4th Common Review Mission Report

Punjab

CHAPTER ONE

CRM team members

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Ms. Divya Shree	Consultant, NRHM	Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi.

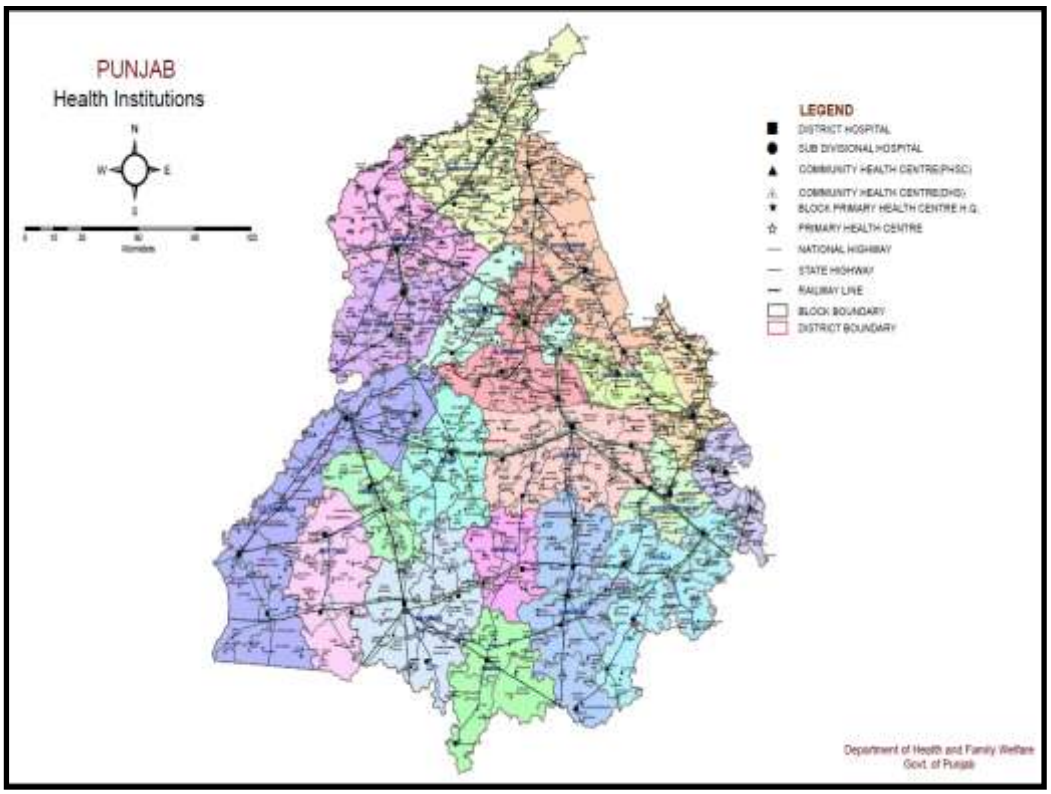
The team divided itself into two sub teams as follows:

Dr T Sundararaman, Dr P K Nayak and Mr. Pradeep Tandon constituted one sub-team which went to Jalandhar and Dr. D.K. Mangal, Dr S Mishra, Dr. Ankur Yadav and Ms. Divya Shree constituted the other group which visited the district of Muktsar. Both the teams returned to Chandigarh on 21th Dec 10.

CHAPTER TWO

INTRODUCTION

a. Introduction of the State.



Punjab is geographically situated between 29^{o} 32' to 32^{o} 32'N latitudinal and 73^{o} 55' to 76^{o} 50'E longitudinal. Physically, the state may be divided into two parts; sub-Shivalik Strip and Sutlej-Ghaggar Plain. The state has an area of 50,362 sq. km. and a population of 24.36 million. There are 20 districts, 141 blocks and 12673 villages. The State has population density of 483 per sq. km. (as against the national average of 312). The decadal growth rate of the state is 20.10% (against 21.54% for the country) and the population of the state is growing at a slower rate than the national rate.

Table 1: State Profile

Total Area	50,362 sq. km

Total Population(in lakhs)	244
Rural Population (In lakhs)	161
Number of Districts	20
Number of Sub Division/ Talukas	77
Number of Blocks	141
Number of Villages	12673
Number of District Hospitals	20
Number of Community health centres	129
Number of primary health centres	445
Number of sub centres	2950

Table 2: Demographic and Health profile of Haryana State as compared to India figures

Indicators	Punjab	All India
Infant Mortality rate (SRS 2009)	38	50
Maternal Mortality Rate (SRS 2004-06)	192	254
Total Fertility Rate	1.9	2.6
Institutional deliveries (DLHS-3)	63.3%	47%
At least 1 ANC (DLHS-3)	96.4%	75.2%
Full ANC (DLHS-3)	48.5%	18.8%
Full Immunisation rate	3.6% (CES, 2009)[i]	
Early initiation of breast feeding (DLHS-3)	44.6%	40.5%

Table 3: Year wise cumulative funds released for NRHM

Year	Allocation	Release	Expenditure
2005-06	81.88	90.71	65.45

2006-07	130.42	138.93	86.62
2007-08	161.69	107.84	111.64
2008-09	185.89	183.03	190.08
2009-10	209.32	221.74	215.03
2010-11	246.32	159.93	93.05

Table 4: Progress of NRHM in state

Activity	**Status**
24x7 PHCs	219 of 394 Primary Health Centres are functioning on 24x7 basis
Functioning as FRUs	20 District Hospitals (DHs), 35 SDH (Sub Divisional Hospital) are working as First Referral Unit (FRU).25 CHCs/129 CHCs are working as FRUs
ASHA selected	17229 ASHAs selected, 14026 ASHAs is trained up to 4th module and 14500 provided with drug kits.
ANMs at Sub Centres	Out of 2950 SCs, 1980 are functional with one ANM and 970 are functional with 2nd ANM.
Contractual appointments	91 Doctors, 45 paramedics, 1099 Staff Nurses, 44 specialist & 1856 ANMs are positioned.
Village Health & Sanitation Committees (VHSC)	12673 Villages,13108 constituted VHSCs.
CHCs Selected for upgradation	114 CHCs are selected for upgradation.
Physical upgradation started	114 CHCs Physical upgradation started.
No. of District Hospitals which have been taken up for upgradation under NRHM	20 DHs are taken up for upgradation.

Table 5: Physical progress of JSY

Year	Home Deliveries	Institutional Deliveries	Total
2005-06	7489	4106	11595
2006-07	9466	6613	16079
2007-08	5494	4423	9917
2008-09	40350	27561	67911
2009-10	54090	42999	97089
2010-11 (April to June)	8959	9752	18711

Table 5: Status of Family welfare Services

(Figures are in Lakhs)

Services	**06-07**	**07-08**	**08-09**	**09-10**	**10-11**
Male Sterilisation	0.06	0.13	0.13	0.11	0.84
Female sterilisation	0.88	0.91	0.85	0.66	0.36
Full immunisation		4.63	4.39	4.31	2.62

