Report of 5th Common Review Mission
Haryana

November 2011

CRM Report – Haryana

Objectives: To assess progress against:

- 14 NRHM Components
- NRHM outcomes
- Approved PIP of 2011-12
- Issues identified by previous CRM

Methodology:

- Qualitative
  - Interaction with complete team of officers from state health department under the leadership of Health Secretary.
  - Interaction with CS, Medical Officers, Staff Nurse, ANMs, DPMs, ASHA, AWW in the assigned 2 districts of Hisar & Mewat.
  - Interaction with Community, Pregnant women, Patients and relatives.
  - Observation on service delivery and technical protocols
- Quantitative
  - Secondary Data from Hospital Registers and HMIS
  - Monitoring Formats
  - PIP-2011-12
  - DHAP

Following health facilities/ institutions were visited in Hisar:

1. State Health Society, Panchkula, Haryana
2. District Health Society, Civil Hospital, Hisar
3. District Medicine Store, Civil Hospital, Hisar
4. Sub District Hospital, Adampur
5. CHC, Mangali
6. CHC, Barwal
7. CHC, Seeswal
8. PHC, Ladwa
9. PHC, ChuliBagaria
10. Sub Centre, Bagana
11. Sub Centre, Bahbalpur
12. Sub Centre, Seeswal

Following health facilities/ institutions were visited in Mewat:

- District Hospital-Mandikhera
- CHC-Nuh
- PHC-Nuh
- PHC-Tauru

- SC-Bhadas
- Delivery Point-Nautki
- Outreach Session-Dabla
- FGD-Nautki and Pada

Team Composition: Mewat :

- Sh. Sanjeev Chadha, Director PMSSY
- Dr.Aruna Jain, AD (NVBDCP)
- Dr.R.K.Pal,Advisor (NHSRC)
- Dr. Sunita Paliwal, consultant (MoHFW)
- Ms. Neha Agarwal consultant (MoHFW)

State Representative: Dr. Suresh Dalpat

Hissar:

- Dr. Syed Shahid Abbas, PHFI
- Mrs. Kimberly Allen, ARSH Expert (UNICEF)
- Dr. Ankur Yadav, NIHFW
- Mr. Utpal Kapoor, Consultant (MoHFW)
- Dr. Sawinder Singh

State Representative

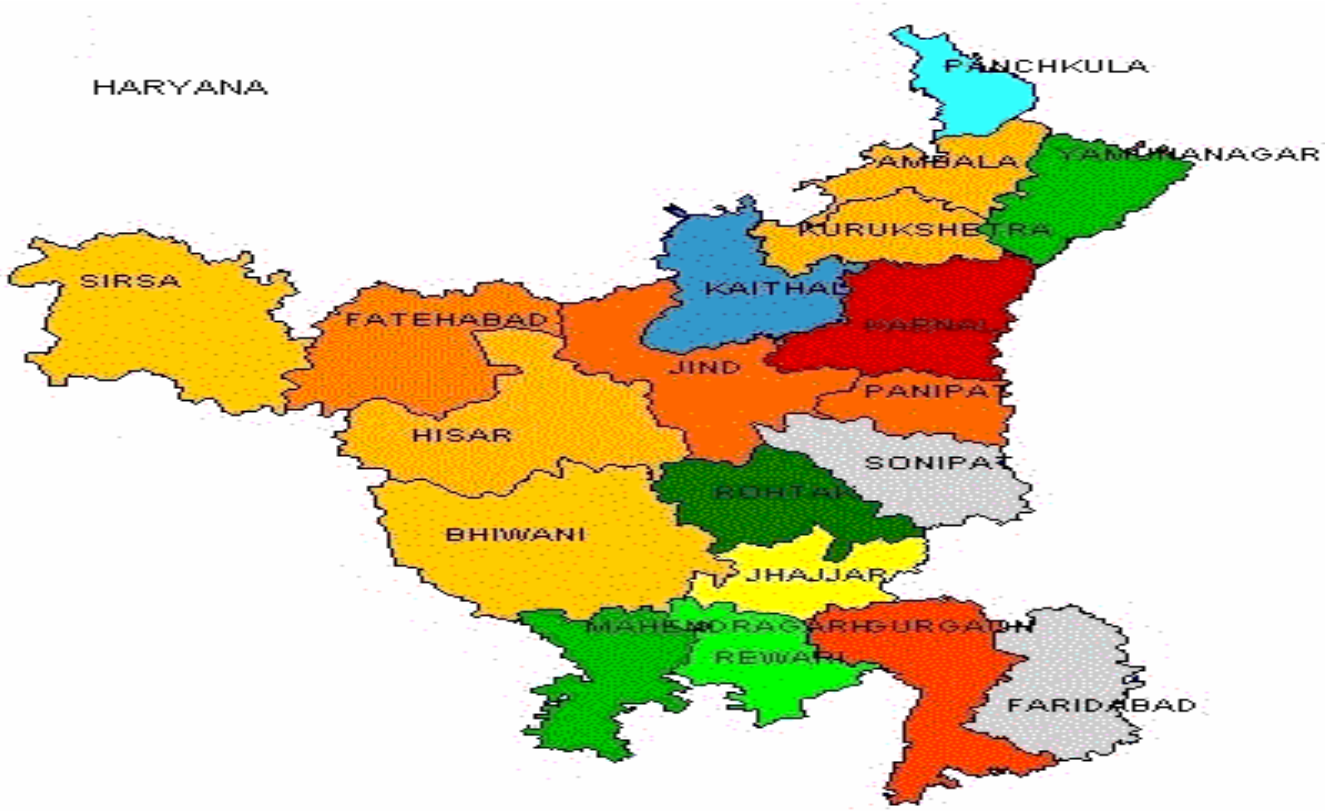
- Dr Amit Phogat
- Dr. Vandana

State Profile

Haryana is located in north of the country, covering 44212 sq km area, representing 1.4% of total area of the country. Total population of state stands at 253.53 lakhs (2011 Census), which represents 2% of country's population, out of this 165.31 lakhs is rural Haryana has about 0.40 crore of Schedule Caste population, while the state has no tribal population. While the sex ratio is 877 (2011 Census). State has an overall literacy rate of 76.64%, while that for males are 85.38% and for females is 66.77%, respectively.

Administratively, Haryana is divided into 4 divisions, 21 districts, 54 sub-divisions, 119 blocks and 6955 villages.

Rural Population (In lakhs) (Census 2011)	165.31
Number of Districts (RHS 2010)	21
Number of Sub Division/ Talukas	54
Number of Blocks	119
Number of Villages (RHS 2010)	6955
Number of District Hospitals	21
Number of Community Health Centres (RHS 2010)	107
Number of Primary Health Centres (RHS 2010)	441
Number of Sub Centres (RHS 2010)	2484



HEALTH INDICATORS OF HARYANA

The Total Fertility Rate of the State is 2.5 as per SRS 2009. The Infant Mortality Rate is 51 (SRS 2009) and Maternal Mortality Ratio 153 (SRS 2007-08) which are lower than the National average. The Sex Ratio in the State is 877(as compared to 940 for the country). Comparative figures of major health and demographic indicators of Haryana viz-a-viz India are as follows

Indicator	Haryana	India
Total population (Census 2011) (in crore)	2.53	121.01
Infant Mortality Rate (SRS 2009)	51	50
Maternal Mortality Rate (SRS 2007-09)	153	212
Total Fertility Rate (SRS 2009)	2.5	2.6
Decadal Growth (Census 2011) (%)	19.9	17.64
Crude Birth Rate (SRS 2009)	22.7	22.5
Crude Death Rate (SRS 2009)	6.6	7.3
Natural growth rate (SRS 2009)	16.0	15.2
Sex Ratio (Census 2011)	877	940
Child Sex Ratio (Census 2011)	830	914
Total Literacy Rate (%) (Census 2011)	76.64	74.04
Male Literacy Rate (%) (Census 2011)	85.38	82.14
Female Literacy Rate (%) (Census 2011)	66.77	65.46

Key demographic indicators*

	2001			2011		
INDICATORS	**HARYANA**	**MEWAT**	**HISAR**	**HARYANA**	**MEWAT**	**HISAR**
Population in lakhs	211.44	7.90	15.36	253.53	10.89	17.42
Decadal growth (%)	28.43	45.67	27.11	19.9	37.9	13.4
Sex Ratio	861	899	851	877	906	871
Total literacy	67.9	43.5	64.8	76.64	56.1	73.2
Male literacy	78.5	61.2	76.6	85.38	73.0	87.4
Female literacy	55.7	23.9	51.1	66.77	37.6	62.3

**Census 2011, #Census 2001*

HEALTH INDICATOR

	SRS 2005	SRS 2009
Indicators	**HARYANA**	**HARYANA**
Infant Mortality Rate	60	51
Natural growth Rate	17.6	16.1
Crude Birth Rate	24.3	22.7
Crude Death Rate	6.7	6.6
Maternal Mortality Rate	186	153

Comment on the 15 NRHM components reviewed are stated below:

1. Infrastructure development.
2. Health Human Resources
3. Health care service delivery- facility based- quantity and quality.
4. Outreach services
5. ASHA Program
6. RCH II (Maternal Health, Child Health & Family Planning Activities)
7. Preventive & Promotive health services including Nutrition and Inter- Sectoral convergence
8. Gender issues & PCPNDT
9. National Disease Control Programmes
10. Program Management
11. Procurement System
12. Effective use of Information Technology
13. Financial Management
14. Decentralized Local Health Action
15. Overall Outcomes

NRHM Component 1: Infrastructure development:

State Profile

Population of the State = 253.53 Lakh, No of Districts = 21
No of Blocks = 119 No of villages = 6764

Health Facilities	No.	Population covered per facility (in Thousand)
Sub-centres	2630	State Average 8, Av. Max-13(MWT), Av. Min- 6.5(BWN), Hisar-6.6
PHC	330	State Average-45, Av. Max-80 (MWT), Av. Min- 32 (BWN), Hisar-36
CHC level hospitals	111	Average-175, Max-350 (FBD), Min-103 (NNL), Hisar-157, Mewat-346
SDH	25	Average 102

Health Facilities	Number	Population covered per facility (in '000)
District Hospitals	21	Average 121
Medical colleges	3	1 Govt. , (PGIMS Rohtak), 1 Govt. Aided (Agroha), 1 Pvt. (Mulana)
Upcoming Govt. Med. Colleges	3	Nalhar- Mewat, Khanpur Kalan- Sonepat (Women), Karnal

Progress in Infrastructure Development

Number of Facilities functioning	As on 01.04.2005	As on 31.03.2011	
	Total No of Facilities	Total No of Facilities	Functioning as per IPHS
DH/SDH	49	53	0
CHC	72	111	0
PHC	294	330	0
Sub centre	2433	2630	0

Number of 24x7 facilities –PHCs (297), Number of FRUs/CemONC – DH (20), SDH (6), CHC (5), Urban FRU, FBD (2)

Facility	No. of New buildings Completed in NRHM period	No. of New building Occupied and used	No. of Ongoing Works	No. of buildings with Quality certification
SC	144	100	64	0
PHC	36	28	38	0
CHCs	6	6	14	0

All Construction and maintenance work in the State is being executed by PWD (B&R)

Infrastructure	As on 01.04.2005	As on 31.03.2011
Blood Storage Units	0	24
Blood Banks	49 (19+30)	64 (20+44)
SNCUs	0	6+4
NBSU	0	66
NBCC	0	638
ASHA Ghars	0	0
Total Number of Beds (Including Medical College Rohtak)	4761	**5136**
Bed population Ratio (No. of beds per thousand population)	**0.52**	**0.39**

- Issues
  - Lack of effective utilization of funds
  - Absence of professional agency for infrastructure planning and proper execution
  - Conformance to IPHS standards not initiated yet.
- Recommendations
  - Separate institutional mechanism/agency required for effective planning, monitoring and maintenance of infrastructure as per approved standards.
  - Prioritization of Construction according to case load, manpower and location.
  - GIS mapping of Health facilities.

