilization be ascertained. If deputed manpower at Manimajra is more than that of the required its rationalization may be thought of.

- *Ensure availability of human resources for effective utilization of services at the facilities*

  Human resource has been major constraint at general hospital and CHCs in providing the requisite services as per the norms. The need for human resources for all hospitals and facilities be assessed and vacant posts should be filled up either on contractual basis or by locating some of the employees from low used to overused facilities. Ensuring availability of the required human resources will immensely help the facilities working at optimal efficiency as all other infrastructure and resources are in place.

- *Partnership with other institutions individual providers to provide specialist services*

  Chandigarh has the advantage of having many of the specialized institutions and private providers. In order to get the man power for vacant positions and to provide specialist services, option of partnership with private institutions and individual providers may be explored.

- *Promote use of JSY benefits to poor*

  On account of lack of availability of BPL cards JSY benefits have been provided to very limited families. In order to increase institutional deliveries in the poor settlements people should be allowed to get the benefits of JSY either by MOs certifying the status of people or by discussing the issue with appropriate authorities to ensure the availability of BPL cards to the poor.

- *Strengthen RKS to increase involvement and ownership of the community*
  The RKS needs to be further strengthened by increasing active participation of civil society groups. In order to realize the RKS's purpose of increasing the involvement of the communities in decision making and bringing-in the ownership of the communities in the hospital matters, they needs to be strengthened and nurtured by sensitizing their members and making the RKS true representative of all sections of the community, particularly the poor and marginalized.

- *Identifying floating migrants with the help of AWW will help extending health services to them*
  Chandigarh health department is going to involve AWWs as link workers in place of ASHA. By increasing their remuneration and enhancing the capacities and improving monitoring the AWW can help identifying the large floating and vulnerable population and help providing the services.

- *Identify hidden poverty clusters*
  Apart from slums in Chandigarh there are other various small poverty clusters and vulnerable people staying at construction sites, brick clines and surrounding factories as well as homeless staying at the places like railway station, bus stops etc. These hidden poverty clusters needs to be regularly identified, listed and mapped with the help of community level workers so that they could also be provided the health services through outreach.

Outreach Services

- The immunization may be extended to the Mobile Medical Units. The MMUs visited were not providing immunization on the days of the visit.

- Data management and analysis for immunization should be done routinely by stratifying the facilities and population on Urban, Rural and Slum areas.

- 6 days Immunization in a week may be extended to the CDs in / near the slum and rural areas. Identification and up gradation of the CDs, in terms of resources may be planned for this year's PIP

- *Include hidden poverty clusters under outreach services*

  The outreach services which are provided at slums and villages should also cover the hidden poverty clusters such as workers at construction sites, brick kilns and pavement dwellers.

- *Change the timings of mobile medical units to make them more suitable to the working poor population*

  The timings of the medical mobile units are not suitable to the community as they coincide with their working timings. To get the services of these facilities poor have to lose their wages. Therefore to ensure proper utilization and increase access of poor to these facilities timings of these facilities may be changed to morning and late evenings.

Immunization services can also be provided from the medical mobile units. This will help the communities which are distantly located from the sub centers.

ASHA / Link workers

Training of AWWs as link workers should be completed on priority. All 7 ASHA modules to be covered for the AWWs and an orientation of all program management units should be planned.

RCH-II

- It is operationally possible in the UT to computerize the records up to the sub center level to operationalize the name based tracking of pregnant women and children. The AWWs, who will be used as the link workers, should also be sensitized on MCH name based tracking.

  The linkages between service delivery and demand generation should be increased for the slum pockets by convergence of the activities of IEC activities of different programs and involving the AWWs who will be used as the link workers.

- Extend the benefits of the JSY scheme to the underserviced and other needy who do not have the BPL card.

  The two NRC in the medical college and PGI are away from the slum clusters in the city. Establishing an NRC in the CHC in the bigger slum pocket should be considered.