4th Common Review Mission					
17th December 2010 to 23rd December 2010					
Name of State			Punjab		
Names of Districts visited					
Sl no.	Name	District HQ	Name of DM		Name of CMO
1	Jalandhar	Jalandhar			DR. S.K. Gupta
2	Muktsar	Muktsar	Sh. Varun Roojam		Dr. Tirath Goyal
Health Facilities visited					
Sno	Name	Address / Location	Level (SC / PHC / CHC/other)		Name of the Person in Charge
1	District Hospital Jalandhar	Jalandhar	District hospital		Avtar Chand
2	Sub Divisional Hospital Nakodar	Nakoder	CHC		Dr Ruplal
3	Bakoli Mini PHC	Bakoli	PHC		DR.Harvinder Kaur
4	CHC Kala Bakra	Kala Bakra	PHC cum CHC		Dr.Ajay Khosla
5	Kingra Sub centre	Kingra Sub Centre	Sub centre		Tarsum Kaur
6	Subsidiary health centre Ladhra	Ladhra (Kala Bakra)	Other		Dr.Vipin
7	CHC Adampur	Adampur	CHC		Dr.T.S.Randhawa
8	CHC Kartarpur	Kartarpur	CHC Kartarpur		Dr.Harpal Kaur
9	Sub centre	Fatehjalal	Sub Centre		Indira Devi
10	District hospital Muktsar	Muktsar	District hospital		Dr. Hari Narayan Singh
11	SDH Malout	Malout	Sub Divisional Hospital		Dr. H.S. Bhullar
12	CHC Sarawan bodhla	Sarawan bodhla	CHC		Dr. Rajender Kumar
13	CHC Chak Shere Wala	Chak Shere Wala	CHC		
14	PHC thandewala	Thandewala	PHC		
15	PHC Kanianwali	Kanianwali	PHC		Dr. Priyanka Davla
16	PHC				
17	Sub Centre Burjsidhwan	Burjsidhwan	Sub Centre		Ajit Kaur
18	Sub Centre Tamkot	Tamkot	Sub Centre		Ranvinder Kaur

19	Sub health Center Kanianwali	Kanianwali	Sub health Center	Ravi Kaur Veer Pal
20	Sub Health Center Bhangewala	Bhangewala	Sub Health Center	Ms Gurvinder Kaur Ms Sarbjeet Kaur
21	Sub center – Sarainaga	Sub center – Sarainaga	Sub center – Sarainaga	Ms Babita Rani Ms Gurmeet Kaur
22	NSV Camp	Thandewala	NSV Camp	
23	AWC-1, Bhangewala AWC-II, Bhangewala AWC-III, Bhangewala	Bhangewala	AWC	Ms. Murti Kaur Mrs. Bhupender Kaur Mrs. Neetu Kaur

CHAPTER THREE

FINDINGS OF THE 4TH CRM IN THE STATE

1. **INFRASTRUCTURE UP-GRADATION** (Rs.7.25 crore- PIP 2008-09 and Rs. 15.51 Crore PIP 2009-10).

- In Punjab, Punjab Health Systems Corporation (PHSC) act as a Nodal Agency for health infrastructure up-gradation. The State has prepared a comprehensive plan for up-gradation of civil infrastructure and equipment with an outlay of Rs. 350.00 crore. The state would have implemented this plan fully by June 2011- and potentially all identified infrastructure needs would have been met. This includes district hospitals, sub-divisional hospitals, CHCs, PHCs and sub-centers. Thus the state may be one of the first to declare a complete infrastructure as per needs put in place.
- Construction work is efficiently organized and both time delays and quality issues are at a minimum. Maintenance of infrastructure is also good. The role of the PHSC in overseeing this work and the availability of untied funds from both NRHM grants and user fees has no doubt crucial to this success. Equipment is categorized into three groups and for A category the AMC is by the PHSC itself. For B it is outsourced from PHSC and monitored by hospitals and for the third category it is local workshops. The PHSC is a 3000 employee strong organization, with its own budget and governing board, managed by a senior IAS officer. It looks after infrastructure development, procurement of equipment and drugs, and secondary and tertiary hospital management support.
- In the total of 21 District hospitals, a new maternity word construction was planned in all to take up the increased case load. Work is completed in one and in progress in 13 district hospitals. Work is yet to start in 7 District hospitals. Four district hospitals are being upgraded.
- In total there are 35 Sub divisional Hospitals. Work was completed in 10 SDHs in this year. Another 3 Major civil works were completed earlier. Work is in progress in the 15 SDH. 8 SDHs are being upgraded.
- Of the total of 129 CHCs, work is completed in 120 CHCs in this year. Work is in progress in the one CHC and work is yet to start in 6 CHCs. (Govt. of India provided Rs. 23.20 crore for the repair & renovation of 127 CHCs during the years 2005-06 & 2006-07). One of these, CHC Dhakoli (Mohali), has been taken up for major construction at a cost of Rs. 292.25 lakh work and the work is likely to be completed by 31/3/2011. In addition to this by the year 2010-11 all the 114 CHCs under PHSC have been identified for providing Level-III - CEmOC services. (Currently under this plan, 30 new Community Health Centers are being upgraded / extended / constructed??).

- In 445 PHCs repair and construction work was earlier and in 76 in this year and work is in progress in the 42 PHCs. Works yet to be start according to the previous plan in the 101 PHC. 204 Primary Health Centers are being taken up for extension / up-gradation.

- Under the World Bank project which was completed in the year 2004, PHSC has got constructed 332 Staff Quarters of different categories. Most facilities would have at least two doctors and two nurses quarters, which may not be enough to accommodate all doctors or nurses, but at least is enough to keep a few available on campus.

- Maintenance activity of civil infrastructure is helped by NRHM funds. Secondary level hospitals generate annually approximately Rs 25 crore user charges, which are retained by the institutions and out of this 15% are being spent on Building Maintenance and 15% on Equipment Maintenance. This is a substantial amount and for district hospitals and civil hospitals the major source of maintenance funds. Apart from this, special repairs for civil infrastructure as well as equipment are being undertaken from funds provided by the State Government from the Non Plan side through the Punjab Health Systems Corporation. It has its own online equipment monitoring system.
- At the sub-center level, the renovation and new construction work is undertaken through the Panchayats. In total there are 2950 Sub centers. Of these 252 Health sub- center and 216 Subsidiary health centre were taken for any up-gradation. Minor work was completed in 51 Sub-centres and major work completed in 4 subsidiary health centres. Work is in progress in the 17 sub centre and 76 subsidiary health centers. Work yet to be started in the 184 health sub centre and 136 subsidiary health centers. The works of construction of about 175 institutions are awarded to 175 Village Panchayat. If these are completed, the infrastructure gaps in sub-center would have been attended to. This may take till June 2012. .
- CRM visits shows all facilities to have good infrastructure, very clean and well maintained, with proper drainage. Untied funds have contributed significantly to achieve this. Quality of construction in Muktsar district hospital and one PHC- some concerns- as seepage was visible in walls, and in boundary walls.

2. HUMAN RESOURCES PLANNING

- According to Indian Public Health Standards (IPHS), total 2427 doctors are required in the health facilities of Punjab. In Punjab 2064 doctors are working as regular employee. Under NRHM 112 doctors are working as a contractual employees, and another 86 are to be recruited. Punjab state has shortage of 363(14.95 %) doctors. (Total sanctioned post for doctors are 2657).

- According to Indian Public Health Standards, total 1114 specialist doctors are required in the public health facilities of Punjab. Total 865 specialist doctors are working in the public health system of Punjab among them 807 are regular employee and 58 are contractual employee under NRHM- 30 pediatricians and 21 gynecologists at CHC level and another 7 gynecologists under DH level. There are shortages of 249 (22.35 %) specialist doctors in the state. Under what was planned by the state in NRHM 39 gynecologists posts, and 30 pediatrician posts remain vacant.