NRHM Component 2: Health Human Resource:

HR Status in the state:

HR status	Required	Sanctioned	In position		Gap
			Regular	Contractual	
Doctors (Allopathic)	3120	2813	2239	113	461
AYUSH doctors		729	442	155	124
Specialists	1536	-	475	246	815
Paramedics*	-	914	697	18	199
Staff Nurses	4440	3416	1554	1295	567
LHV	492	492	345	0	147
Pharmacists	775	961	698	114	149

*Includes Opth. Assistant , OTA, Dietician, Dental Mechanic, LT Malaria, BEE, Nursing Sister

HR status	Required	Sanctioned	In position		Gap
			Regular	Contractual	
MPW (Male)	2608	2544	1871	-	673
ANM	5260	5414	2077	2532	805
LT	945	864	531	153	180
AYUSH Paramedic		762	460	161	141

Cleaning Staff				87	
ASHA Facilitators	-	0	0	0	0
ASHA Co-ordinators	-	0	0	0	0

Observations:

Recruitment of Doctors:

- A Rolling system of recruitment of Doctors since Nov., 2008
- Web enabled Recruitment system
- Applications on continuing basis
- Interview on regular basis
- Immediate appointments
- Merit based criteria and transparency
- 2254 Doctors have been recruited out of which 811 are Specialists till Aug., 2011, about 40% are LMOs

Higher Pay Scales & Allowances:

- Pay Scales & emoluments of Doctors improved
- Three ACPs introduced with 25% NPA
- Two years rural service at each stage of ACP made mandatory
- Each Doctor renders a minimum of six years of rural service
- Additional increments for Specialists
    - Difficult area allowance is being given to Doctors posted in Mewat and Hathin block of Palwal (Rs. 25000 per month for Specialist, Rs. 10000 per month for other Doctors)

Placement Policy & Accountability:

- Stable tenure of at least 3 years
- Posting of doctors as per specialization
- Increased strength of specialists at DH/SDH & CHC

Training institutions in the State:

Category	Institutions and Annual Intake capacity							
	Govt. (Sept 2011)		Govt. (added during Mission Period)		Private (Sept 2011)		Private if any - (added during Mission Period)	
	No	Intake	No	Intake	No	Intake	No	Intake
ANM Schools	8	203	-	-	42	2320	37	2180
LHV Schools	-	-	-	-	-	-	-	-
GNM Schools	3	60	-	-	49	2725	28	1710
MPHW Schools	2	120	-	-	7	420	-	-
Post Basic B.Sc (Nursing)- College	1	60	-	-	25	2400	-	-
B.Sc. (Nursing)- College	1		-	-	25		-	-
M.Sc. (Nursing)- College	-	-	-	-	1	20	-	-

Status of Training in the State:

Type of Training	Cumulative number of functionaries trained -2005 to Sept. 2011)		
	MO	**ANM/LHV**	**SN/ PHN**
IUCD	287	2757	527
NSSK	837	2521	1087
SBA	124	2076	1279
IMNCI	1623	4347	881
F-IMNCI	520		771
BeMOC	42 (in Oct)		
CeMOC	83		
LSAS	27		
MTP/MVA	223		
NSV	152		
Minilap	258		
Laproscopy	22		19
PP IUD	42		
ASHAs Trained at Block			
ASHA Mod I	ASHA Mod II to IV	ASHA Mod V	ASHA HBPNC
13600	13211	10985	11443

Reforms in Medical & Para- Medical Education:

- New Directorate of Medical Education established in January, 2009
- 3 new Govt. Medical Colleges being established in the State
  - Khanpur Kalan, Sonepat – 100 seats (for women)
  - Nalhar, Mewat – 100 seats
  - Karnal - 50 seats
- New nursing policy for issuing NOC to private Nursing institutions in the State

- Issues
  - Availability
  - Training
  - Recruitment
- Recommendations
  - In high focus areas (Mewat) compulsory rotational posting along with incentives in form of weightage for PG seats for MO can be thought of
  - Annual training plan for all levels to be planned and implemented
  - Selecting the suitable candidates from the community and sending them for appropriate training

Strategies for Mainstreaming of AYUSH in the state:

- Co-location of AYUSH facilities
- AYUSH Doctors are member of SKS/ DHFWS
- School Health & Immunization Programme
- Promotion of early breast feeding
- Anemia control
- Polio eradication
- Patients can be referred to allopathic system of medicine
- No. of OPD in AYUSH in 2010-11 was 1633548
- In 2011-12 no. of OPD is 908689 till Sept. 2011
- 163 facilities have been co-located out of which 142 are funded by NRHM
- 504 stand alone AYUSH facilities

NRHM Component 3: Health care service delivery - Facility based quality and quantity

Status of Health Care Service Delivery in the State:

No of subcentres with Second ANM	1841
No. of sub-centres with MPW	1758
No. of PHCs with 3 Staff Nurses	298
No of CHCs with 9 Staff Nurses	53
% of 24x7 facilities where 24X7 lab services are available	0
No of facilities providing safe abortion services	36
No of RTI/ STI Clinics in State	27
Bed Occupancy Rate ,(Lowest MWT, Highest YNR)	40 -170 %

Issues and Constrains/ limitations

District Mewat & Hisar

- District Quality Assurance Committees (DQACs) to review sterilization deaths, complications, failures yet not constituted
- Some monitoring checklists were found available which were being used for field visits by MOs and supervisory staff. Standardized quality assessment tools are not developed and strategy to visit health institutions with the help of these tools has not been initiated.
- Essential drugs and equipments in place in most of the facilities visited.
- Treatment protocols for management of obstetric emergencies are in place in labor room, In district Hospital. However, these need to be displayed at the readable height
- Quality of services provided in labor rooms through maintaining privacy, clean & separate toilets for women, availability of essential drugs and equipments etc.
- Signage's generally in place at all the facilities visited.
- Citizen charter and Janani Shishu Suraksha Karyakram (JSSK) guidelines displayed only in DH
- Entitlement under Janani Shishu Suraksha Yojana (JSSK) especially free delivery, referral transport, and free treatment for sick neonates is in place.
- Lack of manpower at district level and block levels was brought out as the major constraint for regular QA and quality improvement initiatives in Mewat
- Nonfunctional OT at CHC-Nuh and 24x7 PHC Tauru due to shortage of MOs in Mewat district.
- SBA training of Staff Nurses and ANMs at District Hospital is having constraint of lack of clinical exposure of trainees for delivery cases with complications (PPH, Retained placenta, eclampsia etc). As there's no gynecologist available in district hospital in Mewat, these cases may be going to private facilities in Delhi, Gurgaon or

Faridabad. Zero reporting of post delivery complication is reported in district Mewat under HMIS since April 2011

- All the three CHCs of the district Mewat have been designated as an FRU/CEmOC, but yet not made functional due to lack of human resource& Blood Storage Unit (BSU). In order to improve the service delivery, the district has to make CHCs functional as FRU at the earliest. To meet the requirement of FRU in term of human resource (team of OBG, Paediatrician and Anesthetists), two MOs have already been sent by civil surgeon for refresher training in EmOC.
- The radiant warmer at 24x7 PHC Tauru in Mewat is available but being placed at unusable location (no nearby electric socket)
- There are number of registers in use in labor room of most of the facilities visited to record the same information leading to wastage of time for recording same data.
- There are residential quarters for medical and support staff within the premises of most of the visited facilities
- Adequate availability of cold chain equipment's at the district, CHC and PHC level cold chain points
- Cold Chain equipment's properly installed as per guidelines
- Power Back up available at cold chain points of the visited facilities

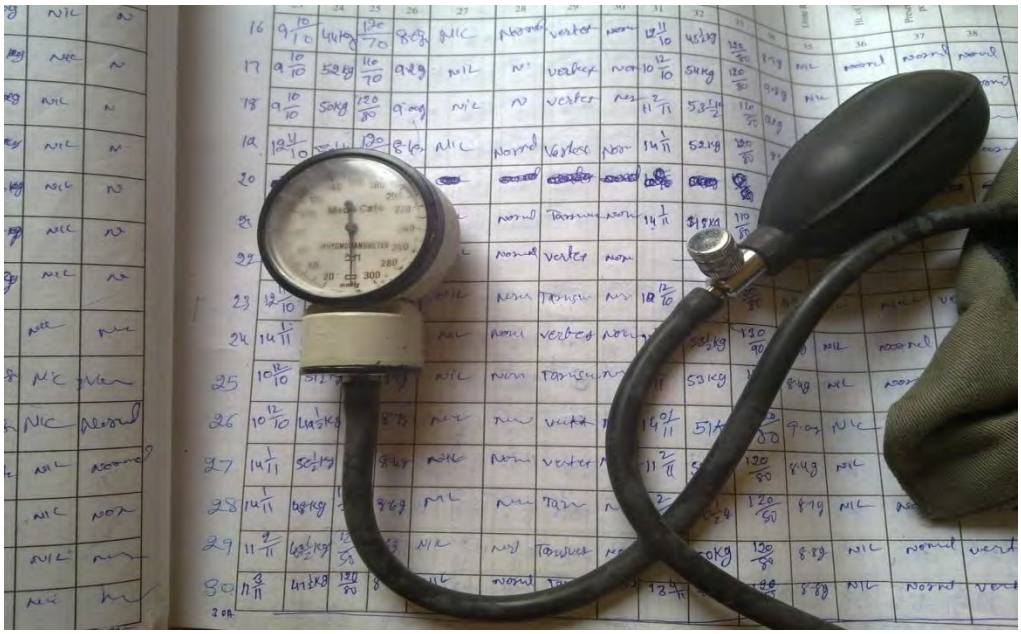
Recommendations:

- Essential equipment and drugs are generally available in most of the health facilities visited. The utilization of health facilities at CHC and PHC level seems good. However, there is a lack of ownership and monitoring to ensure equipments are in working order and Blood Pressure & Haemoglobin records are maintained properly by the health staff at facility level. The district may take it as a priority and make a plan to orient the facility staff on their responsibilities.
- Standard treatment protocols for skilled attendance at birth and provision of essential and emergency obstetric care need to be ensured and monitored carefully.
- There is a need of making community aware about the 10 digit call centre number to get referral transport vehicle. The call centre number “10 digits” to be displayed on all the referral transport vehicles in addition to wall writing.
- Print material on ambulances to be revised as per JSSK entitlements (free referral facility to sick newborn is not mentioned).
- In order to solve inter-district disputes, the referrals system needs to be strengthened, the call centre operators to be provided with phone numbers of call centers of adjoining districts.
- A well defined and implementable system for monitoring and supervision is needed urgently.
- One of the main constraints is poor health seeking behaviour (93% rural population, 80-85% minority community and only 37% female literacy rate, resulting in poor demand for health services. Therefore, there is a long way to cover for improved community behavior through strong IEC-BCC strategies, in partnership with NGOs and SHGs. The help from relevant philanthropic and UN organization such as Mewat development agency can be requested which will overcome the problem of shortage of human resource to some extent.