- UT should grade all facilities based on ‘Operational guidelines for Maternal and Neo-Natal Health‘ and then plan for up gradation of the facilities to rationalize the distribution of load on the facilities and improve efficiency of MCH delivery in the UT

- SHS / SPMU / SHSRC should ensure participation of UT staff in the insuring complete reporting of Maternal and Infant deaths and should participate in the review process to understand the gaps and address them.

Nutrition services for mothers, children and adolescents:

AWWs (link workers) should be oriented and linked to various programs and facilities providing nutrition services to mother, children and the adolescents, like non-communicable disease program, school health program and the nutritional rehabilitation centers.

National Disease Control Program

- **RNTCP**
  Monitoring indicators may be analyzed separately for the slum pockets. Treatment success rate and default rate in retreatment cases in the slum areas, especially in the migrant population should be monitored.

- **NIDDCP:**
  NIDDCP has made good gains and needs to sustain the IEC efforts. The funds for IEC were reduced in the current PIP; in the next PIP the program should get funds for IEC.

- **NLEP:**
  The Project Foundation survey in 2 slum areas yielded 6 cases in a population of 35000; the survey should be extended to the other slum pockets as well. The Prevalence Rate of population from outside state 'Others' of 1.82/10000, should be taken into account when allocating resources from center to the UT. All surveillance, program planning and implementation strategies should be based on the Total PR and not just on the PR

- N**VBDCP:**
  Funds to the program should be released timely. The vector control community IEC special drives conducted during the Malaria month should be extended to the entire pre monsoon and monsoon seasons.

- **IDSP:**
  - The data manager and the data entry operator should be trained and efforts intensified to recruit the epidemiologist.
  - Efforts should be made to sensitize and enroll private service providers in the surveillance network.
  - Completeness and timeliness indicators should be routinely monitored at the Surveillance Unit and validity of the reports routinely checked.
  - Epidemiological analysis of the data should be done routinely and the information should be used for action. There should be a mechanism to give regular feedbacks to all stake holders through reports and newsletters.
  - More resources should be utilized for capacity building

Institutional mechanisms and Programme Management

While preparing health plan for the UT, participation / consultation of all stakeholders, including at the level of sub-cetre should be ensured. There should be smooth coordination of various programme divisions with SPMU, so that their requirements are properly covered in the PIP of the UT. Inputs from District hospital should also be given due consideration as to how to utilize its services under NRHM.

Finance:

- All vacancies should be filled up on priority basis.
- Advance Register should be maintained for all kind of advances.
- Journal Entry must be passed in the books for bills and SOE.
- UT should release funds through e-transfer from SHS to down level.
- State should properly implement customized tally, ERP9, accounting software so that FMR can be generated. All the expenditure booked in the FMR should match with the Tally generated books of accounts.
- Diversion of Funds from one programme to another programme should be avoided for better finance management control.
- State should ask to Concurrent Auditor to submit the Concurrent Audit Report on monthly basis.
- Budget Vs expenditure must be analyze to know the exact variance of budget and expenditure so that proper steps can be taken to improve the utilization.
- UT should deposit its 15% State Share in SHS account.
- Income Tax provision for deduction of TDS must be followed by the State for statutory requirements.
- The reason of Low/Nil expenditure may be clarified.
- UT should submit pending Utilization Certificates for RCH and Mission Flexi Pool.
- UT Should upload FMR regularly on HMIS.

Decentralized Local Health Action

- *Developing health plans at each level of service delivery will help preparing a realistic and better informed State PIP.*

  Efforts should be to done to develop health plans at each level of health facilities in consultation with different stakeholders and community members. These should be prepared on the basis of needs assessment and rationalization of resources at health facilities along with the realistic assessment of the needs of the population, especially of poor and slum dwelling population having access to health services. Developing bottom-up health plans will help preparing realistic and better informed state PIP.

- Stre*n*gthen community level actions to bring convergence, promote healthy behaviors and mobilize the community to access health services.

  Swasthya Manch, is a very good initiative of Chandigarh health department that involve communities and various stakeholders and departments such as health, ICDS, slum development, education, municipal corporation/ panchayat and NGOs. Strengthening this initiative will help mobilizing communities to utilize the health services and promote healthy behaviors. Brining in coordination among different agencies can help them complementing their resources and avoiding repletion of services.