- There is total 3399 Staff Nurses are working in public health system of Punjab against required total 5768. Among total working staff nurses 2300 staff nurses are regular employee and 1122 are working under NRHM as contractual employee- 548 in CHCs, 551 in PHCs and 23 in Mobile Medical Units (MMU). There are shortages of 2369 (41.07%) staff nurses in the state and under NRHM at least 134 nurses need to be recruited. More careful examination of vacancies at district and SDH levels would probably show an even greater deficiency in nursing staff.

- According to IPHS, total 6555 ANM are required in the public health system of state. Total 4505 ANM are working in the public health system of Punjab, among them 21.17% are working under NRHM. There is shortage of 2050 (31.27%) ANMs in the state according to IPHS. Under NRHM 1411 second ANMs and 230 ANMs for urban slums were sought, and of these 970 second ANMs and 224 urban slum ANMs have been deployed. Though another 447 ANMs are required, further discussion shows that the frontier may be more careful application of what exists rather than adding on more staff.

- At the state level 58 contractual technical posts against a projected requirement of 69 have been created and utilized. At the district level 496 contractual posts against a projected requirement of 528 have been created and utilized. Posts created that need to be noted as specific positive developments include for district level school health coordinators, community mobilisers for the ASHA programme, civil registration assistants at district level and information assistants at the block level and in large hospitals. A technical pool of seven persons at the state level also acts as the state's State Health Systems resource Centre (SHSRC).

- Vacancies are small and the state is seized of these also, and there are adequate efforts to close the remaining gaps. However creation of new posts under state budget is a non- starter. If the NRHM support to these contractual posts were to be withdrawn or passed over to the state, there would be a collapse of the gains that have been made.

Human Resources as seen during the CRM

All peripheral facilities visited - PHCs and sub-centers have nurses and doctors as per requirement- often above the current case load. 87 staff nurses added in 30 PHCs (9 of which are mini PHCs) and 10 CHCs –17 PHCs and 4 CHCs. Only 6 nurse posts vacant in Jalandhar and 5 in Muktsar. Two ANMs added in most sub-centers. Two medical officers in all PHC, one of them AYUSH. All PHCs have at least one medical officer. Dispensaries also had medical officers- one in each- but in Muktsar- 30/43 (69.76%) are vacant. However District hospitals and civil hospitals have severe nursing shortage- considerably below both norms and the current case loads. 77 nurses against 430 beds in Jalandhar, (excluding trauma unit); and only 10 nurses for 50 bed at district hospital in Muktsar and 7 nurses in 50 bedded Nakodar. At this level there is also a nursing shortage. Medical officers and specialists are also in short supply, considering the huge case loads of the maternity division.

Availability in the open pool an issue for Muktsar and few other difficult districts it is an issue, but this is not so in Jalandhar. Plan to declare this as most difficult and bring in incentives.

There is a lack of clarity about the functions of the two ANMs. ANMs are often not doing o and not even expected/encouraged to do deliveries at the sub-center or assist at home. Once per week they have an immunization session for which both of them are going. Often two or even three of the four week, the session is in the sub-center facility itself. That is one day of work per week. The meeting at the PHC, including register updating etc is a second day of work. The other work they do is sterilization promotion- and for which some home visits are taking place. There is a lack of clarity about what they are expected to deliver measurably on the other four days of the week. A sort of OPD care has developed, but with minimal skill sets and little public health focus. There is a trend to see the second ANM as junior to the first ANM- but its work performance implications need to be studied further. The ASHA is also present and available and undertaking a lot of the home visits which would have been the ANMs work. There is no specific requirement or monitoring to address issues of nutrition or child illness. The ANM is being monitored on a daily basis through mobiles, which there is a huge resentment against- for obviously there is little to report on other days. Objectively there is considerable work to be done- but there is a failure at the design level to conceive it, and starting with monitoring before work allocation is a lot of cart before the horse. A pilot of introducing non communicable diseases work for ANMs is reported to be ongoing in Jalandhar in the blocks visited- but little evidence of this on the ground. Perhaps it is at an early stage. At Muktsar a newly introduced adolescent girl programme is expected to take up the slack, but that too is at an early stage.

Plan for Augmentation of Health Resources

- Multi skilling : The Staff working at rural areas are being imparted training in various traits to handle the complicacy during pregnancy and other health services. State has a rigorous training calendar.
- Promoting the maximum Health workers to join the Public Health Services by means of:
  - Incentives on achieving benchmarks for doctors.
  - Promoting the doctors to work in the under-serve areas by offering best salaries.
  - Incentives to the doctors after attainment of certain skills.
  - Performance based incentive Plan.
  - Recognition for best services.
- Performance evaluation system for monitoring output.

Short Term Plans for meeting the HRH shortages

- Continuous recruitment prorgamme
- Walk-in-interview system have been started

Planning to overcome the Shortages of the Specialists

To maintain the numeric adequacy of doctors the Govt. of Punjab has done recruitments in regular cadre in recent past.

Workforce Performance

In Punjab there are Employee Friendly rules to motivate the work force like performance based incentive plan for doctors. There is a performance appraisal system in Punjab for quality care of the people. Fixed yearly increments in remuneration are given. Transfer policy is also good it's on the individual case basis. Bio metric attendance system is present in Punjab and they are promoting the online HMIS and OPD monitoring system for best practice of HR policy.

Training

SIHFW, Mohali is a fully computerized, well equipped (Computers, Multimedia Projectors, Digital Presenters, Photocopiers, Fax, web-enabled facilities) facility with teaching space and hostel accommodation. The HFWTC, Amritsar is also undergoing upgradation with new equipment, repairs and internet facilities. All ANMTCs and MPHW (M) Training Centres have been provided with new equipments, books and models.

District Training Centres have only two support staff, but there is class room and office space available and these are located at the district headquarters .Though infrastructure is not a constraint, training pace is however 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. This is the state level trend as can be seen from the table below.

The training is quota- based- with major mismatches between people trained and job expectation. Thus ANMs are trained on SBA, but nurses are doing deliveries. Many of the nurses and ANMs met who are doing the major part of the deliveries in the district had not under gone SBA training – but even as per statement since less than 20% have been trained, they may have missed in sample.

The wrong use of Oxytocin was a problem in some facilities and the non availability of drugs and non use of other SBA related higher skills was a problem in all facilities. Protocols on display – but its use is limited- partly because they are very new, and partly because the protocols are often inappropriate to the 24/ 7 PHC where they are put up.

Training	Mission Period		2010-11		Remarks
	Target	Achievement	Target	Achievement	
LSAS	72	56 (26)	48	32 (12)	Till 2009-10 only one Medical College; 2010-11 - all 6 Medical colleges started
IMNCI	4800	1698	1920	245	ToT could not be conducted. Due next month
F-IMNCI	800	Nil	800	Nil	ToT could not be conducted. Due next month
NSSK	1680	264	1680	264	Training in progress, likely to be completed by 31.03.2011
IUCD Ins (MO/ LHV, ANM	3880	869	960	551	
SBA (MO/ LHV, ANM/ SN)	3500 (500/ 1800/ 1200)	1347	845	314	
MTP	500	220	60	36	
Minilap	240	179	60	23	
Laparo St.	219	186	60	35	
RTI/ STI	7400	2794	1200	470	
IMEP	7400	2525	1200	470	

Training	Mission Period		2010-11		Remarks
EmOC	25	Nil	25	Nil	

Training achievements (IMNCI 0 %, NSSK 22%, and SBA 38 %, EmOC 0%) shows that training activity is slow and there is need to strengthen the training capacity in state. The central gaps are the availability of adequate training facility and the planned development of training sites.