NRHM Component 4: Out Reach Services (Immunization & ANC sessions, MMUs, VHNDs)

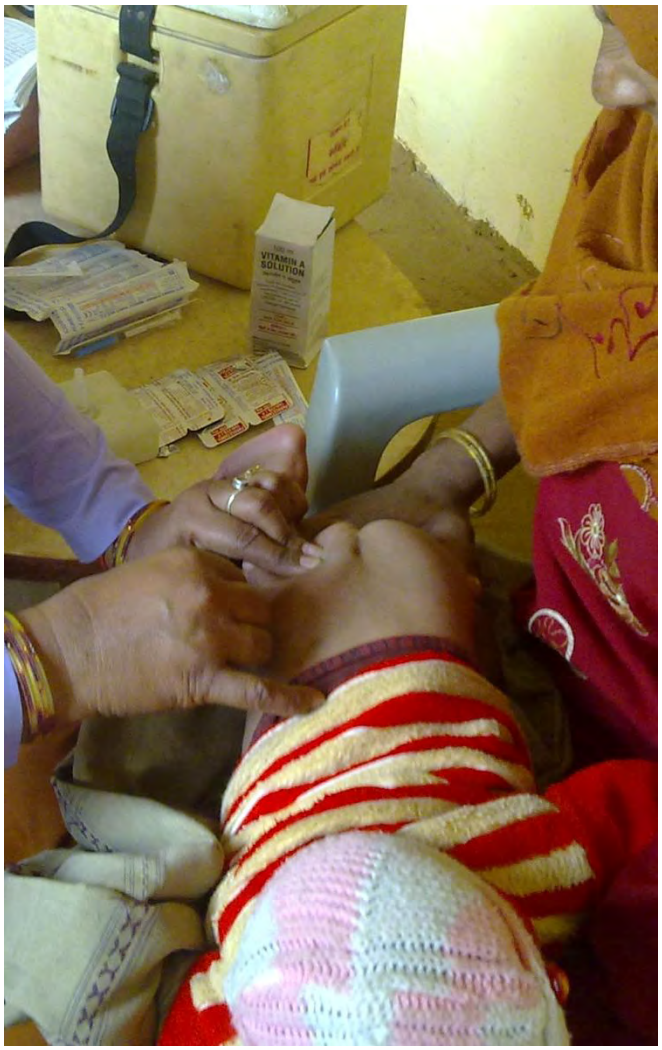
Issues and Constrains/ limitations

- **Routine Immunization (RI) & ANC sessions:**
  - All vaccines except BCG available at the session site
  - Auto Disable (AD) syringes in use, hub cutters available at immunization session site
  - Essential drugs (IF Acid, paracetamol, Vitamin A etc) available at the session site
  - DPT vaccine was found being injected at gluteal region in place of antero lateral aspect of thigh.
  - Non-functional sphygmomanometer and haemoglobinometer found in number of health facilities and also at outreach session in Mewat. Checking instruments for functional status by ANMs & supervising doctors & efforts to get them repaired are missing. Still recording of data about BP & Haemoglobin raises doubts about the validity of data being entered and capacity of system to detect high risk ANC.
  - The beneficiaries were not provided immunization card by the ANM due to shortage of cards in the PHC Mohammadpur in district Mewat. Moreover, the new Maternal and Child Protection Cards (MCP) have also not been provided yet to field staff.
  - List of the beneficiaries was not available with ASHA at the session site
  - IEC measures to be undertaken to facilitate community involvement.



Non-functional BP apparatus still blood pressure was being recorded

Haemoglobinometer with round hole and square glass tube & without N/10 HCl, still haemoglobin was being recorded



Injection at gluteal region instead of antero-lateral part of thigh

Mobile Medical Units (MMUs)- Desk Review

- Six MMUs are in place in the State. One each in Jind, Jhajjar, Narnaul & Palwal and two in Mewat.
- Manpower is Driver, Pharmacist & two Staff Nurses. Medical Officer of the area accompanies the MMU.
- Utilized for OPDs, Immunization services, Antenatal checkup, Family Planning & Referral services.
- Deployed for unserved, underserved, high risk areas.

Achievements of Mobile Medical Units in the state:

F - Year	OPD	Immunisation services	Maternal Health services (ANC, PNC, Anaemic pregnant women, JSY)	Child Health services (Sick new borns)	Family Planning (IUDs, CCs, Oral pills)
2009-10	38435	16229	2064	0	50837
2010-11	47434	37451	10158	50	14280
2011-12 (Apr-11 to Oct-11)	32364	9940	5873	57	3185

In Mewat

- The staff nurse and pharmacist provide OPD services.
- There are no facilities for basic lab investigations (Hb measurement, Urine sugar etc), so the quality of ANC services is lacking to pick up the high risk cases.

Recommendations:

- The PHC and district should ensure the availability of working equipments to maintain the quality of services needed on these sessions.
- Strong need to develop waste management system at these sites with provision of hub cutters and other required equipments.
- If possible, MO could be hired to provide quality OPD services. These MOs can be provided difficult area allowance and transport facility. Hiring of services private medical officers for MMUs could be think of under PPP mode.
- Intensive publicity of each camp/ session to be there to get maximum outcome in term of utilization of services

Initiatives taken up by district Mewat:

- **IEC/BCC Activities through Community Radio**
  - **Mewat FM1 90.4 launched on 29 Sep.2011. It is f**unctioning at Nuh CHC with a transmission limit of 20 KMs covering around 60% of the district. The Radio operates in local Mewat language 3 hrs in morning and 3 hrs in evening
- **State JSY in addition to NRHM JSY**
  - A payment of Rs 1500/- for BPL and Rs. 1000/- for SC/ST women for institutional deliveries. ANC registration during first trimester (Rs 500/-)
- ***Good Practices being implemented by district to improve Immunization coverage:***
  - ***26 vehicles are hired on each Wednesday and 19 on Friday to drop paramedical staff and vaccine for Immunization and ANC session in inaccessible/difficult to reach villages. This initiative has been started since Sept 2010.***
  - ***The activity is financed by MDA (Mewat Development Agency)***
- **Mobile Medical Units**
  - 40 villages of PHC Tigaon which is a difficult block of the district have been provided health services particularly ANC and Immunization through MMU 1. The PHC is facing a problem of shortage of staff
  - Similarly, 42 villages of Ujina PHC have been getting facilities from MMU-2. The villages are located along the Ujina drain therefore on high risk to malaria.
  - In addition to routine health services, MMU staff does active surveillance as well for malaria.
- **Jachcha- Bachcha Scheme in the state to ensure PNC**

Provisions:

- Incentive for Institutional Deliveries payable to Staff Nurses and ANMs up to CHC level.
- Incentive to ANMs at the Sub-Centers after conducting minimum 3 deliveries per ANM per month.
- Incentive to Staff Nurses at PHCs & CHCs after a minimum 3 deliveries per Staff Nurse per month.
- Incentive payable on satisfaction of mother and certification by Community Sub Committee.
- Covers ante-natal and post-natal services.

- Incentive to be paid only after JSY benefit paid to beneficiaries.

Observation:

In the year 2010-11, till Sep., 2011, Payment to service providers has been done for 10335 deliveries.

ASHA to provide quality services

- The qualification required for ASHA has been reduced up to 5th class as the effort to get more candidates in Mewat as availability of candidates for ASHA is a problem in this district.
- To motivate ASHA for bringing the pregnant lady to institutional delivery she was paid incentives of Rs-300

NRHM Component 5 – ASHA Program

Observations:

Recruitment against posts sanctioned: 13204 ASHA were selected out of target of 14000 (94.31%) in the state. In the districts visited achievement observed is 1007 out of target of 1060 (95%) in Hisar and 475 out of 800 (59.37%) in Mewat.

Status of Training in the state:

State/ District	Module I-V		Module-VI / HBPNC		Menstrual Hygiene (07 District under GoI Scheme)	
	Target	Achievement	Target	Achievement	Target	Achievement
State	13204	13730*	13204	11817**	3981	3618***
Hisar	1010	1273*	1010	961**	NA	NA
Mewat	541	620*	541	307**	541	483***
* Some of the trained ASHAs have been dropped/replaced						
** Figures upto August 2011; 100% ASHA to be trained before initiation of 2nd Phase in Dec. 2011						
*** MH training being conducted alongwith HBPNC remaining batches						

Fund Utilization in the state:

Financial Year	ASHA Budget Heads	Budget Utilized (Rs. in Lakh)	
2006-07	Incentive & Trainings	69.00	69.00
2007-08	Incentives & Trainings	112.63	112.63
2008-09	Incentives	217.66	238.56
	Modular Trainings	20.90	
2009-10	Incentives	340.07	471.78
	Modular Trainings	131.70	
2010-11	Incentives	716.11	1409.50

	Modular Trainings	527.39	
	Overcoats/Nameplates/ SAF & Field Diaries	36.00	
	Drug Kits (Booked for Procurement)	130.00	

ASHA Status (From 2005-06 to 2011-12) District Hisar

Sr. No.	Financial Year	No. of ASHA Sanctioned	No. of ASHA Identified	% age of ASHA Identified	Total Expenditure
1	2005-06	200	200	100.00	208828.00
2	2006-07	450	429	95.33	461553.00
3	2007-08	1060	962	90.75	1281871.00
4	2008-09	1060	975	91.98	2083200.00
5	2009-10	1060	965	91.04	5288898.00
6	2010-11	1060	1025	96.70	9594571.00
7	2011-12 estd	1060	1007	95.00	9600000.00

Progress under NHRM in last 5 years:

Cumulative performance of training and fund utilization in last 5 years summarized in 2 tables stated above shows steady progress in both the areas .

Issues:

In State:

- No ASHA has been provided with drug kit. In 3rd CRM the comment in this regard was ASHA to be provided with Drug kits as per GOI norms and state action for it has been documented as – "Order for 10000 ASHA Drug Kits has been placed".
- No apparent evidence of a mentoring process for ASHA

In Mewat:

- Shortage of ASHA even when trained birth attendants (Dies) are also being used as ASHAs in Mewat district
- Variable training status of ASHA in field (newly recruited ASHA have not been trained to 5th module-Dobla , Nautki)
- Most of the ASHA are not carrying their register to ensure the vaccination of children

In Hisar: Availability & recruitment of ASHA is 95% and timeliness for payment of incentives is better. In Hisar, ASHAs are creating demand and making referrals to the facilities for MH, CH and FP services. Most ASHAs interviewed, approximately 20, were earning on average Rs 2,000 per month. During interaction with ASHAs it was evident that most were highly motivated and were able to explain health promotion and education topics without prompting.

Suggestions for problem solving & recommendations:

1. Timely reimbursement of incentives to keep ASHA motivated
2. Preparation of training plan to timely enhance their skill
3. Local purchase of drug kit till state procurement starts.
4. In districts like Mewat, seeking support from ICDS (AWW, AWW sahayika) to get suitable candidates. Coordination with Pradhan, sarpanch, school teachers by Health staff to get list of eligible women for selection as ASHA
5. In monthly meeting at PHCs - reward to best performing ASHA, Close monitoring of performance and any supply constraints such as drug kits & on-spot redressal of grievances of ASHA.

Any examples of Best practices/ Innovations identified: No

Focus areas identified for increased attention in coming years: Same as point no. 1.2 & 3 stated above under suggestions for problem solving.