- *Capacity building of VHSC members will help strengthening community linkages and integrating health system with the community*

  The joint events of VHSC meetings, swasthya manch and VHNDs help integrating health services with panchayats which is an appreciative aspect. The panchayat members, AWWs and ANMs participate in it and a medical officer also visits to these meetings. For effective working of VHSCs their members need to be oriented about their roles and responsibilities and utilizing the funds.

- *Community monitoring needs to be initiated for brining in the transparency and effectiveness in the program implementation.*

CHAPTER 5. STATE SPECIFIC ISSUES

School Health Program:

The school health program is being implemented with 10 teams comprising of medical officer, refractionist, dentist and dietician covering 267 schools and Sarv Siksha Abhiyan (AIE) centers. The program also has a school health OPD in one of the Civil Dispensaries.

S.No.	Schools	No. of Schools	Strength of children
1.	Govt. Schools	106	1,32,517
2.	Private Schools	75	76,014
3.	K.V.	5	6,692
4.	AIE Centers	81	6,552
	Total	**267**	**2,21,775**

The total number of students examined has increased from 57968 in 2009-10 to 82094 in 2010-11 till November – an increase of 212%.

There is good coordination between the health and the education departments in the implementation of the program. A program for raising the program levels and certifying schools as 'Health Promoting Schools" is also in pipeline.

Non Communicable Disease Program

Health manpower (including health workers) is being trained in early diagnosis, timely referral, risk factor screening in both general and high risk population. Budgetary requirement for further expansion of this programme is being included in PIP 2009-10 and 2010-11 but have not been approved in the ROP>

Under this program Diet Clinics have been set up at CHCs and DH in Chandigarh where trained dieticians are screening, counseling and referring general and high risk population referred to them from different departments within the health care facilities.

As pert of the program, health staff in CHCs and DH has been trained to calculate BMI and desired weight of every patient coming to the OPDs in the CHC. Each OPD patient in the CHCs and DH gets a Diet Clinic Number and their height, weight, BMI and expected weight is recorded on the first page of the OPD card. Risk factor screening is done based on the WHO STEPS guidelines for surveillance of non communicable disease.

As part of the IEC – pamphlets explaining the Non communicable – lifestyle disease, risk factors and prevention are distributed to all visitors in the CHCs and DH.

The IEC budget for this program comes from the IEC/BCC cell and the 'Project-Foundation' under NRHM.

Annexures

Annexure 1

List of Upgradation Work taken up under NRHM
(Information to be collected during 4th CRM Visit)

Name of the State: Chandigarh, U.T

Sub-Center:

Sr. No.	District	Block	Name of Sub-Centes	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

PHCs/Addl. PHCs:

Sr. No.	District	Block	Name of PHCs	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

CDs

Sr. No.	District	Block	Name of CDs	Date/ Month of Work Sanctioned	Date/Month of Work Completion
1	Chandigarh		Industrial Area, CD-CITCO	20.3.2009	Under Construction
	-	-	-	-	-

CHCs:

Sr. No.	District	Block	Name of CHCs	Date/ Month of Work Sanctioned	Date/Month of Work Completion
1	Chandigarh		CHC, Sector-22	4.12.2006	
	-	-	-	-	-
	-	-	-	-	-

Sub Divisional/ Area Hospital:

Sr. No.	District	Block	Name of Sub Divisional/ Area Hospital	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

District Hospital:

Sr. No.	District	Block	Name of District Hospital	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

List of New Constructions under NRHM

(Information to be collected during 4th CRM Visit)

Name of the State: Chandigarh, U.T

Sub-Center:

Sr. No.	District	Block	Name of Sub-Centes	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

PHCs/Addl. PHCs:

Sr. No.	District	Block	Name of PHCs	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

CHCs: State Health System & Resource Centre and Warehouse:

Sr. No.	District	Block	Name of CHCs	Date/ Month of Work Sanctioned	Date/Month of Work Completion
1.	Chandigarh		CHC, Sector-22	26.3.2009	Under Construction
	-	-	-	-	-

Sub Divisional/ Area Hospital:

Sr. No.	District	Block	Name of Sub Divisional/ Area Hospital	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

District Hospital:

Sr. No.	District	Block	Name of District Hospital	Date/ Month of Work Sanctioned	Date/Month of Work Completion
	-	-	-	-	-
	-	-	-	-	-

Annexure 2

Details of ANC, deliveries and family planning since implementation of NRHM in Chandigarh

Unit	**2008-09**	**2009-10**	**2010-11 (Up to Oct 2010)**
Pregnant Women registered for ANC service	33109	42135	21807
Registered Pregnant Women received three check-ups	26533	34910	17061
Institutional Deliveries	18563	19257	11269
Home Deliveries	3672	2961	1457
Still Birth	395	646	397
Sterilization	2086	2179	1153
IUD Insertion	4042	3802	1978
Condom Pieces	866126	995713	552420
Oral Pills Pcs.	9428	11846	5331

Annexure 3

No. of patients treated at AYUSH centres in Chandigarh

Year	Patients	Increase in the patients
2008	123670	
2009	160792	37122
Nov. 2010	183392	22600

Source: Dept. of AYUSH, Chandigarh

Annexure 4

ANCs conducted at CHC sector 22

Year	ANC registration
2000-01	**887**
2001-02	**763**
2002-03	**1109**
2003-04	**1394**
2004-05	**1532**
2005-06	**1544**
2006-07	**1956**
2007-08	**2215**
2008-09	**2223**
2009-10	**1982**
2010-11	**1437**

Source: records of CHC sector 22

Annexure 5

Human Resources at CHCs-22 & Manimajra

	Sanctioned (no.s)	**In-Position (no.s)**		**Residing on campus**	**Whether any of the staff listed received training in any of following?** (*Pl. put code and number of staff trained against each in the rows below)*	
		Regular	**Contractual**		a. SBA/ BEmOC b. IMNCI c. MTP using MVA d. Blood banking/ storage e. RTI/STI	f. IUCD g. Minilap/ Lap h. NSV i. EmOC j. LSAS
Ob/Gyn		**4**				
Anaesthetist		**2**				
Paediatrician						
Surgeon		**1**				
Other						
Medical Officers		**11**			**e-38** **NSSK-13**	
Nurses		**12**	**28**			
ANMs	**133**	**43**	**85**		**e-128, f-15 and b-142**	
Lab technicians	**10**		**10**			
LHVs	**26**	**11**	**9**			
MPHWs	**31**	**8**	**22**			

Annexure 6

Human Resources at GMSH-16

	Sanctioned (no.s)	**In-Position (no.s)**		**Residing on campus**	**Whether any of the staff listed received training in any of following?** (*Pl. put code and number of staff trained against each in the rows below)*	
		Regular	**Contractual**		k. SBA/ BEmOC l. IMNCI m. MTP using MVA n. Blood banking/ storage o. RTI/STI	p. IUCD q. Minilap/Lap r. NSV s. Em OC t. LSAS
Ob/Gyn SMO	**2**	**1**	**-**	**-**	-	
MO	**3**	**7**	**-**	**-**		
Anaesthetist SMO	**1**	**-**	**-**	**-**	-	
MO	**5**	**5**	**-**	**-**		
Paediatrician SMO	**2**	**1**	**-**	**-**	-	
MO	**3**	**4**	**-**	**-**		
Surgeon SMO	**4**	**1**	**-**	**-**		
MO	**3**	**8**	**-**	**-**	-	
Other	**-**	**-**	**-**	**-**	-	
SMO **Medical Officers** **AMO** **Dental Surgeon**	**6** **25** **10** **2**	**4** **33** **-** **-**	**-** **-** **3** **-**	**-** **-** **-**	-	
Nurses	**144**	**89**	**59**	**-**	-	
ANMs	**1**	**1**	**1**	**-**	-	
Lab technicians	**24**	**24**	**9**	**3**	-	
Other support staff	**94**	**94**	**3**	**4**	-	