3. HEALTH CARE SERVICE DELIVERY – FACILITY BASED - QUANTITY AND QUALITY

- There is an increase in case loads at all levels. In terms of outpatient attendance at Jalandhar: DH records show 300/day SDH, Nakodar is at 500 /day, the two CHCs visited were at 100 and 200 day and the PHCs recorded - 30 to 50 per day. At Muktsar the DH records 250/day the two CHCs at 60/day; the SDH- Malout 425 per day. These levels have been consistently increasing, though with a small dip in the graph in the year 2009.
- In terms of inpatient care in Jalandhar, the DH records 62 admissions per day, the civil hospital- 56, the CHCs 8 and 15. In Muktsar the DH records 50/day, the SDH – CHC- 5/day.
- Institutional delivery- Jalandhar: Civil hospital records 54 deliveries per month, the CHCs 40/month; and at Muktsar: the DH records 122 /month, and the CHC 54/month
- Large number of trauma cases are being seen and managed at all the facilities visited. This is particularly so at DH Jalandhar where there is a new trauma care block that has opened up, but even at Nakodar, SDH which is not a designated trauma center, a significant part of the inpatient loads and surgeries are orthopaedic.
- Another impressive performance was the Thalassemia clinic ++ in the district hospital which was managing a huge load of Thalessemic babies registered with them with regular blood transfusions and medication. Care levels by our public health standards were excelled, but even more needs to be done in terms of infrastructure and supportive arrangements. NGO participation with patient user groups involved was making a big difference to quality of care. There are six such units in Punjab.
- Yet another impressive performance was the HIV services. Every aspects of the service, the ICTC, the ART clinic, the targeted interventions were all doing well. NGO involvement was again making a significant contribution to quality of care and bringing invaluable additional human capacity and motivation into the care process.
- A third impressive DH performance relates to the high dengue load managed and the platelet concentration and transfusion facilities that are in place.

Determinants of Quality of Care

a. **Human Resources**

- Numerically, this is adequate in peripheral facilities- but the case loads have increased disproportionately at the SDH and DH and here there major gaps in nurses, specialists and support medical officers. Technical support staff were also reported to have gaps- but the team could not examine this aspect.

b. **Drugs and Supplies**

- At DH most patients interacted with were buying drugs from outside. Huge costs on outside prescription must be contributing to high out of pocket expenditures. Internal supply very weak. This is despite a very robust user fee collection of over Rs 15 lakhs per month!!
- At SDH- most patients interacted with were receiving drugs based on free internal supply, with only minimal outside prescriptions. However the source of supply was based on user fees and bulk of purchases were made locally. Consequently low out of pocket expenditures. However user fee collection is as robust as or even more so than the district hospitals and flow mainly from diagnostics. So the hospital earns on diagnostics and spends on drugs!!
- At CHC- drugs are based mainly on internal supply- but delivery from the state. There is a mixed pattern- but there could be substantial out of pocket expenditures. Certain RCH drugs like Misoprostol, Magsulf not available. Many key drugs could go out of stock due to supply driven logistics- e.g. Copper –T and Doxycycline.

c. **Equipment**

This seems adequate in all facilities visited. No major gaps observed.

d. **Laboratory Services and Diagnostics**

Laboratory services available at all facilities as planned. The CHCs visited had a set of 27 investigations and covers the entire basic range. This is most welcome. The investigations at the more peripheral PHCs are however limited and there is no system of referring samples for investigation to the CHCs.

e. **Diet**

This is not provided in any facility at any level- even in DH. This is a major lapse, and it was informed to us, that though diet was earlier provided, it was stopped as part of the reforms of mid nineties. The hospital managements were keen to re-start diet.

f. **Security**

This was reported as a major issue at the peripheral health facilities, especially for women staff members to stay overnight. The sub-center and PHC location outside the main village was a problem. At the higher facilities, security guards were in place and functional.

g. Laundry services

These were adequately managed and linen seen was clean.

h. Sanitation and hygiene

This was good in all facilities visited. This is not surprising when an announced visit of this sort is being made. However based on user fees or untied grants most facilities have made enough human resource and organizational arrangements, leading us to be positive about the standards of hygiene being maintained.

i. Biomedical waste management

These systems are in place. Training of staff could be improved.

j. Assured Referral Transport

No effective assured referral transport services in place. Limited use of available vehicles for transport to higher facilities. At the time of the CRM, the government has entered into an agreement with a firm for the provision of emergency response services state-wide. This is not operational as yet, but once it starts, the situation should be much improved.

k. AYUSH co location is effectively put in place and increasing OPDs attendance substantially. Drugs for AYUSH delivery are also available.

l. Signages

Signages were found to be good; Citizens charter prominently displayed.

m. Women friendliness

There are separate and clean toilets for women. Privacy was good in labour rooms and in examination rooms. Labour rooms were clean. Lack of supply of diet a problem.

<u>User Fees collection and expenditure</u>

One feature of the Punjab public health systems is the relatively high level of user fee collection, along with an effective organization of its use. Of the total user fees collected, 10% is given to PHSC, for use as part of an emergency revolving fund which is ploughed back to facilities which need additional inputs the remaining user fees collected is to spend according to the following norms:

- 45% on drugs and supplies
- 25% on patient comforts

- 15% building repairs
- 15% equipment repair.

Amounts collected are considerable- about Rs. 2 crores per year in the higher facilities and about Rs. 30 to Rs. 50 lakhs per year at the CHC level.

Though exemptions to the poor are available as per the rules, in all the facilities visited, exemptions are given to less than 10%- and in investigations the percentages given exemption could be even lower. The main source of user fees is the charges on investigations.

This finding has to be interpreted along with substantial out of pocket expenditure in public hospitals as reported by external surveys. NSSO data shows Punjab as having the highest OOPs at the public hospital.- rural Rs. 9774 per hospitalization episode and urban Rs. 10323. Though this is substantially less than OOPs in the private hospital Rs. 13,044 rural and Rs 19035-urban – it is still high enough to result in considerable exclusion.

The contributions from the united grants provided under NRHM are thus only a small part of the total funds that the facility raises for local expenses. The RKS has command over the untied NRHM grant, but none over the user fees collected. The NRHM untied fund is used for expenditure on maintenance and patient comforts over and above what can be allowed under the user fee collection route.

The total user fee collection in state is over Rs. 25 crores per year. When hospital managers were asked about withdrawing user fees, their main response was that while they would welcome it, the whole quality and even range and volume of care provided rested today on this large user fee base, and without an alternative, there would be a loss of immense operational flexibility that it provides.

The table below gives the situation in user fee collection and expenditure for the district of Jalandhar :

Facilities	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

Facilities	Monthly	Staff salary	Drugs	Patients	Maint.	Maint.
CHC Lohian Khas	318905	0	169471	99022	12436	0
CHC Apra	141647	0	36380	49015	2993	21383
Total	52,91,741	1,71,182	24,38,040	12,61,460	6,00,801	462303

One interesting feature of the Punjab public health system is the subsidiary health centers or dispensaries. These are all under the district panchayats, which hires a doctor under an annual contract and also supplies them with drugs and supplies. It is upto the doctor to hire support staff and pay them from the amount he gets under the contract. In the main these run OPD facilities. Though they are to supervise sub-centers they do not seem to be actively engaged in doing so, and their public health understanding and population based care is very limited, if at all. In a standard block which should have about three or four PHCs, one or two have been made into subsidiary health centers and of the other two or three, usually one is upgraded into a 24/7 PHC and the other continues as a PHC at much the same level of performance as a subsidiary health center.