Additional outcomes observed other than envisaged under NRHM: Nil

NRHM Component 6: RCH II

Issues and Constrains/ limitations

- **Maternal Health**

Reproductive and Child Health

Status of Reproductive and Child Health in the state:

Indicators	**2010-11**	**2011-12 (Upto 30th Sept)**
ANC (%) registration of estimated pregnancies	96	97
Institutional deliveries (%) of estimated deliveries	73.9	76.4
% of institutional deliveries hospital stay of > 48 hrs	10.4	10
% of delivery conducting institutions having a Newborn Care Corner	34	70
No. of districts with at least 1 neonatal intensive care unit	3	3+4*
% of post natal mothers with post natal follow-up (Source HMIS)	80	82
% of children (12-23 months) with complete immunisation	97.13	97.72
C-section rate	10%	10%

*** Equipments have been installed, renovation is under process**

MCH Centers in the State:

Category of Centre	**No. proposed**	**No. functional**
MCH III	44	33
MCH II	400 (297 PHCs & 103 CHCs)	400
MCH I	461 Delivery Huts + 46 PHCs	507
Total	**951**	**940**

- Performing more than 10 deliveries

Trend of Institutional deliveries in the state:

Institutional Deliveries as per CRS data

Year	Govt. Inst.	Pvt. Inst.	Total Inst.	Non Inst.	Total
2006	83133	166464	249597	259373	508970
	16.30%	32.70%	49%	51%	
2007	96948	178273	275221	236752	511973
	18.90%	34.80%	53.70%	46.20%	
2008	120042	198053	318095	219224	537319
	22.34%	36.85%	59.19%	40.79%	
2009	164388	196864	361252	177658	538910
	30.50%	36.53%	67%	33%	
2010	205086	197282	402368	142252	544620
	37.65%	36.22%	73.88%	26.11%	

Delivery Hut Scheme:

- **Launched in Sep., 2005 to provide 24-hour delivery service at specified Sub-centres, PHCs & CHCs.**
- **Concept now changed to only standalone Sub-centres.**
- **At present, 455 stand-alone Sub Centres functioning as Delivery Huts.**
- **No new Delivery Huts proposed in 2011-12.**

Institutional deliveries V/S home deliveries in district Hissar:

Year	Institution Delivery			Home Delivery	Total Delivery	%age of Institution
	Govt. Inst.	Pvt. Inst.	Total			
2005-06	3585	9961	13546	19891	**33437**	**40.51 %**
2006-07	5365	10366	15731	18977	**34708**	**45.32 %**
2007-08	5917	11664	17581	15720	**33301**	**52.79 %**
2008-09	6505	12652	19157	13077	**32234**	**59.43 %**
2009-10	10279	13246	23525	8846	**32371**	**72.67 %**
2010-11	13390	13656	27046	5660	**32706**	**82.69 %**
2011-12 Estd.	14868	13772	28640	4146	**32786**	*** 87.35 %**

***76.8% as per CRS,**

Institutional deliveries V/S home deliveries in district Mewat:

Deliveries	2008-09	2009-10	2010-11	2011-12 (upto oct.11)
Total deliveries	30203	31034	31732	20247
Govt facilities	3180	3660	7474	6599
%	12	12	24	24
Pvt facilities	1965	1978	2085	970
%	6	6	7	5
Total Institutional deliveries	5145	5638	9559	7569
%	18	18	30	37
Home deliveries	25058	25396	22173	12678
%	82	82	70	63

- 24 x 7 deliveries facility was available at 6 of 84 SCs (Level 1-MCH facilities)
- There are three PHCs which are functional as 24 x 7 PHC (Level-II MCH facilities)

- All the three CHCs of the district has been identified as FRU but yet not functional as FRUs.
- No provision of C section and assisted deliveries across the district.
- Active management of third stage of labour (AMTSL) was being followed at most of the health facilities
- Hardly any woman after delivery stays for 48 hours. The reason being "community behavior". The district population constitutes 80-85% Muslim community where community does not believe in institutional deliveries and in case, delivery happens in hospital, women are not allowed to stay in hospital and take rest even at home.
- Free diet provision made at facilities to indoor women in the maternity wards. was available in DH (district hospital) only
- Due to shortage of ASHA in the district, only few of the indoor women in maternity wards were found with ASHA. However, ASHA escorts a pregnant woman to health facility and then leaves.
- Essential laboratory investigation facility was available at all the facilities visited

In Hissar:

The MCH services such as antenatal care, institutional deliveries and use of partograph in labor rooms was happening with regularity. The formulation of micro-birth plans and the compulsory 48 hour stay in the facility after delivery were not happening. Even the provision of food for mothers and a caretaker could not convince the women to stay 48 hours. The average seemed to be 8-10 hours maximum. If it is impossible to convince mothers to stay, the only other option seems for ASHAs to track these women post-partum to ensure they don't have hemorrhage or sepsis.

- **Maternal Death Review (MDR)**

Process being followed in the state:

- ASHAs/ANMs to inform the maternal death to the MO PHC and on toll free No.
- MO PHC to get the community based audit of the maternal death and send a report to the district level Maternal Death Review Committee (Chairmanship of CMO).
- Review in district level Maternal Death Committee, corrective actions initiated and report sent to head office in prescribed format.

Maternal Death Reporting & Audit : Progress in the State

Estimated Maternal Deaths (SRS 2009)	826
Reported Maternal Deaths 2009-10	164
Reported Maternal Deaths 2010-11	200
Reported Maternal Deaths 2011-12 (Up to Sep.)	203

MDR Audit Report Review of Dist Hisar for the period 1.04.2011 to 31.10.2011

Total No. of Maternal Deaths	35
No. of cases outside district	13
No. of cases within district	22
MDR Reviewed	19
Reasons: Anemia	7 (37%)
Infection	6 (32%)
Others (Hematemesis, Multiple Organ Failure, Suspected poisoning, HIV)	6 (32%)
Total Expenditure up to Oct. 2011	13700

In Hissar: Maternal Death Review and Infant Death Review are in place and are being conducted. One **innovation** is that these deaths are being encouraged to be reported through the referral transport call center of 102. Registers were shown at the CHC facilities.

Infant Death Audit: Process being followed in the state

- State has initiated IDR since May 2011.
    - Community based review
    - Facility based review
- Informers get Rs. 100/- for Infant Death Reporting
- Can be intimated at 102
- Field verification of infant death & community based investigation is done by team
- Rs. 250/- to Medical Officer as mobility support
- Rs.300/- each for 2 persons of the deceased family attending the IDR meeting

Progress in the State on Infant Death Audit:

- 863 Infants Deaths & Still Births reviewed
- Data analysis started for planning of interventions

In Mewat:

- The District MDR committee under the chairmanship of CMO has yet not been constituted.
- The blocks have started reporting maternal deaths to the district for further transmission to the state. "Zero" reporting of the district to state for maternal deaths since April 2011,
- ANM reported one maternal death (occurred on 17th April 2011) at PHC Tauru but block's monthly report to district missed this case.
- Grass root workers and paramedical staff were not aware of MDR.
- No community awareness on MDR
- Due to non availability of EmOC facilities particularly C-Section, it is a practice to refer women with complications to adjoining districts e.g.Gurgaon, Faridabad and Alwar of Rajasthan. The maternal deaths among these cases might be happening in these districts. Therefore, a system for inter-district and interstate notification for maternal deaths to be established.

- **Referral transport system and 24 x 7 call center:**

Referral Transport -102 in the State:

- **Launched w.e.f. 14th November, 2009**
- **A fleet of 335 ambulances in the state**
- **23 Advanced Life Support ambulances are being added**
- **All ambulances are fitted with GPS and are operational 24x7**
- **Central control room is established at District Hospital**
- **Two telephone lines of toll free telephone no. 102 are installed at each control room**
- **One ambulance available at each District Hospital, Sub district Hospital, CHC and one for every 2 PHCs**

Achievements of Referral Transport in the State:

Financial Year	Total patients transported	Pregnant women transported	Road side accident cases transported	No of patients transported Referred from one health facility to another	Other Medical emergencies
2009-10	53790	25891	4711	10265	12975
2010-11	252192	99075	13831	51364	46201 (data includes patient transported back home)
2011-12 (Apr-11 to Oct-11)	211494	77097	8414	43164	10314

Achievements of Referral Transport scheme in Hisar – 14.11.2009 to 31.10.2011

Total Ambulances allotted	22
Total Functional Ambulances at present	22
No. of calls attended	45768
No. of average calls per day (Current)	4.7
Average time taken between call recd and patient dropped at health facility	23 minutes
No. of free patients	37438
No. of free kms covered for free patients	1065512
No of paid patient	8328
No. of kms covered for paid patient	268173
Ambulance used for Pregnant Women	22255
RSA Pts	5203
Refferal	4302
Other emergencies	4161
. Average cost per call	Rs. 304.00

Pregnant beneficiaries under referral transport system in District Mewat:

Month	Beneficiaries in Year 2008	Beneficiaries in Year 2009	Beneficiaries in Year 2010	Beneficiaries in Year 2011
January	257	214	374	826
February	210	199	307	660
March	183	174	379	754
April	226	192	362	597
May	255	258	463	897
June	329	218	682	862
July	490	207	983	1190
August	478	51	1051	1048
September	479	339	959	1113
October	435	429	812	1348
November	354	332	773	
December	256	364	782	
Total	3952	2977	7927	7947

The significant increase in utilization of referral transport may be due to launching of emergency referral transport free of cost.

- The district had a well-functioning 24 x 7 call center located in the district hospital with four operators working on shift basis. The center was coordinating the fleet of 16 ambulances located at different delivery points. The number of ambulances attached with each CHC/PHC has been calculated as per delivery load. The number of call center (102) has been widely publicized in the community. However, due to some problem in cable, 102 service is not functional and instead, the district is using "9254333102—"as call centre number.
- The available ambulances are equipped with oxygen cylinder and IV stand.

- Any pregnant women or sick child can be transported from community to health facility by calling the call center. Total 17795 pregnant women were transported since 14th Nov 2009 using this service with most of the beneficiaries from SC and OBC category. The service is being provided free of charge.
- The service is available for road side accident cases, other emergencies but on payment (@Rs 7 per KM)
- The call center uses simple software which can generate periodic reports on different parameters like response time, distance travelled to reach health facilities, call conversion rate etc.
- The ASHA and Anganwadi workers in the district were aware of the call center facility and using it to transport pregnant women for institutional delivery. Large number of women were using the call center facility to get vehicle for reaching the health center for institutional delivery.
- The drop back at home facility to mothers was also found available at all the facilities.

Well equipped ambulance for referral transport

- **Janani Suraksha Yojana:**

Janani Suraksha Yojna Beneficiaries in the state:

Year	Total no. of JSY Beneficiaries
2007-08	**48076**
2008-09	**57447**
2009-10	**63326**
2010-11	**63171**
2011-12 (Upto Sep-2011)	**25842**

JSY Beneficiaries (From 2005-06 to 2011-12) in District Hisar:

Year	Home Del.	Inst. Del.	Total	Expenditure
2005-06	3094	897	**3991**	8,11,960
2006-07	1728	713	**2441**	13,54,200
2007-08	1858	828	**2686**	14,87,200
2008-09	1532	1379	**2911**	17,04,300
2009-10	1487	2474	**3961**	24,35,300
2010-11	746	2735	**3481**	24,59,000
2011-12 Estd.	570	3132	**3702**	25,00,000

In district Hissar:

JSSK is happening and is in full swing. Every facility conducting deliveries has a sign board listing the entitlements. All women who delivered were given fruit, milk and biscuits.

JSY payments in Hisar District are happening rather regularly, by bearer check, within a week or two post-delivery, however, the process is very cumbersome for a mere Rs 500 or 600. The amount of paperwork that a beneficiary must present to prove that they are a BPL was found very time consuming. The cost of travel and photocopies in addition to waiting time may defeat the motivation of beneficiaries to utilize the facilities for

institutional delivery. The time and effort which is required for the ANM to process the payment also needs to be considered as this time could have been better utilized for providing services, she is trained for. It makes more sense to provide a flat amount to all women who deliver regardless of whether they are BPL or not. Rs 1,000 was the suggested amount.

In district Mewat:

- The beneficiaries were paid JSY incentive by cheque after getting the required documents.
- JSY disbursements to the beneficiaries and ASHAs were reported on time except in PHC Mohammadpur of district Mewat. However, beneficiaries do not get the payment at the time of discharge due to completion of a number of formalities related to payment (submission of document for BPL, SC/ST, ANC registration card etc).
- Adequate fund available in the district to accommodate increased demand with smooth fund flow to the peripheral health facilities.