Annexure 7

Human Resources at CHC-22

	Sanctioned (no.s)	**In-Position (no.s)**		**Residing on campus**	**Whether any of the staff listed received training in any of following?** (*Pl. put code and number of staff trained against each in the rows below)*	
		Regular	**Contractual**		u. SBA/ BEmOC v. IMNCI w. MTP using MVA x. Blood banking/ storage y. RTI/STI	z. I UCD aa. Minilap/ Lap bb. NSV cc. EmOC dd. LSAS
Ob/Gyn MO	- -	**3**	- -	- -	-	
Anaesthetist SMO **MO**	- -	- -	- -	- -	-	
Paediatrician	-	-	-	-	-	
Surgeon	-	-	-	-		
Other(Ortho)	**1**	**1**	-	-	-	
Senior MO	**6**	-	-	**1**	-	
Nurses	**2**	**1**	**2**	**1**	-	
ANMs	**1**	**1**	-	**1**	-	
Lab technicians	-	-	**3**	-	-	
Other support staff	**1**	**1**	**1**	**1**	-	

Annexure 8

Human Resources at PC-45

	Sanctioned (no.s)	**In-Position (no.s)**		**Residing on campus**	**Whether any of the staff listed received training in any of following?** (*Pl. put code and number of staff trained against each in the rows below)*	
		Regular	**Contractual**		ee. SBA/ BEmOC ff. IMNCI gg. MTP using MVA hh. Blood banking/ storage ii. RTI/STI	jj. I UCD kk. Minilap/ Lap ll. NSV mm. EmOC nn. LSAS
Ob/Gyn	-	**1**	-	-	-	
Anaesthetist	-	-	-	-	-	
Paediatrician **SMO** **MO**	-	-	-	-	-	
Surgeon	-	-	-	-	-	
Other	-	-	-	-	-	
Medical Officers **Dental Surgeon**	**2** **1**	**1** **1**	-	-	-	
Nurses	-	-	-	-	-	
ANMs	-	-	-	-	-	
Lab technicians	-	-	-	-	-	
Other support staff	-	-	-	-	-	

Annexure 8

Human Resources at CHC-Manimajra

	Sanctioned (no.s)	**In-Position (no.s)**		**Residing on campus**	**Whether any of the staff listed received training in any of following?** (*Pl. put code and number of staff trained against each in the rows below)*	
		Regular	**Contractual**		oo. SBA/ BEmOC pp. IMNCI qq. MTP using MVA rr. Blood banking/ storage ss. RTI/STI	tt. I UCD uu. Minilap/ Lap vv. NSV ww. EmOC xx. LSAS
Ob/Gyn	**-**	**2**	**-**	**-**	**-**	
Anaesthetist	**-**	**1**	**-**	**-**	**-**	
Paediatrician SMO	**-**	**1**	**-**	**-**	**-**	
Surgeon	**-**	**1**	**-**	**-**	**-**	
Other	**-**	**-**	**-**	**-**	**-**	
Medical Officers **Dental Surgeon**	**9** **1**	**3** **1**	**1** **2**	**1** **-**	**-**	
Nurses	**15**	**9**	**-**	**3**	**-**	
ANMs	**4**	**4**	**-**	**1**	**-**	
Lab technicians	**3**	**3**	**-**	**1**	**-**	
Other support staff	**6**	**6**	**-**	**2**	**-**	

Annexure 9

HR status as on date: \

Category	**Sanctioned**	**In Position**			**Required as per IPHS**	**Shortfall against IPHS**
		Regular	**Contractual**			
			NRHM Funds	Other Sources		
Doctors	96 16 (Dental Surgeon)	74 13 Dental Surgeon	9 14 D.S	8		
Specialists	26	36	-			
Staff Nurses	166	103	29	64		
MPW	7	7	23	-		
ANM	44	43	85			
Lab Technician	27	27	10	13		
Other supportive staff	101	101	-	4		