The net result of this is that the concept of a sector as a unit of public health management has all but disappeared, and public health management occurs only at the block level.

4. OUTREACH SERVICES

Sub Centers do not perform deliveries by administrative policy. If they do occur in some place, they are to be counted as home deliveries done with SBA assistance. We also did not find sub-centers doing deliveries.

The main activity of the sub-center is the immunization session- both ANMs go for it- and it is usually once a week, rarely twice. Number of session points have not increased with the second ANM. In one sub-center visited, 3 out of 4 sessions in month was in sub-center HQ- a large village perhaps.

78.52% sessions have been held and 15312 pregnant women registered, and provided nutrition counseling. There is also a programme of counseling adolescents. 1789 children with malnutrition were reported and provided prophylactic treatment. There is no clear demarcation of geographical or thematic work between two ANMs.

Other than this, the only other activity that ANMs report are visits to home for promoting sterilization- and sometimes accompanying them for sterilization. Also to manage a sterilization complications. There is an incentive attached to this.

Family Health camps are another major activity. These are meant to increase the access to health services in underserved/ uncovered areas and to provide an array of good quality health services

in a safe, client friendly and infection free environment with the involvement of community. One camp per month per district per block by rotation are being organized.

School health campaigns have been started in the state.ANMs have been trained in NCDs in Kala Bakra block but no work started on the ground. Sub-centers visited had adequate infrastructure, with a separate building and quarters located in them. A number of sub-centers are in PHC/ CHC premises and meant to provide outreach services to families in the adjacent 5000 population.

Mobile Medical Units are functional but could not be assessed by the CRM team. There are 4 such units in Muktsar, one supported by NRHM and three by Ranbaxy.

5. ASHA PROGRAMME

The ASHA programme is functional and has the respect of both the health system and the community. ASHAs were available in all villages/ facilities visited.

The number of ASHAs are less than is needed for full coverage. For example 80 ASHAs in Kala Bakra population serve a 1.04 lakh population, and further in FGD with ASHAs find that most of the ASHAs in the block are seeing a limited 600 to 800 level of population. Are there significant number of families with no ASHA coverage? One gap that was admitted was the missing out on families in small urban townships. Especially in the below one lakh town, we should have ASHAs under NRHM, but the system is waiting for the urban health programme.

ASHAs are functional on promotion of institutional delivery and immunization- and have knowledge related to this. ASHAs not functional on any area of nutrition or on a childhood illness management. ORS supply is weak. Payments received Rs 200 for promotion of JSY and Rs 350 for accompanying- but number of cases are not substantial and therefore the earning is limited.

The major issue of concern is that ASHAs are clearly missing those with home deliveries- since there is no incentive available for the same. Recognition of considerable levels of home deliveries that are happening in their areas is an issue and understanding of marginalization and need to give greater efforts to such communities is also weak.

Training has been completed in the 1st to 4th Module- but not in the 5th Module. The state is planning introduction of IYCF. The understanding of modules 6 and 7 is very weak and the planning for it is nonexistent. There is no support system in place- but regular monthly meetings help. Since the focus is only on their bringing the patients to the facility, there is no urgency felt to other forms of support.

Attrition of ASHAs in Jalandhar is less than 2%, but 15% in Muktsar. Process of selection and training for new entrants is weak.

6. RCH II (MATERNAL HEALTH, CHILD HEALTH AND FAMILY PLANNING ACTIVITIES)

On the positive side, the FRUs are in place and so are the 24*7 PHCs. FRUs in Jalandhar are adequate to meet norms- there are seven which are functional within the district. There are two which are functional in the relatively smaller district of Muktsar. The problems however are many.

In FRUs blood is still a bottleneck, and even storage is not available anywhere except in the district hospitals and one SDH. But blood on demand is supplied promptly from these facilities.

One thirds of the cases go to private hospitals in Jalandhar- with all its attendant costs. One thirds choose public sector deliveries and one thirds don't go anywhere, choosing to deliver at home.

The single most disturbing feature is the high persistence of home deliveries in a context where supply side availability is not an issue – about 30 to 40%. Reasons for this ill are ill understood and ill studied. Since every facility is managing a good case load, and there is no culture of analyzing the HMIS data, there is also a poor recognition of the extent of the problem. There is first a denial, and then when shown the data from their own center for the previous month, there is considerable puzzlement. Since Punjab has a persistent high maternal and child mortality and since even the few maternal deaths reviewed as of date show links to these home deliveries, the team explored this aspect at some length. Village visits showed that the following three reasons seemed important-

a. Marginalization- many of them were from communities which are known to be marginalized- in-migrants, Gujjar, Sensi etc.

b. Women headed households- often because their men had migrated/working elsewhere.

c. High costs of care.

The last should not be a problem because recently user fees for all pregnant women has been stopped- but perhaps the news has not got around or perhaps there are still other less obvious costs of care still remaining.

Facility based child care has just not arrived- there is no training that has taken place, there is no newborn stabilization unit anywhere and there is no SNCU in either of the districts. Some critical care for sick newborns was seen at Jalandhar, but not organized into a special unit. No protocols of care are in place. On a positive note, newborn corners are present at all levels. However radiant warmers are not always used. Still births are high in the facilities and some of them could be newborn deaths. In the FGD with ASHAs and in the visit to sub-centers the team came across considerable newborn deaths- both institutional and at home- but there is not enough

recognition of this at the management level. Cases where we inquired further appeared like asphyxia related deaths- but a more systematic enquiry is needed.

Management of complications in both pregnancy and newborn weak, except in DHs. The DH is therefore greatly over worked and needs a greater specialist's concentration and more supportive doctors and nurses. The specialists are distributed too thin across 7 CHCs & the SDH and if we are unable to get more, then one or two marginally functional FRUs may have their specialists redistributed to the DH. Range of services is much better at the higher level where all the complications are attended to.

JSY- payments are as a rule good, though there is still delay at PHC level- as powers of disbursement is at block level. Also payment is delayed for the lack of bringing along JSY card- a problem for which a more consumer friendly solution should be found.

Sterilization benefits are being received by users and performance in family planning is good. A positive development is that NSV rates show very good progress in both districts.

In adolescent health, the teen clinics at sub-center level- having trained male and female health workers is a good beginning.

Maternal death reviews are happening- but not yet understood in the spirit of using it as a tool for systems improvement. Most reviews relate clinical death causation only and are unable to relate it to systemic causes. There is therefore no meaningful follow up actions. Maternal deaths are clearly under-reported.

PCPNDT implementation- structures and processes are in place- and there is recognition of the seriousness of the problem. But implementation in terms of examination of the forms submitted by the clinics and follow up action needed on finding suspicious patterns are just not there.

7. NUTRITION

Visit was made to 3 Anganwadi centers (AWCs) and discussion held with 3 Anganwadi workers (AWWs) on ICDS services. Areas enquired on includes health checkups, immunization, nutrition and health education, use of medicine kits and referral.

Anganwadi Centres visited were in Bhangeywala Sub center area, and in Kanianwala PHC and Chakasherawala CHC area in Muktsar district. There was provisions of health check-up for children(0-6 years), lactating mothers and pregnant women, immunization for children and pregnant women, and providing nutrition and health education to women (15-45 years), supply and use of medicine kit and referral services for women and children under ICDS. Health check-up was being done for lactating mothers and pregnant women but not for children. Children and pregnant women are immunized on a fixed day called the Mamta Day. Children and pregnant

women who are missed could attend the sub center. Nutrition and health education on selected topic/issues are provided to women. However, the topic of this NHE in AWC-I in December was on need and importance of giving polio drops for mobilizing mothers / community for making use of polio day for eradication of polio. Every AWCs visited have been provided with the Medicine kit along with a small printed book/ write-up on use of medicine. However, despite this the medicines have not been used effectively and referrals have not been made- which is in contrast to the ASHAs where medicines had run out of stock and referrals were frequent. This could indicate further training and support needed for AWWs to become active on this work. AWCs should have referral slips to promote referrals.

