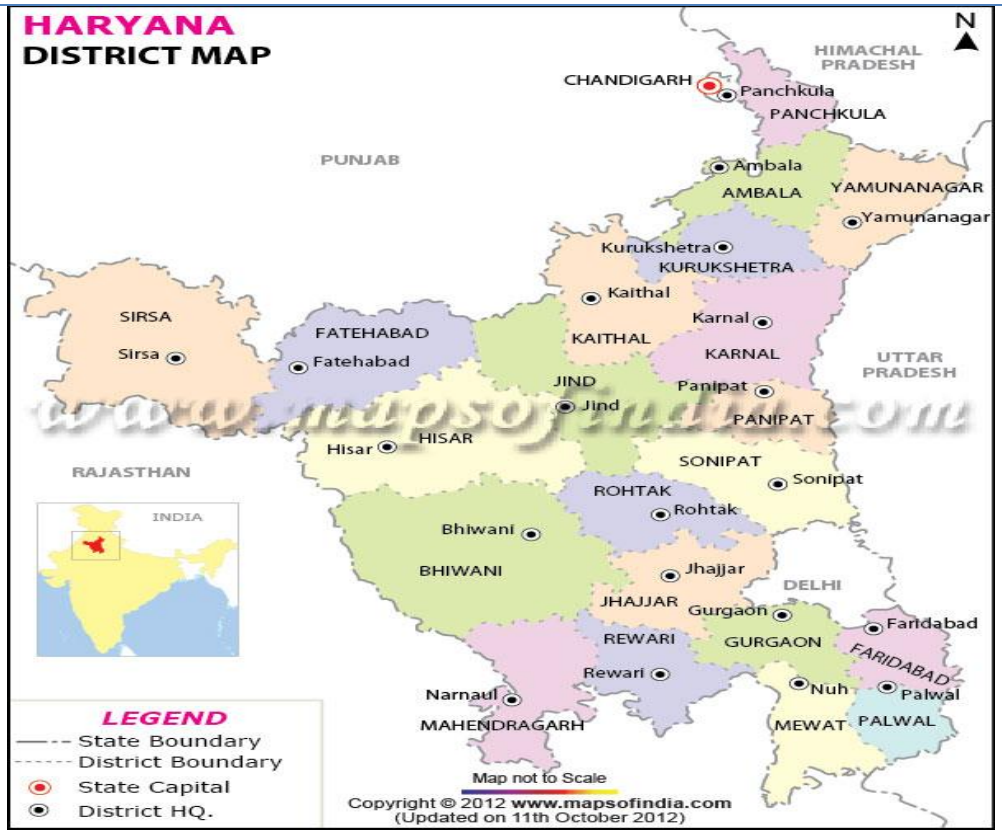
HARYANA - 7TH CRM REPORT



9TH TO 15TH November 2013

NATIONAL RURAL HEALTH MISSION

MINISTRY OF HEALTH & FAMILY WELFARE
GOVERNMENT OF INDIA

CONTENTS

PART I

1.1 OVERVIEW

The 7th Common Review Mission (CRM) is the beginning of a new chapter with the introduction of NHM, as a new mission NUHM has rolled out in few states in 2013 onwards.

Haryana has made good progress during the period under review and has set up several systems to make this progress evident. The team was pleased to note that there is openness at all the levels towards improvement and genuine efforts are being made, particularly in last few months with the enforcement of quality driven supervisory and review mechanism in place.

The state has been able to sanction health facilities and take up construction works in collaboration with PWD (B&R), though a great number of facilities needs to be completed on war footage as there has been delayed in expedition of this process. State has put a transparent system in place for hastening the recruitment of regular doctors through direct-walk interviews for filling up the vacancy of doctors in the public health system. Many specialists got hired through contractual appointment.

The state has able to put a quality improvement system in place with strengthening of labour rooms of all delivery points through establishment of septic and aseptic labour rooms, pre-natal and post natal wards, MTP/procedure rooms and availability of drugs and functional equipments, display of guidelines/protocols, use of partograph – improvement observed in almost all facilities visited.

Improvements are also observed in areas of iimplementation of Quality Intra Natal Care and Immediate Post Partum Care Standards through Supportive supervision mechanism which has been initiated with technical support from MCHIP-USAID. A Facility Readiness assessment initiated with support of MCHIP /USAID and all delivery points of 17 districts covered till now; Gaps analysis initiated and support provided to district to fill them.

There have been quality improvements in immunization programmes and outreach sessions as a result of the availability of due-lists, efficient cold chain management and availability of trained HR and good record keeping. Measles Surveillance has been initiated in all 21 districts with technical support from NPSP-WHO. The Quality Assurance in Immunization constituted and closer monitoring and evaluation of immunization programme through RAPID & IFVs, implementation of Effective Vaccine Management.