- **Child health**

Status of neo natal care units in the state:

- **10 District level SNCUs has been setup in 2010-11**
- **SNCUs are being setup in remaining 11 districts**
- **66 Level-II Stabilizing Units are setup at Sub District and CHC level**
- **171 Level-I Stabilizing Units are being setup at CHC and PHC level**
- **471 Stabilizing Units without Warmer are setup at Delivery Huts and PHC**

Sick Newborn Care Unit (SNCU) performance since Sept 2010 in Mewat:

MONTH	ADMISSION	DISCHARGE	LAMA/DOR	REFERRED	DEATHS
Sept 2010	40	12	20	3	5
Oct	25	9	12	1	3
Nov	19	13	6	0	0

Dec 2010	23	18	1	1	3
Jan 2011	20	15	0	4	1
Feb	15	11	0	3	1
March	17	12	0	3	2
April	27	23	2	1	1
May	42	37	1	2	2
June	58	52	0	4	2
July	70	59	0	8	3
Aug	72	56	0	9	7
Sept	72	53	5	5	7
Oct 2011	63	38	2	4	3
Total	**563**	**408**	**49**	**48**	**40**

- **Special Care New Born Unit at District Hospital in Mewat:**
    - The district had a well-functioning eight (8) bedded Special care New Born Unit (SCNU). It is attached to the labour room
    - The unit has a dedicated team of two paediatricians and 7 staff nurses who are providing quality care to the admitted new born. The different services like Breast feeding room follow up OPD, staff duty room and ward to keep mothers of the baby admitted in SCNU are all a part of the unit.
    - The staff of SCNU has been trained in IMNCI.
- No functional New Born Stabilization Unit (NBSU) was observed in any of the CEmOC/ BEmOC (CHC/24X7 PHC) facilities visited. However, Newborn care corners are functional in all delivery points visited. The main constrain in making NBSU functional is shortage of manpower (paediatrician/ MO trained in F-IMNCI)
- Adequate utilization of new born care corners is needed, skill up gradation of the health workers is also necessary along with optimal utilization of available equipments like suction machines and radiant warmer.
- The district is planning to start IMNCI and FIMNCI training of MOs and paramedical/support staff to make Newborn Stabilization Units at CHC/24X7PHC functional.
- 307 ASHA have been trained on HBNBC (Home based New born care) so far
- Jachcha- Bachcha Scheme to ensure PNC, however, no PNC visit by staff, they maintain the contact number of delivery cases and call them to confirm newborn

survivability and immunization. There is need to improve home visits in the district with quality and timing of home visits

- ORS available at all the health facilities

In Hissar:

With regards to essential newborn care and establishment of safe newborn corners, this was happening however, only one functioning Neonatal Intensive Care Units was observed in all the facilities visited.

Accreditation of health facilities is not happening.
The only private sector partnership is between medical colleges for blood.

- **Family planning**

Comparative Statement of Various F.W. methods

Methods	Target for the year 2010-11	Achievement for the year 2010-11	% Ach.	Last year Ach. (April, 10 to Sep, 10)	2011-2012 (September, 2011)			
					Target	Prop. Target	Cumm. Ach.	% Ach. Against Prop. Target
Vasectomy	24000	6193	25.8	2791	22370	11185	3189	28.5
Tubectomy	96000	71965	75.0	31629	89630	44815	33425	74.6
Sterilisation	120000	78158	65.1	34420	112000	56000	36614	65.4
IUD	230000	182286	79.3	86207	240000	120000	97247	81.0
C.C. Users	395000	210469	53.3	70184	395000	197500	127985	64.8
O.P. Users	80000	67907	84.9	28609	80000	40000	42383	106.0

Achievements under Family Planning in Mewat:

Method	2007-08	2008-09	2009-10	2010-2011	2011-12 (up to Oct.11)
Vasectomy	47	174	34	14	10
Tubectomy	585	951	815	513	153
Total Sterilization	632	1125	849	527	163
IUD	5851	5873	4344	2888	1918
CC Users	14945	13120	6912	5415	4567
OP users	4466	4954	3067	1536	1237

- Family Planning counselors in place at District Hospital Mewat
- The district TFR 4.6 is the highest in the state.
- The OT (operation theatre) at district hospital is being used for providing family planning surgeries (permanent FP methods).
- The OT at CHC Nuh and PHC Tauru are lying non-functional since last 4-5 months as medical officer has been transferred out of the district who was conducting family planning operations. No replacement of this M.O. has been done so far.
- Social Marketing of contraceptives by ASHA (Pilot project) has yet not started due to negative publicity by media (print media- Amar Ujala)

- **Safe Abortion Services (SAS)**

- District Level Committee for SAS had not been constituted.
- No provision of safe abortion services across the district due to non-availability of OBG/LMO. MOs have been trained in MTP but these trained medical officers hesitate to perform MTP due to lack of confidence. There is a practice of referring cases that require MTP to adjoining districts.
- Very poor Information Education and Communication (IEC) for SAS (availability in the health facilities, MTP Act etc) both in health facilities and community

- **Bio Medical Waste management**
  - Waste management is outsourced by the Civil Surgeon three years back.
  - The company ensures collection of waste from all the health facilities up to PHC level daily. However, there is no proper system for waste management at subcentre level including delivery huts.
  - Waste dispersal outsourced, but the health staff and workers are unaware of final dispersal processes undertaken
  - Bins for waste management observed at all the facilities visited
  - Awareness and practices of segregation and disinfection lacking

Recommendations:

- There is a need of refresher training on SBA (Skilled birth attendance)of labour room staff to update their skills
- The paramedical and field staff to be oriented on MDR (maternal death review) during monthly meeting.
- MDR Process: the process of the MDR to be established at the earliest with constitution of District MDR Committee by CMO and assigning an officer at district level for it. The responsible officer will ensure training and sensitization of staff on MDR, reporting of maternal deaths within 24 hours, review of reported maternal deaths and correctness of "Nil" reporting
- The district has to ensure that JSY payment to the beneficiaries is done at the time of discharge and if possible, only after ensuring 48 hours stay in the facilities after delivery. A system of providing birth certificate and discharge ticket along with JSY cheque could be developed.
- NB Stabilization Units should be established at CHC / BEMONC facilities
- Post partum family planning needs strengthening
- The 48 hrs stay after delivery should be utilized for counseling for FP by staff nurses in the hospital. Similarly, VHND may be used as a good platform for providing counseling for Family Planning services to ANC mothers.
- There is a need for constitution of District Level Committee so that private health facilities are accredited for MTP services to expand the service delivery. It becomes more crucial in the absence of OBG/ Lady Medical Officer in the district.
- Up scaling of MTP training of medical officers needed with rational deployment of trained doctors
- Up scaling of all the multi skill trainings of MOs and paramedical staff, ASHAs with immediate and rational deployment to ensure their training utilization.
- District has to plan training chart and follow it as at present it has "Zero" achievement under training on MTP, IMNCI for ANMs, F-IMNCI, NSSK for MO/SN and ANMs.
- There is a need of establishment of waste management system at SC level and orientation/ training of paramedical staff (ANMs, support staff at SC) on disinfection.
- Standard treatment protocols for skilled attendance at birth and provision of essential and emergency obstetric care need to be ensured and monitored carefully.

- There is a need of making community aware about the 10 digit call centre number to get referral transport vehicle. The call centre number "10 digits" to be displayed on all the referral transport vehicles in addition to wall writing.
- Print material on ambulances to be revised as per JSSK entitlements (free referral facility to sick newborn also need to be displayed).
- In order to solve inter-district disputes, the referrals system needs to be strengthened, the call centre operators to be provided with adjoining districts call centre numbers.
- The district needs to strengthen training quality and follow up supervision as well.
- At the district level, specific officer to be designated to look after specific programs with detailed guidelines and job responsibilities.
- A well defined and implementable system for monitoring and supervision is needed urgently.
- In view of the unmet need for family planning in the district, the achievements and focus solely on limiting methods will not yield any significant changes in the reduction of unmet need for Family Planning. There is need for focused promotion of spacing methods through IEC and training of staff and Social Marketing by ASHAs.

NRHM Component 7: Preventive & Promotive Health Services including nutrition & inter sectoral convergence:

Observations:

Status of Anaemia in Pregnant women & Malnutrition in children in the state:

	2010-11	**2011-12 (Sept)**
No of pregnant women with severe anemia	6.63%	6.39%
No. of pregnant women consuming 100 IFA tablets	88.4%	88.5%
No. of pregnant women receiving iron sucrose injection	-	-
No of children with anemia	26%	21%
No of children with severe malnutrition	0.08%	0.01%
No. of Nutrition rehabilitation Centers functioning in the State	-	-
No. of children admitted in NRC in a year	-	-

INDIRA BAL SWASTHYA YOJNA (IBSY):

- IBSY launched on 26th Jan 2010 in convergence with Health, SSA, WCD and Social Justice & Empowerment.
- The scheme was implemented in a phased manner with focus on identification and management of disease, deficiency and disability
- During phase IV remaining children were examined alongwith follow up action.

Achievements Under IBSY 2010-11 in the state:

- Total Number to Schools/Anganwadi Covered -- 32493
- Total Children Covered -- 3065974
- Total Number of Children found Anemic -- 1381736.
- No. of Children having Ht/Wt for age below mean value -- 113156
- No. of Children with suspected Vitamin –A Deficiency -- 6246
- No. Of suspected T.B. Cases -- 1030

IFA doses given to Anemic Children Under IBSY in the state: 2010-2011

Phases of IBSY	**No. of Anemic Children**	**No. of Iron & Folic Acid Doses Given**
Phase 1	570163	27451063
Phase 2 & 3	258569	12393983
Total	**8,28,732**	**4,01,45,046**

- **No. of Children Given Vitamin A Doses under IBSY :- 2,404**
- **No. of Children Given Deworming Doses under IBSY:- 8,66,230**
- **No. of Children Referred :- 2,63,386**
- **No. of Teachers Trained so far under IBSY :- 7,179**

In district Mewat Vitamin A administration is done along with vaccination to all children and IFA is given to pregnant, lactating and anemic woman. Most of the time women are not completing the course of 100 tablets as advised.

IEC/ BCC activities in regard to preventive & promotive health is done through Sakshar Mahila Samiti (SMS) in the form of 26 fortnightly programs per year. This program as reported by district authorities was not found very popular.

Recently they have started IEC/ BCC through 'Mewat Radio' which is gaining good popularity. Salt testing for Iodine is in practice.

VHNSCs are functioning and VHNSDs are being held once a month which however could not be confirmed by community.

Goitre and Iodine deficiency disorder are not a problem in district Mewat. Anemia requires attention. There has not been much improvement regarding anemia in women and children in the last 5 years. High birth rate, ignorance and non compliance to treatment by women and children are the reasons for rampant anemia in the community.

In district Hissar:

Only IEC materials on breastfeeding and nutrition were observed. Any nutrition counselling was not observed and there were no steps found to identify and manage severe malnutrition.
Sufficient supplies of Vitamin A and IFA were found at all facilities.

No Nutrition Rehabilitation Centers were seen.

Recommendations

- IEC/ BCC on nutrition to be enhanced.
- Effectiveness of SMS & Community Radio to be assessed scientifically & accordingly corrective action be taken as IEC/ BCC are reportedly not very effective.
- VHNSDs to be held more frequently.

NRHM Component 8: Gender Issues & PCPNDT:

Observations:

In the district of Mewat Advisory Committee for PC & PNDT Act has been constituted as per recommended constitution. Meetings however are infrequent as new registrations/ renewals are few. Reports are sent by 8 ultrasound clinics out of 11 as three clinics are non-functional due to lack of staff or equipment. Reporting and record maintenance is good. Court cases are NIL as on date. Last case was in 2007. Reason could be very few inspection by the authorities. Reports / Form F sent by the ultrasound clinics are not analyzed. When discussed with Civil Surgeon, it was informed that sex ratio was better than many other districts of Haryana, hence much attention on inspection was not given.

In Hissar: Enforcement of PCPNDT happens by the Civil Surgeon at the District Level. In 2008, three persons were sent to jail for informing the sex of the child.

Recommendations:

- Meetings of DAC to be organized once in 60 days.
- Periodic inspection of ultrasound clinics needs to be ensured.
- Ultrasound Clinic inspection and thorough study of Form-F is needed with special emphasis on Gravida – 2&3 ultrasound done between 11 to 13 weeks where previous children are females only.
- All these cases should be followed till delivery to know sex of child and survival.
- Gender sensitive policies to continue.
- IEC/BCC to be enhanced.