There are no NRCs existing or planned in the state. SAM identification and referrals are not taking place. New WHO standards are not available at any facility visited.

Infant and Young Child Feeding (IYCF) Counseling: Breast-feeding Promotion has been taken up under NRHM (2010-2011). An intervention was been carried out on pilot basis in two districts i.e. Gurdaspur and Ferozepur of Punjab in – 2008-2009 and this was planned in collaboration with National level NGO- the BPNI (Breastfeeding Promotion Network of India). 29 Medical Officers & 77 Staff Nurses have been trained as Middle level trainers from the health sector, who could act as support system for any referral. All these Middle Level Trainers have been further trained 3500 Frontline Workers (ANM & ASHA etc.) of the districts in counseling on breastfeeding and complementary feeding. The independent evaluation of IYCF training of the frontline workers (ASHA, ANM) in the districts of Ferozepur and Gurdaspur revealed positive improvements in breastfeeding. Besides IYCF, Village Health and Nutrition Day are being organized as Mamta Diwas at AWW centres , where besides immunization, supplementary nutrition for pregnant mother and the child being ensured through ICDS.

Health Check up of under 5 Children in AWC are also to be ensured under School Health Program. Under School Health program, besides treatment for deworming , Iron folic acid tablets are being provided to anemic children

There is a proposal to give ASHAs an incentive of Rs 25 per pregnant women to act as IFA provider and to ensure that there is correction of anemia of pregnant women to an above 10gm Hb level.

8. NATIONAL DISEASE CONTROL PROGRAMMES (NDCP)

- Case detection rates for tuberculosis are good at Muktsar, but poor at Jalandhar. The main problem seems to be inadequate chest symptomatics examined, both from public sector and from private sector. Case cure rates are good. There is a MDR-TB problem but the programme

for this has not started up.

- The main vector borne disease is dengue. There is an advanced management available at Jalandar. In some blocks malaria is still a persistent problem.
- HIV facility with ART: well functional on all parameters at DH Jalandhar- ICTC functional in Muktsar.
- The main issue with the IDSP is that it is more seen as a means for generating and sending up reports, rather than to undertake local action. Thus measles outbreaks are being reported, but there is no public health response, and even the awareness of the protocol of response is weak. When pointed out, the instinct is to question the report, rather than worry about the action taken. After questioning the number of cases fell
- Typhoid and hepatitis are reported on IDSP- but again there is no public health response. One CHC visited had a large number of typhoid reports which were used for clinical management, but not for public health action.

9. INSTITUTIONAL MECHANISMS AND PROGRAMME MANAGEMENT

The district health societies are functional and meet with at least once a quarter frequency. The Rogi Kalyan Samitis are also functional and they also meet with once a quarter frequency. Their composition is made up of PRI leadership, medical professionals and NGO representatives. Minutes of meetings were well maintained. Only the NRHM RKS grant is brought under this committee's purview.

Programme Management Units in state and district level are also well staffed and functional Most contractual staff are in position. Program officers are aware of the program. Hospital administrators have been appointed for District Hospitals.

There is good integration of the DPMU with the CHMO office and unlike many other states, there is no separate identity for the DPMU. Seamless integration is a strength if the new tasks are also managed adequately e.g. planning, logistics etc.But if the DPMU staff become only assistants to the CHMO and do not expand the range of tasks performed it could be a problem. Both trends are seen.
A team of consultants in the SPMU play the function of a SHSRC and another team of five act as the state data management unit.
The PHSC acts as a management structure for hospital management of civil hospitals and district hospitals as well as for infrastructure development, equipment purchase and maintenance and

drugs procurement and supply. In drugs procurement and supply it work needs to improve- but for the rest, it is doing well.

HMIS has made considerable advance. Quality data is available from every block and district and has been analyzed. There is however an issue of incomplete reporting, and much of this seems to be stemming from primary registers being incomplete on many data elements that HMIS requires. Intra-hospital data gathering and aggregation also needs strengthening in the larger hospitals. Reporting from the private sector is weak, though picking up.

One interesting feature is ANMs reporting monthly data on mobiles. The report on monthly data allows quick updates of information and save times and efforts and increases validity of data. The use of daily data is questionable and it is causing tensions out of proportion to any possible benefits. Monthly data is adequate if well utilized. When use of monthly data is inadequate, to start on daily data serves no purpose, but a vague notion of worker surveillance, even which does not happen because the capacity to read, analyze and respond to data on a daily basis is not available. Also a clearer work allocation to ANMs for each day would be a more logical first step, then a daily report on what they did.

Hospital information software is in place in Jalandhar hospital and is reasonably functional.
There is considerable lack of clarity on pregnancy tracking- and no systems in place yet. The staff find the forms large and unwieldy and difficult to fill. There is no working software available.
Private sector accreditation is weak. Only few facilities linked up to, though a large number of private facilities are providing RCH services including delivery.

10. FINANCIAL MANAGEMENT

There is no director- F&A- at state level. But a state finance and accounts manager in place. Transfers of funds up-to district by e-transfers and below this by cheque. District accounts staff in place. Untied funds are 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. Not all facilities are equally functional Slow rates of expenditure in poorly performing facilities slows down the overall rate of expenditure. There is a need to move money in line with the demand and requirements.

11. DECENTRALIZED LOCAL HEALTH ACTION

- District Plans of both districts are good in objectives, indicators, and strategies. However funds have not been provided in line with district plans. Funds are given as per budget line items.
- 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 data and IDSP data for district planning could be strengthened much further.
- Community monitoring not in place.

CHAPTER FOUR

RECOMMENDATIONS

Human resources and Infrastructure

1. Main problem is of creating more posts and recruiting more doctors in facilities which are providing high volume of care.
2. There is a need to rationalize existing human resource use. Ensure clearer work allocation for ANMs and ensure both ANMs have an eight hour working day as well as utilize the male workers available.
3. Retraining for use of new equipment and new diagnostic and treatment procedures
4. Effective and rational policies for career progression at all levels like GDM0s, Specialists, nursing, and other cadre
5. DPMU and SPMU to be trained and involved in program supervision including disease Control programs using respective program modules. Provide them check lists of respective programs for field visits.

Health Care Service Delivery

1. 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.
2. State should plan for provision of diet supply to the patient (minimum at district level facility).
3. State should plan a training schedule for health staff to handle the bio medical waste.
4. State should plan to develop a programme for NCDs.
5. Quality Management systems which record patient satisfaction levels, and which ensure basic processes of quality and effectiveness of care should be put in place.
6. Strategy of facility supervision could be improved with PHC/CHC medical officers, district program officers should monitor programs implementation with defined checklists.
7. User fees to be re-examined in view of high degree of exclusion seen. As an immediate start exemptions to be made more liberal and adequacy of exemptions to be monitored. Would need differential financing on scale to compensate the losses of withdrawing user fees- and this should be planned out before any change is made. But the direction should be towards phasing out user fees.
8. The subsidiary health center as a concept should be re-examined. Need to make it work by linking it up better with public health work and better support and a more effective clinical care. .
9. Also need to recover the concept of the sector as the unit of public health management and ensure that PHCs and subsidiary health centers play this role.

ASHA Programme

1. Emphasis to the roll out of module 6 and 7.
2. High level of home deliveries also needs to be reached to. Trend now to reach only those where institutional delivery is more likely.
3. Ensure that every household is covered by ASHAs.
4. Bring in a special sensitization programme on marginalization- so that ASHAs reach out to the most dispossessed categories.
5. Greater skills in nutrition counselling and in illness care would make better use of the time she spends on her work and greater impact on child survival.

Nutrition

1. Health check-up of children (0-6 years) at least once in 6 months need to be institutionalized and mechanism development
2. Orientation of AWWs on use of Medicine Kit.
3. Development of detailed guidelines on Mamta Day.
4. Mechanism to strengthen NHE through Mamta Day.

RCH Program

1. Need to initiate on scale the development of facility based newborn and child health care.
2. Home based new born care services needed to reach out to stagnant neonatal mortality over the entire decade.
3. Improve blood storage facilities and availability of blood in FRUs.
4. Ensure human resources matches case loads.
5. Special focus on technical protocols of labour rooms, make them more appropriate and effective and support with necessary drugs and supervision.
6. Targets for family planning being achieved at health facilities but other spacing methods like condoms, IUCD mare missing, needs these to be strengthened.
7. Weekly outreach sessions at AWC and other outreach activities needs to move out to more peripheral areas instead of remaining largely from the headquarters. Need to identify and reach to marginalized sections.
8. In-service training, particularly skill based training like LSAS, EMOC, SBA, IMNCI; NSSK needs immediate implementation with quality protocols. The status of training is inadequate. Need based training is to be strengthened. IMNCI needs to be completed on priority.
9. Study the reasons for persisting home delivery and high mortality further- and develop strategies to show improvement.

Disease Control Programs

1. Improve response to disease outbreaks in IDSP and also in analysis and use of IDSP sourced information for public health programmes.
2. Strengthening of disease surveillance mechanism above PHC levels

3. Increase case detection in TB through private sector partnerships and also through greater sputum examination in chest symptomatics in the public facility.
4. Reorientation of health care providers and community screening for leprosy cases, efforts to make early identification of leprosy cases need attention
5. Cross sharing of reports/results across all programs including disease control programs not only with respective program officers but also with DPMUs and SPMU.
6. Eye care facilities at CHCs need focus

Improving Management

1. Greater use of HMIS data for state and district level management purposes.
2. Improve financing of facilities and districts to make it more responsive to case loads.
3. Stabilise and build up the SHSRC.
4. 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.
5. Build up an ASHA resource center to manage both the ASHA and the VHSC programmes together.

CHAPTER FIVE

Field Visit Reports

District Muktsar

Health services in Muktsar are delivered through one District and three sub district hospital. There are 4 CHC, 17 PHCs and 102 Sub centre. Few private nursing homes are registered with health department. The connectivity of roads is exceptionally good. However transport facilities between villages appear to be limited. Water and electricity situation are satisfactory in the areas that we visited. At the state governments initiatives a system of ambulances will be launched through Bombay based organization in the month of January which should help persons from the community to access health services even from the remote areas. Currently available ambulance services will be used to take person form lower to higher facility. At the district, sub-divisional hospital and CHC there will be one ambulance each. Equipment has been procured are as per the norms of IPHS. All equipment for basic functioning of the visited sub-centre, PHC, CHC and district hospitals were available and the state has to make efforts to procure these items and reach the IPHS standards. In every 24 x 7 PHC and Sub center are located in same campus. From last year 11 PHCs starts conducting deliveries. Most of the SC are having one or more ANM. Out of 102 SC most of them are functioning in government buildings.

Detailed report is provided below:

District Hospital : Muktsar

- S.M.O. In charge Dr. Hari Narayan Singh
- Situated in the city.
- It is a 50 bed facility.
- 150 to 300 OPD cases per day are registered in a month.
- Total 491 institutional deliveries (includes 349 Normal and 142 C-Section) are conducted in the facility till 2010-11.
- Bed occupancy 35 to 40 per cent.
- IPD 40-50 per day.
- They have blood bank and collected 300 -450 units of blood which is the minimum requirement to run blood bank.
- Family planning services are provided including (224 Tubectomy & 88 vasectomy during 2010-11)
- MTP service are provided 20-22 per month.
- Surgery: 1663 major, 1702 minor
- Funds : User Charges : 2-3 Lakhs per month;Expenditure: 45% medicine, 15% maintained of building, 15% maintenance of equipments, 25% patients services;RKS : 5 lakhs per annum.

Facilities provide free to Yellow card holder, Govt. Servants and pensioner, RNTCP patient, HIV/AIDS, freedom fighter and Members of legislative and parliaments.

Human resources

- 1 SMO
- Medical officer
- Specialists
- 10 Staff Nurses 3 are SBA trained
- Pharmacists
- Lab technicians

Services Available

- C-section
- Ultra sound
- X-Ray

Sub Divisional Hospital, Malout

- S.M.O. Incharge Dr. H.S. Bhullar
- It is a 50 bed facility.
- 94345 OPD and 4058 IPD cases are registered in 2010-11.
- 516 institutional deliveries (Normal and C-Section) are conducted in the facility.

Human resources

- 1 Medical officer
- 8 Specialists
- 11 Staff Nurses
- 5 Pharmacists
- 3 lab technicians

Services Available

- C-section
- Sonography
- X-Ray

CHC Sarawan Bodhla

- In-charge of the facility: Dr. Rajender Kumar
- Medical officer: Dr. Mrinal Bansal

Human resources

- 2 Medical officers
- 5 Staff Nurses
- 2 Pharmacists
- 4 class IV employees

Services available

- CHC Sarawan Bodhla comes under Alamwala block. It is designated as FRU. But the services delivered were not satisfactory, due to lack of human resources.
- It is a 30 bed facility but only 15 beds are functional.
- C-Sections are not conducted in the facility
- JSY: 234 deliveries were conducted upto 17th December 2010; Incentives were given at the time of discharge.

RKS

- No proper utilization of RKS funds is being done. There were no records maintained with respect to RKS meeting held.

Services provided

1. 24x7 Delivery services
2. X-ray machine is there, but no technician is available.
3. Immunization is conducted on every Thursday.

SC is also facilitated in the CHC building. One ANM is positioned in the SC.

CHC , Chak Shere Wala

Human Resource

NRHM Staff	In Position	Vacant	Regular Staff	In Position	Vacant	Remarks
M.O	1	0	S.M.O	1	0	
A.M.O	1	0	M.O	1	5	
H.M.O	1	0	Chief Pharmacist	1	0	
Staff Nurse	5	0	Pharmacist	1	0	
B.S.A	1	0	Staff Nurse	4	0	3 Regular 1 DHS
B.C.A	1	0	O.O	1	0	
Information Asst.	1	0	Trained Dai	1	0	
Computer Operator	1	0	BEE	1	0	
MLT	1	under RNTCP	Steno Typist	1	0	
Radiographer	1	under Corporation	Sr. Assistant	1	0	
Upvaid (AMO)	1	0	Clerk	0	1	
Dispenser (HMO)	1	0	Computor	1	0	
			MLT	0	1	
			Peon	2	0	1, Deputation
			Ward Attendent	3	0	2, Deputation
			Sweeper	1	0	1, Deputation
			Chowkidar	1	1	

PHC Thandewala

Human Resource

NRHM Staff	In Position	Vacant	In Position	In Position	Vacant
M.O	1	0	M.O	0	1
A.M.O	1	0	Pharmacist	1	0
Staff Nurse	3	0	Staff Nurse	1	0
Upvaid (AMO)	1	0	MLT	0	1
			Ward Attendant	1	0
			Sweeper	1	0

Sub Centre, Burjsidhwan

- ANM- Ajit Kaur(working since 1997).
- One MPW (Harwinder Singh) is also positioned.
- Sub centre caters the population of 8109.
- 2 villages are under this SC.
- ANM has undergone IUD training.
- Immunization services and ANC check ups are done by the ANM.
- ANM does not have proper knowledge of the VHND guidelines. No prior planning is being done for conducting MAMTA DIVAS.
- 4 VHSCs are constituted under this SC.