NRHM Component 9: National Disease Control Program (RNTCP):

Achievements of State under RNTCP (Year 2005/06/07/08/09/2010/1st to 3rd Qtr 2011)

Performance Indicators	Expected	2005	06	07	08	09	010	1Q11	2Q11	3Q11
Annualized Total Case Detection Rate/ lac/ year	Universal Access	158 (61 %)	151 (60 %)	152 (59 %)	149 (58 %)	159 (62 %)	146 (57 %)	134 (52 %)	174 (68 %)	159 (62 %)
New Smear Positive Case Detection Rate /lac/year	Universal Access	58 (61 %)	57 (60 %)	56 (59 %)	55 (58 %)	57.3 (60.3 %)	54 (56.3%)	49 (52 %)	65.4 (69 %)	58 (61 %)
3 Months Conversion of New Smear Positive Patients (Previous Quarter)	90%	86.40 %	88.10 %	90 %	90 %	90.4 %	90.0 %	90.2 %	90.0 %	89.3 %
Success Rate of New Smear Positive Patients Registered During Year Q 04/05/06/07/08/09/10/	85%	81.18 %	83.30 %	85 %	85.3%	85.2 %	85.2 %	85.5 %	86.0 %	86.0 %

Observations:

There is good acceptance to TB in the community and it is not considered a stigma. Incomplete treatment however leads to Category II cases.

The treatment is provided to the patients through DOTs centers. Many a time patients are reluctant to come to DOTs centers to combat with the problem. Designated boxes are issued to ASHAs who visit patient home for giving DOTs therapy.

In Mewat case detection rate had been in the range of 300-400 cases per quarter. In the last 4 years approximately 1/3rd of these cases are Category.II cases. These cases are on higher side as patients are reluctant to complete the full course when symptoms have subsided. Efforts are however being made through ASHAs to complete the course but all patients do not take full course of DOTs therapy.

Recommendations

- IEC/BCC to be enhanced.
- Incentives to patient for complete treatment may be considered.
- Review meeting with RNTCP officials to explore solutions.

Leprosy

Observations: Prevalence of Leprosy in the State:

Year	Prevalence Rate
2005-06	0.20
2006-07	0.19
2007-08	0.13
2008-09	0.17
2009-10	0.14
2010-11	0.13
2011-12(Upto sep.11)	0.17

Cases are very few. There are total 23 cases from 2007-2011 in the Dist. Mewat. There has been a decrease in the number of cases detected. In the year 2011, only 2 cases have been detected as compared to 2009 & 2010 where 10 & 7 cases were detected respectively.

NPCB

Observations:

Prevalence of blindness in Haryana: 1.1 % (2 lacs)

- There are 10 Eye Banks, 4 Corneal Transplantation Centres & 3 Eye Donation Centers run by NGO's and 20 Eye Donation Centers are established under Nehru Drishti Yojna in each District except Rohtak.
- There are 63 Vision Centers in the State where eye care services are provided to patients.

Status of Manpower for NPCB in the state:

Sr. No.	Manpower	Regular	Contractual	Actual No. required
I	Ophthalmic Surgeon	82	Nil	10 vacant on contractual basis
II	PMOA	91	9	1 contractual basis
III	EDC	Nil	4	1 contractual basis

Cataract Operation performed in state:

Year	Target	Achievement	Percentage
2005-06	110000	107799	98%
2006-07	110000	112894	102%
2007-08	110000	132581	121%
2008-09	125000	135569	108%
2009-10	125000	137188	110%
2010-11	125000	130004	104%

2011-12 (up to Sept, 2011)	170000	49847	29%

In Mewat, OT for eye surgeries and FACO facility is there . Two ophthalmologists are performing about 500 cataract surgeries annually. But case load for cataract may be much more. Number of cataract surgeries performed annually had almost been the same in the last few years and require improvement. There is issue of limited capacity in Hisar: 2 Ophthalmologists 1 OT in Hisar, General Hospital.

Recommendations

- IEC/ BCC to be enhanced for increasing awareness about cataract.
- Increase capacity to conduct cataract surgeries in the district possibly through alternative models (eg. sourcing of expertise from medical colleges, other districts etc.)
- Camp approach for screening of patients may be done.

NIDDCP

- An area is declared of endemic for IDD, if Goiter prevalence rate is more than 10% (GoI norm) Resurvey for endemic area is carried out to ascertain the efficiency of the NIDDCP. 2 to 3 districts are covered per year. Survey in three districts (Panipat, Karnal & Jhajjar)was conducted last year and all are non endemic.
- Salt testing kits supply is irregular Last supply received on May, 2009.
- State IDD laboratory has been established at Karnal, and is testing the samples of urine and salt.
- Four out of five post are filled under the program.
- Salt testing kits are used at household level to monitor the quality of Iodized salt. Salt testing kits stock is exhausted and urgently required.
- District IDD survey has been conducted.

Goitre is not a problem in District Mewat. We may however do screening for hypothyroidism once in a year. Salt testing may be done more frequently.

Malaria

Observations:
Surveillance of Malaria in Haryana State – Performance in last 5 Years

Year	Population	BSC	BSE	ABER	Malaria Cases	API	Pf %	SPR	SFR	No. of

					Pv	Pf					Death
2005	22419315	2538143	2538143	11.3	33250	244	1.48	0.7	1.3	0.009	0
2006	22350498	2653461	2653461	11.8	47077	507	2.1	1.0	1.7	0.002	0
2007	22563872	2482343	2482343	11.0	30781	347	1.36	1.1	1.2	0.01	0
2008	23034303	2571866	2571866	11.17	35683	1397	1.54	3.9	1.3	0.05	0
2009	23574967	2250118	2250118	9.5	31747	525	1.3	1.6	1.4	0.02	0
2010	24730830	2336280	2336280	9.4	18158	763	0.8	4.0	0.8	0.03	0
2011	25185921	2532913	2532913	10.1	30984	1046	1.3	3.3	1.3	0.04	1

Surveillance of Malaria in District Mewat & Hisar in last 5 Years:

District	Year	Population	BSC/ BSE	Cases	ABER	API	SPR	Deaths
Hisar	2007	1634934	157097	4718	9.61	2.9	3.0	0
	2008	1668519	178836	8268	10.7	4.9	4.6	0
	2009	1664358	231012	9553	13.9	5.7	4.1	0
	2010	1693267	169146	5726	10.0	3.4	3.4	0
	2011 (Up to Sept.)	1757504	182511	8556	10.4	4.9	4.7	0
Mewat	2007	1117858	152520	599	13.6	0.5	0.4	0
	2008	1164653	141118	1139	12.1	0.9	0.8	0
	2009	995263	82133	90	8.25	0.1	0.1	0
	2010	1036501	82957	216	8.0	0.2	0.3	0
	2011 (Up to Sept..)	1074397	127311	1528	10.1	1.4	1.2	0

In Mewat: There has been increase in malaria cases in the year 2011. Compliance of drug guidelines is not being followed by all patients. Presumptive treatment of 4 Chloroquine tablets is given at the time of preparing blood slide.

In the last 5 years, Blood Slide Collection (BSC) has reduced. In the year 2007, it was 105572, while in the year 2011 (October, 2011) only 12731 slides have been made. This indicates that surveillance has decreased which may have led to rise in number of cases. Total number of cases has increased as compared to previous years. Upto October, 2011, 1528

positive cases have been reported out of which 154 are *Plasmodium falciparum*. Paucity of staff may be one of the main reasons. Comparative view of last 5 years in Mewat is as below :-

Year.	*Plasmodium Vivax*	*Plasmodium falciparum*
2007	298	31
2008	729	55
2009	86	4
2010	205	11
2011(upto Oct.)	1374	154

Recommendations

- Infrastructure improvement to decrease water logging with the help of civil authority.
- Indoor Residual spraying & Rapid Diagnostic Kits to be included for quicker diagnosis. Field staff for spraying activities and blood slide collection to be increased.
- Lab Technicians and field staff presently hired for 6 months. Needs to be hired for whole year.
- Training to all Medical Officers about Malaria Control Programme for better monitoring.
- Drug guidelines to be followed.

Dengue, Chikungunya, JE, Kala-azar & Filaria:

Fiver Year Incidence of Dengue, J.E. and Chikungunya in Haryana State

Year	Dengue		Japanese Encephalitis		Chikungynya	
	Cases	Deaths	Cases	Deaths	Cases	Deaths
2005	183	1	4	2	0	0
2006	838	4	3	1	0	0
2007	365	11	32	18	13	0
2008	1159	9	0	0	20	0
2009	125	1	1	0	0	0
2010	866	21	1	1	1	0
2011 (up to Oct.)	184	2	12	5	70	0

Dengue, J.E. and Chikungunya in District Mewat and Hisar

District	Year	Dengue		Japanese Encephalitis		Chikungynya	
		Cases	Deaths	Cases	Deaths	Cases	Deaths
Mewat	2005	0	0	0	0	0	0
	2006	4	0	0	0	0	0
	2007	0	0	0	0	0	0
	2008	0	0	0	0	1	0
	2009	0	0	0	0	0	0
	2010	0	0	0	0	0	0
	2011 (up to Oct.)	0	0	0	0	0	0
Hisar	2005	9	0	0	0	0	0
	2006	65	1	0	0	0	0
	2007	2	0	0	0	0	0
	2008	11	0	0	0	5	0
	2009	0	0	0	0	0	0
	2010	2	0	0	0	0	0
	2011 (up to Oct.)	0	0	0	0	0	0

IDSP:

- Integrated Disease Surveillance Project (IDSP) started with the second phase of program in April 2005 with the assistance of World Bank. Now it is up to 31st March, 2012.
- Strengths:
  - Portal reporting Started.
  - All Vacant posts of have been filled.
  - 74.18 Lac have been spent up to 30th sep, 2011
  - Audit have been completed.
- Weakness :
  - Lab Confirmation is still weak.

Status of Manpower for IDSP in state:

Sr. No.	Name of the Post	Posts Sanctioned	Currently working	Vacant at
1	State Surveillance Officer	1	1	-----
2	State Nodal Officer	1	1	-----

3	District Surveillance Officer	20	20	DSU has not been set at Distt. Palwal
4	Epidemiologist	21	20	Kaithal
5	Data Manager	21	19	Bhiwani and Mewat
6	Data Entry operator	21	19	Bhiwani and Jind
7	Microbiologists	3	3	-----
8	Entomologist	1	1	-----
9	Consultant Training	1	1	-----
10	Consultant Finance	1	1	-----

Data Reporting through S, P, L Form in the state:

- All of the Districts are reporting regularly and timely (>90%).
- Gurgaon and Bhiwani are the low percentage reporting (<80%) districts.
- Hisar, Kurukshetra, Karnal, Sirsa and Yamunanagar- best performing districts as per the reports of S, P, L form.
- All Surveillance units are operational Except Palwal

- Issues (in Hisar)
  - Limited capacity of DSU staff; involved in multiple activities
  - Minimal analysis of collected data
- Suggestions
  - Early warning and control systems for JE outbreaks needs strengthening
  - Technical feedback & consultations on collected data at all levels (state ↔ district & district ↔ sub-district)
  - FETP Training (Field Epidemiology Training Programme)
  - Sensitisation of district health machinery on importance of surveillance, possibly using real life case studies
- Good practices
  - Monthly disease surveillance initiated and then stopped in Hisar because of lack of feedback and action
  - Tie up with Agroha Medical College for testing for Chikungunya & Dengue in Hisar in place

NRHM Component 10: Program Management

The State of Haryana has NRHM Cell in state capital responsible for overall management of the Program with one NRHM nodal officer. (State administrative services officer) and Program

management staff. The state presentation includes the following as staff of State Program Management Unit:

Mission Director (NRHM)
Director (Finance & Accounts)
Director (Planning, implementation, monitoring & Review and Community Processes)
Director (Procurement & logistics)
Director (IT, HMIS, Infrastructure and establishment)
State Consultant Procurement/ Deputy Director (NRHM)
Principal SIHFW
State Data Officer/Deputy Director (M&E)
State NGO Coordinator
State Finance Manager
State Accounts Manager
Net working Engineer

At district level CMO is over all responsible for the program implementation and monitoring with support from district Program management team (Manager/ Accounts) and with public health specialist at district level. Decentralization of district program management is being practiced i.e. Additional CMO and /deputy CMOs are assigned responsibility of the various programs and reporting to CMO.

District Program management unit supports CMO on day to day basis in planning, implementation and monitoring of the NRHM and other health activities. IDSP, RNTCP, NLEP, NIDDCP, NBCP, NVBDCP programs have their designated nodal officers or independent program staff, supporting districts and Block officers in program management.

Issues Identified

- District DPUs & DPM lack the support & capacity to take up the massive planning and monitoring role. MOs are handling administrative and financial responsibilities also, as observed in districts visited.

There is urgent need of regular program audit and strengthening monitoring as evident from the following observations:

- The regular meetings & review of activities and financial status of Village Health & Sanitation Committees & Rogi Kalyan Samitis is lacking leading to large amount of SOEs (statement of expenditure) pending with VHNS & lack of utilization of funds available with RKS.

- Recording of data about BP & Hemoglobin was observed at number of facilities where BP instrument & Haemoglobinometer were found out of order. This raises doubts about the validity of data being entered and capacity of system to detect high risk ANC.
- Checking instruments for functional status by ANMs & supervising doctors & efforts to get them repaired are missing.
- The drug kits for ASHA were reported as not procured since last one year.
- In Mewat no District Health Mission meeting has been held since March 2011.
- In Mewat at PHC Nooh the Government residential accommodation for doctors and staff was found "at risk" for living, still staff was living there due to non availability of rented accommodation. Some staff quarters had been abandoned. This situation was reported to be existing since last 3 years, yet no efforts for repair/ new construction had been made reportedly because of non availability of architect to get the estimate prepared for construction. The local PWD staff was reported to be not cooperating for the same.

Recommendations:

- Existing role & expertise of DPM need to be expanded and number of relevant experts to be added.
- As being implemented in Mewat for blocks having poor access, weekly provision of hiring vehicles for team of ANMs & supervising MOs need to be initiated & continued in relevant blocks of other districts also, where similar problems exist.
- Regular supervision of functional status & checking also the calibration of equipments & efforts to develop a system for their prompt repair are crucial & require urgent attention
- The tendency to record false data in absence of functioning equipment needs to be curbed.

Areas which have not been addressed during conceptualization of the mission or during implementation of the Mission: Areas which have not been addressed that are important for all NRHM components are:

- Adequate capacity building and support systems for State, District & Block Program Management Units.
- Recruitment or hiring activity/ project based services of adequate manpower at state & district Program Management Units, with expertise in public health, management (Building construction & maintenance, procurement, Information Technology), monitoring and financial management with support staff, mobility and funds to ensure effective monitoring and utilization of increasing fund flow under NRHM.

NRHM Component 11: Procurement System:

- Well defined Drug Procurement Policy
- Well managed State and District drug Store
- A clear policy on entitlement has been put in place
- A decision taken to provide free drugs to all OPD patients, casualty cases and institutional deliveries including LSCS
- Surgical and non-surgical package system introduced for IPD patients
- BPL patients and residents of urban slums entitled for completely free indoor treatment including surgeries and implants, others pay a nominal fixed charges
- Comprehensive Essential Drug List (EDL) prepared for District Hospitals (DH), CHCs & PHCs
- EDL contains 385 essential drugs for DHs, 112 items for CHCs & 84 items for PHCs
- EDL prepared in consultation with specialists

Procurement Reforms:

- New Drug Procurement Policy put in place
- Policy weeds out sub standard Pharma Companies
- WHO- GMP Certification, annual turn over of Rs.35 crores for last three years is qualifying criteria
- About 110 reputed Pharma companies are eligible to compete in State RC
- Procurement strictly based on Indian and British Pharmacopoeia

Broadening of Supply Sources:

- Multiple sources approved for supply to avoid disruption and maintain supply chain
- Purchase preference is given to 5 CPSUs for 102 Essential medicines
- State RC finalized at highly competitive rates.
- DGS&D and ESIC rate contract also declared as approved sources
- Competitive rates negotiated for local purchases in emergency

Decentralization of Procurement:

- Procurement completely decentralized
- Broad based District Procurement Committee constituted to indent and procure
- Specialists are empowered to indent medicines as per need and are part of procurement committee
- Procurement done on quarterly basis
- Equipments are being procured through UNOPS, HLL under NRHM
- Procurement of equipments under State Budget is done through DS&D Haryana

Issues

  - Quality testing of Drugs
  - Equipment procurement and maintenance to be streamlined
  - Non-provisioning of ARV at PHC
  - ProMis software of GOI not being used
- Recommendations
  - To explore possibility of establishing an equipment procurement agency like TNMSC

Adaptability of ProMis software with DDMS being used

NRHM Component 12: Effective Use of Information Technology:

MCTS

As reported in state presentation:

- Nodal officers at all level (Upto PHC) are being notified
- State and District e-Mission teams are being constituted and accordingly notified.
- Verification of data is being done with ANMs /ASHA and Beneficiaries.

Mother and Child tracking System in the state:

	Sub-centres	PHCs and Other Health facilities above SC but below block level	Other than CHC at or above block level but below District Level	CHCs & Area Hospitals / General Hospitals	DHs
No of data entry points	-	-	-	111	-
No. of facilities reporting on MCTS portal	2205	420(315+105)	-	105	-

No. of ANMs/ DEOs trained	At Block	At block	18	222	21
No. of facilities using CSC (Common Service Centre) SWAN centes for data entry			Not Available		
No. of facilities generating work-plan using MCTS	2205	420	-	-	-
No. of facilities doing verification of data				111	

Issues

- 6 data entry operators available against 13 posts at CHC/PHC (Mewat)
- MCTS data uploading started for pregnant women; not yet for children
- Sub-district entries created by DPMU; Work plan starting to be generated
- Huge backlog of data entry as data entry confined to CHCs

Recommendations

- Workforce Fast recruitment & effective quality training
- Offline data entry format to be encouraged for MCTS
- Initiate data entry at PHCs as soon as possible.

Issues

IDSP Portal

- Slow and cumbersome online data entry
- Limited analysis conducted

Recommendations

IDSP Portal

- Allow direct uploading of filled S,P, L forms
- Include epidemiological analytic tools in portal

HMIS

Status of Health Management Information System (HMIS) in the state:

- Introduced in FY 2008-09 (Dec. 2008) – up to District
- Reporting formats and operational manuals available up-to sub-centre level
- Regular Capacity building of teams in data usage for monitoring and planning
- Core team notified State & District level implementation

- Feedback mechanism in place
- Computers available up to PHC level (FY 2011-12)
- Sub-District rollout of HMIS (DHIS-2, NHSRC) is being piloted shortly in Panchkula district

Issues:
- Data provided to DPM in hard copy format from where it is uploaded on web portal (Mewat)
- Limited use of maps for planning or database management

Recommendations:
- Finalize Information assistants
- Provide training in health mapper / Epi Info
- Provide district shape files

NRHM Component 13: Financial Management

The key findings of 3rd CRM, the response of the State to the recommendations of 3rd CRM and observations of 5th CRM are summarized in the Table below ;

Key Findings of 3rd CRM	Response of the state	Observation of 5th CRM
Funds transfer is delayed in absence of proper communication to Districts	State is transferring funds to Districts through e-transfer but sanction letters are delayed	State should adopt Kitty or Flexipool method instead of issuing activity-wise sanctions which is the main reason for delayed funds release to districts
Financial Management systems need to be standardized	Customised Tally ERP 9.0 has been installed in all districts and running successfully with few teething problems	State to improve system of trouble shooting of problems faced in implementation of Tally with Tally Solutions

		PvtLimited
ASHA and JSY payments are made in cash and also delayed by 3 months	Payments to ASHA and JSY are being made through cheques	Adequate documentation has been made in this regard by the State and no backlog of payments was seen
JSY funds were not available at all levels	Funds release for JSY is available at all Subcentres and PHCs	Adequate funds availability for JSY was seen

Financial Management Checklist

a. Comment on availability of sufficient manpower for handling accounts and manpower position on key posts of Director (Fin. & Accounts), SFM and SAM.

All key posts viz. Director (Finance& Accounts), SFM, SAM and Audit Manager at State level are in position. All key posts of District Accounts Manager (DAM) are filled up except DAM for Rohtak and Mewat district which fell vacant during the month of October 2011. Few posts of Accounts Assistants are lying vacant in Civil Hospital, District Hisar and CHC level which need to be filled up on urgent basis.

b. Comment on the electronic funds transfer system being used in the State and the extent to which it is used and the bank used for electronic fund transfer.

Funds transfer from State to Districts is done through electronic channels (RTGS) and funds are transferred on the same day. From District to CHC also funds are transferred electronically in District Hisar but funds from CHC to PHC and Sub Centres are transferred through cheques which takes about 15 – 20 days time in clearing.

c. Comment on usage of Customized version of Tally ERP 9 software upto District/Sub district/CHC/PHC level and response from Tally Solutions Pvt. Ltd. in trouble shooting measures. If Tally is not implemented, please elaborate the progress status when the State is thinking to adopt any other accounting software?

Tally ERP 9.0 customized version has been installed and implemented in all Districts and State office and running successfully. State is planning to install Tally software on all CHCs within the current financial year. All DAMs have been trained in Tally and training of Account Assistants is in currently in progress. The

response of TSPL has been good in trouble shooting of problems. All accounts personnel have to appear in a test on Tally accounting conducted by State Head Quarter failing which their contract are not renewed.

d. Comment if the funds released are being utilized for the approved activities with reference to key activities and monitorable targets.

   Yes , the funds released have been utilized for the approved activities as per the SPIP.

e. Comment on auditing procedures adopted by the State and the Districts for their timeliness and effectiveness. Comment on implementation of the concurrent audit in the Districts to improve the internal control system and sending the summary reports and the action taken on the deficiencies pointed out.

   The statutory audit report for FY 2010-11 covering all National Disease Control Programs has been submitted to the Ministry. The concurrent auditors for FY 2011-12 have been appointed in 17 districts and state. State needs to improve the system of monitoring the concurrent audit in districts and timely submission of action taken reports by districts and ensure early submission of executive summary report to Ministry.

f. Comment on Delegation of Financial & Administrative Powers down the level as per GoI guidelines.

   The state has issued detailed guidelines on delegation of financial and administrative powers based on GOI guidelines to all districts on 15-12-2009 which are being followed at district and state level.

g. Comment on Training measures adopted by the State to improve capacity building of finance personnel of the State.

   Training of all DAM in Tally ERP 9.0 customized version has been completed and training of Accounts Assistants posted in districts and CHCs is currently in progress and likely to be completed within current financial year. State has signed an MoU with Institute of Public Auditors of India (IPAI) to visit all districts and conduct on the spot training of district accounts staff and to ensure that all necessary books of accounts are maintained and updated regularly.

h. Comment on regular updation of financial status under HMIS by the State and Districts. Are there efforts at monitoring and evaluation of financial systems?

HMIS training was imparted to all District Program Managers, however, uploading of FMR on HMIS portal by districts has not started as yet. State is required to arrange HMIS training for DAMs and initiate steps to monitor progress in this activity.

i. Comment on the records, their timeliness and accuracy, submission of MIS, Statement of Expenditures at various levels, time lag between receipt and disbursement of funds from each of these levels. If not, please elaborate on the reasons for delay in disbursement especially at sub district levels.