Sub centre, Tamkot

- ANM- Ranvinder Kaur(working since last 2 years)
- ANM is not SBA trained.
- SC caters for the population of 6264.
- This SC is vaccine storage point. ILR and refrigerator are there and regular temperature is being monitored.
- 4 ASHAs are working under the sub centre.
- LHV supervises the ANM in regular intervals.

PHC: Kanianwali (It is a previous mini PHC upgraded in 24x7)

This PHC comes under CHC- Chak Sherawala which is about 45 Kms away from PHC. It has six sub center, Kanianwali, Khakaphaniwali, Bhagewala, Jondoke, Lbiananwali and Sangrana. It covers a total area of 10 sq.kms. The PHC we visited is the outer most PHC in the CHC after it district Ferrozpur and Faridkot starts. It is a 4 Bedded facility with generator, inventor for power backup but no fire fighting system.

No proper waste management system is in place although disposal is segregated in different bins but disposed in non-concrete pits. It has also no staff quarters. Some of the good incentives are

provision of birth certificate distribution with discharge. New born care units with all equipments and trained staffs are available. Proper diagnosis of pregnant women during pregnancy and timely referred to District hospital.

Human Resource

- Incharge of the facility: Vacant
- Medical officer (Ayush): Dr. Priyanka Davla joined on 15 May, 2010

Post	**Sanctioned**	**In place**	**Vacant**
MO	01	00	01
MO (AYUSH)	01	01	00
Pharmacist	01	01	00
Ayurvedic dispenser	01	01	00
Staff Nurse	3 (NRHM) 1 (Regular)	03 00	00 01
Laboratory Technician	01	01	00
Driver	0	0	0
Class IV	2	2	0

Records from NRHM

	2005-06	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-upto Nov. 2010**
OPD	1621	2992	3010	4068	4906	3960
IDP	NIL	NIL	NIL	150	455	355
Deliveries	NIL	NIL	NIL	56	183	162

Sub health Center : Kanianwali

It is situated within PHC Kanianwali. Well infrastructures and well connected. But have no staff quarter for residence.

Sub Health Center : Bhangewala

It has two ANMs one from NRHM and one from DHS there is proper work distribution between them ANM Gurvinder Kaur have two villages for cover Bhangewala and Mansingh wala, ANM Sabarjeet

Kaur have two villages Seeriwali and Dohak. It is a old building with proper space about five kms away from PHC with no staff quarters. It is situated outside the village with boundary, water and electricity facility.
Innovation: Both Sub-centers have ARSH clinic which need to be strengthened as it is a good incentive.

- Anganwadi Derra Bhangewala-I
  AWW:- Ms. Murti Kaur
- Anganwadi Derra Bhangewala-II
  AWW:- Mrs. Bhupender Kaur
  Helper: Harbansh Kaur
- Anganwadi Derra Bhangewala-III
  AWW:- Mrs. Neetu Kaur
  Helper: Manjeet Kaur

At both the place VHND days are celebrated but are still at week collaborations, no sign board for this day's celebration needs to be strengthened. AWW are supplied with 11 essential medicine boxes with proper diagnosis booklet. This needed to be strengthening by the ANM and MO in-charge PHC and SMO CHC.

Sub center – Sarainaga

Visited to see the functioning of ARSH clinic. It is a good initiative needed to strengthen. Two ANMs and one MPW (Male) which is trained in ARSH and ILR point is also there.

- AWCs visited

AWC-I, AWC-II and AWC-III of Bhangeywala Sub center Kanianwala PHC of Chakasherawala CHC in Muktsar district.

Observation

There is a provision of health check-up for children(0-6 years), lactating mothers and pregnant women, immunization for children and pregnant women, providing nutrition and health education to women (15-45 years), supply and use of medicine kit and referral services for women and children under ICDS. During visit to these AWCs, it was observed that health check-up was done for lactating mothers and pregnant women but not for children. Children and pregnant women are immunized on fixed day on VHND/ Mamta Day. Left over children and pregnant women are also immunized at sub center. Apart from immunization and health checkup on VHND/ Mamta Day, Nutrition and Health Education (NHE) on selected topic/issues is provided to women. However, the topic of this NHE in AWC-I in December was on need and importance of giving polio drops for mobilizing mothers / community for making use of polio day for eradication of polio. Every AWCs visited have been provided with the Medicine kit along with a small printed book/ write-up on use of medicine. However, due to inadequate knowledge of AWWs, Medicines have not been used effectively. Referral service is not functioning. No AWCs visited had the referral slip to refer children and women with health problem to health facilities.

Suggestion/Recommendations

- 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.
- Development of detailed guidelines on Mamta Day.
- Mechanism to strengthen NHE through Mamta Day.

District Jalandhar

Field Visit

Summary

For the Common Review Mission, visit to the district of Jalandhar in Punjab from 17th December 2010 to 21th December 2010 was done. The facilities visited and key persons visited for Common review are enumerated in the Table 1 shown.

Brief Review: - Jalandhar District is located in North West part of Punjab state, with total population of 2245473 (2001 Censes). The Public health system is existent in the form of one district hospital, 2 Sub Divisional Hospitals, 9 Block PHCs, 29 PHCs, 15 24X7 facilities, 12 FRUs, one Urban and 9 rural CHCs, 198 sub centers and catering health services to the rural and urban population of the Jalandhar district.The District's visit depict that, there is need to address the following issues.

Major issues observed in the district :

- Home deliveries are more than 40%.
- Many drugs could go out of stock due to supply driven logistics- e.g. Copper-T, Doxycycline .
- Diet is not provided in any facility at any level- even in DH. It is very important for patient comfort.
- Security reported as a major issue at peripheral facilities.
- Biomedical waste management systems in place. But awareness among the health staff regarding to hazards due to bio medical west is low. Training of staff could be improved.
- Amounts collected by user fees are considerable- about Rs. 2 crores per year in the higher facilities and about Rs. 30 to Rs. 50 lakhs per year at the CHC level. 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 13,044 urban 19035.
- Presently no deliveries are conducting in the Sub centers by order. There is no clear demarcation of geographical or thematic work between two ANMs in the district. ANM's are trained in NCD in Kala Bakra health Block but no work yet started at ground level.
- In Jalandhar District 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 not functional on any area of nutrition or on a childhood illness management.

- There no newborn stabilization unit and SNCU in the district below district level facility.
- Maternal death review happening- but not yet understood the spirit of it as a tool for systems improvement. Clinical death causation only and no follow up actions. We may also suspect that there is Under-reporting in the cases.
- There is no NRC at any level of health facilities in the district and not even planed for any NRC.
- 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.

[i] 2009 Coverage Evaluation Survey, Punjab Fact sheet