The Statement of expenditure is submitted by all CHC/PHCs to the DHS by 4th of every month and from DHS to State by 10th of every month. There is inordinate delay in submission of SoE from Subcentre and VHSC to PHC which results in higher unadjusted advance reporting and low funds utilization. Due to high unadjusted advances of Rs. 32.03 Crorewith districts as on 30-09-2011, the funds release of AMG, UTF and RKS grants was withheld to many PHC and Sub centres. The funds release to PHC and Sub centre takes upto 45 days due to sanction procedures and unsettled advances. No funds have been released to VHSCs during current year. The main reason for delay in funds release to VHSCsis non-submission of utilization Certificates for last three years by VHSCs. State needs to issue instructions to districts for quick settlement of outstanding advances to VHSCs before release of funds.

j. Comment upon the progress made on integration of financial management processes with NDCPs and integration of individual programme societies with the State/District Health Societies, integration of finance staff at SHS/DHSs, number of bank accounts at state/district level and integrated reporting systems.

The financial integration of NDCPs with state health Societies has been achieved and a single statutory auditor is being appointed by the State to carry out statutory audit of State Health Society and NDCPs and a consolidated FMR is sent covering expenditure details of all NDCPs. However, at district level, the financial integration with NDCPs is yet to be completed. State needs to examine the possibility of merging standalone societies of NDCPs within the State Health Society at State level andwith District Health Societies at district level.

k. Implementation of the Model Accounting Handbooks for sub-district level finance staff in the states to bring about uniformity in books of accounts.

Model Accounting Handbooks published by the Ministryhave been circulated upto district level but not available at sub-district levels. State has signed MoU with Institute of Public Auditors of India (IPAI) to visit all districts and conduct on the

spot training of district and sub-district accounts staff in Model Accounting Handbooks published by the Ministry. State should distribute Accounting Handbooks translated into vernacular language to Sub-district accounting staff for easy understanding and frequent usage.

l. Whether Procurement Manuals have been framed and procurements are being made as per procurement guidelines.

State has issued detailed guidelines for procurement of drugs and consumables which is in line with State govt procurement policy. Procurement is mostly centralized at state level and orders are placed by State to CPSU at Haryana Govt approved rate contract. If items are not available in HRC, next preference is given to ESI Rate contract or DGS & D rate contract whichever is lower. State has well managed State and District Drug stores which are using the locally developed software for records keeping and reporting. State needs to examine possibility of adopting procurement software ProMis developed by GOI.Purchase Committees have been formed at State, District and SKS levels for procurement of goods and services not covered under centralized procurement. Generally, no instances of mis-procurement were noticed in the State.

m. Comment on the reasons for pendency of UCs from 2005-06 to 2010-11 with specific reference to the status available with FMG, GoI.

The statutory audit report for FY 2010-11 has been submitted by the state and Utlization certificates have been submitted. No pendency was observed in submission of UCs from 2005-06 till 2010-11.

n. Comment upon the reasons for longstanding advances to implementing agencies pending for settlement.

As on 30.09.2011, the total outstanding advances to the implementing agencies were of Rs. 105.97 Cr out of which Rs. 31.68 Cr were under RCH, Rs. 38.64 Cr were under Mission Flexipool and Rs. 31.99Cr under other Programs. This is due to delayed release of funds by the state to districts and non-submission of SOE by the implementing agencies. To avoid delays, State has now started Flexipool method instead of activity-wise release of funds. State is also required to submit reply to the management letter and the audit para on longstanding overdue advances as pointed out in the statutory audit report for 2010-11.

o. Comment upon tracking of expenditure against untied funds and AMG to District Hospitals, CHCs, PHCs, SCs, and VHNSCs, whether such releases are being treated as expenditure.

The funds releases to CHC, PHC, SC being treated as advances in books of accounts maintained at Districts and CHC, PHCbut funds released to VHSCs were being booked as expenditure without obtaining SOE/ UCs. The matter was referred to Ministry and State has been advised to issue necessary instructions in this regard and obtain settlement of pending advances from VHSCs.

p. Comment if the funds released are adequate and commensurate with the need and whether funds are utilized more than the approved PIP of the Year 2011-12.

The sufficient funds have been released to the State for 2011-12 as per SPIP of the state and funds utilization is being monitored.

q. To look into the reasons for low utilization of funds and identify the deficiencies for the same. Comment on the activities identified for low/under utilization. If any, please elaborate the reasons therefor.

As per the FMR for quarter ended Sept. 2011, the following activities have shown low/ nil utilization in the current financial year ;

Program	**SPIP (RsCrore)**	**Utlization %**
RCH Flexipool	103.87	29.35
Mission Flexipool	94.90	32.59
Immunization	15.53	5.75
NIDDCP	0.26	0
NVBDCP	2.02	16.67
NPCB	8.85	0.08
IDSP	1.85	39.45

RNTCP	6.71	30.61

State has been advised to identify reasons for low utilization of funds and speed up activities where funds utilization is low or Nil.

r. Comment on RKS constitution, fund utilization and the accountability of public health providers to the community.

State has preferred to rename RKS as SKS (SwasthyaKalyanSamiti).There are 487 registered SKS in the State out of which 39 SKS were in district Hissar. As per the user charges report compiled by the State, funds of Rs. 34.45 Cr were available under this head in the State out of which an expenditure of Rs. 7.44 Cr was reported upto Sept. 2011. The SKSs were periodically depositing income from user charges into separate bank accounts but were not utilizing it. SKS need to deposit income from user charges into bank account on daily basis. The community participation was found to be low in the monthly meetings of SKS. State is advised to issue revised guidelines to SKS for effective funds utilization in view of revised instructions issued by the Ministry in 2010 - 11.

s. Is the state contributing its share? What activities are carried out from state contribution? Whether these activities commensurate with NRHM activities?

The State has been contributing its matching share and the following table shows the year-wise contribution received from the state Govt.

Year	Amount credited (Rs. Crore)	State Share expected	Shortfall / Excess
2007-08	24.28	20.43	+3.85
2008-09	24.00	29.13	- 5.19
2009-10	28.07	33.25	- 5.18
2010-11	35.63	38.77	- 3.14
2011-12	20.00	41.15	- 21.15

The State Govt has been requested to contribute shortfall in the matching state share for previous years. In response, Rs. 20 Crore have been credited in the bank account of State Health Society as matching share for the current year.

t. Situation in compliance with instructions with reference to i) income tax, b) unspent balances under RCH-I and EAG schemes, c) interest earned against NRHM funds d) diversion of funds

i) TDS quarterly e-return in being filed by the State and District Hissar but many other districts in State are not filing e-return.

ii) Rs. 1.63 lacs is the unadjusted advance of RCH-I which is required to be adjusted or refunded to Ministry

iii) The total Rs. 2.37 Crore is the amount of interest earned by the State as on 31-03-11 as per Statutory audit report for 2010-11

iv) No diversion of funds to other Program except a loan of Rs. 80.00 lacs given to NLEP was observed during 2010-11. DHS District, Hissar has kept Rs. 1.00 Cr in Fixed deposit which is not permitted as per NRHM Financial guidelines.

Recommendations :

- The concurrent audit system needs to made more effective by enhanced monitoring of the audit process so as to ensure timely completion of concurrent audit of all districts and action taken on the observations of concurrent audit
- There is need to strengthen internal control at all accounting centres particularly at Districts, CHC, PHC and Subcentres
- State to start training and implementation of HMIS System
- VHSCs and ANMs need orientation in proper utilization of untied funds and Annual Maintenance Grants
- All districts and State to carry out age-wise analysis of Advances and submit it alongwith monthly FMR
- Monthly review meetings of DPM, DAMs to be held regularly to monitor growth in funds utilization and reasons to be identified for ensuring optimum utilization
- State to issue revised guidelines for funds utilization by SKS and in the light of instruction issued by Ministry in Dec. 2010 and Model Accounting Handbook issued in April 2011

- State to strengthen trouble shooting mechanism in Tally implementation and sort out teething problems faced by implementing units particularly relating to balance sheet
- The unadjusted advance of Rs. 1.63 lacs lying under RCH-I needs to be adjusted or refunded to Ministry
- The reply to the audit paras in the statutory audit report and management letter to be submitted to FMG at the earliest
- State Govt. be requested to bring in the remaining portion of the matching state contribution at the earliest

NRHM Component 14: Decentralized Local Health Action

VHSC

- Village Health Sanitation Committee (NRHM) and Village Level Committee (VLC) have been merged in the State.
- 6280 VHSC/VLCs formed for 6955 revenue villages.
- Aanganwadi Worker and Lady Panch (i.e. Head of VHSC/VLC) designated joint Account Holders.
- To ensure better utilization of NRHM funds, ANM is also being made the joint Account Holder in 2011-12.

- Out of Rs. 628.00 lacs sanctioned for VHSC/ VLCs in Haryana Rs. 540.98 lacs i.e. 86.14% utilized in 2010-11.

SKS

The SKS has been constituted with the Civil Surgeon as the Chairperson and the MS of the GH (General Hospital), as the Co-chairman. Other members include medical officers from various departments, matron, and drug controller, district AYUSH officer, locally elected municipal counselor, representatives from NGOs, IMA and others according to the guidelines. Most of the money spent is for purchase of drugs and medical supplies, office supplies, minor repairs and items for facility improvement (e.g. bed sheets), patient satisfaction (e.g. - water coolers), contractual human resource and other operating costs.

21 DH, 102 CHC and 343 PHC are registered with SKS in the state.

Issues Identified

- Confusion regarding scope of functioning and funding of VHS&NC and VLC still persists
- Infrequent meetings; no planning. In Hissar VHNDs are said to happen every month on the first Wednesday but it was not observed.
- No record of activities and fund utilization was available to be observed. In Mewat district only at village Nautki under PHC Nagina, record of activities of VHS&C with some bills attached was observed.
- No system for periodic review of activities & expenses
- Limited awareness regarding grievance redressal mechanism.

Recommendations:-

- Regular review of activities & expenses required for VHSCs and SKS
- Fast recording & redressal of grievances.
- The supervision and facilitating above activities need to be realized as regular deliverables of MOs, ANM, Civil Surgeon and DPM

NRHM Component 15: Overall Outcomes

Suggested action areas:

- Develop health workforce policy in consultation with all stakeholders
- Strengthen management capacity at district and sub-district levels
- Competent and effective mechanisms / agency for
  - infrastructure planning, execution and maintenance
  - drugs and equipment procurement, supply and maintenance
  - tracking and submission of SOEs, especially from VHSCs and SKS (RKS) and concurrent audit
- Mobilize communities in decision making, possibly through SHGs (Self Help Groups) and CBOs (Community Based Groups), using a well planned multi-year strategy
- Program auditing of schemes should be done

NRHM- Goals and Achievements

Parameter	Expected Outcome	Outcome of the Mission in the State
Maternal Mortality Ratio	100 per 100,000 live births	153
Infant Mortality Rate	30 per1000 live births	51
Total Fertility Rate	2.1	2.5
Malaria Mortality Reduction Rate	60% by 2012	60%
Kala Azar Mortality Reduction Rate	100% by 2010 and elimination by 2012	
Dengue Mortality Reduction Rate	50% by 2010 and sustaining that level until 2012	50%
Cataract operations	Increasing to 4.6 Million	Target increased from 1.25 Lakh to 1.70 lakh
Leprosy Prevalence Rate	Reduce from 1.8 per 10000 in 2005 to less than 1 per 10000 thereafter.	0.14
Tuberculosis	Maintain 85% cure rate through entire mission period and also sustain planned case detection rate.	85%

Areas which have not been addressed during conceptualization of the mission or during implementation of the Mission: Areas which have not been addressed that are important for all NRHM components are:

- Adequate capacity building and support systems for State, District & Block Program Management Units.
- Recruitment or hiring activity/ project based services of adequate manpower at state & district Program Management Units, with expertise in public health, management (Building construction & maintenance, procurement, Information Technology), monitoring and financial management with support staff, mobility and funds to ensure effective monitoring and utilization of increasing fund flow under NRHM.