The state has been able to put a supportive Supervision system in place. Certain gaps in infrastructure, knowledge and practices observed in delivery of health care services as well as availability of adequate drugs, supplies, consumables and other recording/reporting issues got addressed and followed up although variations are observed in terms of action taken up on those issues as observed during facility visits and observations. However, overall knowledge practices and skills had been improved. State performance rose to 56 points in comparison to 35 points of 1st visit (59% improvement). Confidence, knowledge practices and Skills showed massive improvement. The state performance rose to 74 (33% improvement). Overall improvement in 3 rounds has been ***121%***.

The state has also initiated Setting up of separate corporation for procurement of medical equipments, drugs etc namely Haryana Medical Services Corporation, Ltd. An online Asset Management Software is developed for proper management of medical equipments. Computerization and e-indenting is in place in all facilities upto PHC level in both districts visited. Free drug supply across the state, is ensured based on a Centralised Procurement and Decentralised distribution model.

However, the state has certain areas which require improvements and interventions over certain period of time. Few of the notable areas for improvements are the VHND functioning, inter-departmental convergence, quality reporting, prompt grievance redressal system, community monitoring, establishment of Block Programme Management Units (BPMUs) and decentralized planning activities and processes.

1.2 INTRODUCTION TO THE STATE

Haryana state came into existence on 1 November 1966 as a newly created state carved out of the Punjab state on the basis of language. It is a landlocked state in northern India with an area of 1,553 km^2 and is covered by forest. Haryana has four main geographical features i.e. the Yamuna Ghaggar plain forming largest part of state, Sivalik Hills to the northeast and Semi-desert sandy plain to the south west and the Aravalli range in the south.

Hindus are the majority in Haryana and are about 88.23% of the population, Muslims 5.78% (mainly Meos), Sikhs 5.53% and others constitute only 0.45%. Dalits constitute 19.3 per cent of Haryana's population. Haryana is one of the more socially protracted states in India with rampant caste based discrimination. In Haryana, caste politics has given insurmountable powers to an ancient and rudimentary social administration system called khap that several law experts deem unconstitutional.

The state is divided into four divisions for administrative purposes: Ambala, Rohtak, Gurgaon and Hisar. Within these there are 21 districts, 47 sub-divisions, 67 tehsils, 45 sub-tehsils and 116 blocks. Haryana has a total of 81 cities and towns and 6,759 villages. There are six high focus districts namely Bhiwani, Jind, Mewat, Garh, Palwal and Panchkula in Haryana.

Table 1.1: State's facts & figures

Literacy rate:	76.6%
Male:	85.38%
Female:	66.77%
Population 2011:	25353081
Male:	13505130
Female:	11847951
Rural:	16500000
Urban:	8853081
Density of population:	573 per sq.km

Life expectancy:	66.3 (Female)
No. of cities/towns	81
No. of villages :	6,759

Haryana is notably a prosperous and rapidly growing state in terms of population having a decadal growth percent of 19.9 as compared to All India (AI) of 17.64. The TFR (SRS-2011) is slightly lower than AI of 2.4. The CBR (SRS 2013) is the same as AI at 21.6 though the CDR is on lower side at 6.4 than AI of 7.0. Both Haryana and AI has the same IMR (SRS 2012) of 42. It also scores better than AI in terms of coverage of fully immunized children (DLHS-III) at 59.6% and that of AI is 53.5%.

Table 1.2: Key demographic and Health profile of Haryana as compared to India figures

Item	Haryana	India
Total population (Census 2011) (in crores)	2.53	121.01
Decadal Growth (Census 2011) (%)	19.9	17.64
Crude Birth Rate (SRS 2013)	21.6	21.6
Crude Death Rate (SRS 2013)	6.4	7.0
IMR (SRS 2012	42	42
MMR (SRS 2007-09)	153	212
TFR (SRS-2011)	2.3	2.4
Sex ratio (Census 2011)	877	940
Fully immunized children coverage (DLHS-III)	59.6%	53.5
Under 5 Mortality Rate (SRS-2011)	51	55
Contraceptive Prevalence Rate (DLHS-3)	62.9	54.8

1.3 MAJOR ACHIEVEMENTS UNDER NRHM

RCH Indicators

- MMR dropped from 186 (SRS, 2005-06) to 153 (SRS, 2007-09), a drop of 33 point decline.
- IMR has decreased from 60 (SRS 2005) to 42 (SRS 2012) 18 point decline.

Health Care Delivery

- The number of OPD cases increased from 11, 768,761 in 2008-09 to 14,859,416 in 2012-13(HMIS) with OPD visits per 1000 population of 575.2 in 2012-13.
- The number of IPD cases increased from 633, 695 to 717,99 in 2012-13 (HMIS) and IPD per 1000 population is 27.8.

Maternal health

- More than 100% increase in institutional deliveries from 2005 to 2013- an increase of 8.9% in contribution by public facilities from 2009 to 2011 and a 7.3% increase in institutional deliveries from 2011 till 2013.
- Total reported institutional deliveries (to reported deliveries) are 379,736 (82.4%), (HMIS -2012-13) and complicated cases attended is 33,355 (5.4%) out of 456453 reported cases. The number of C-section conducted against reported cases is 33,328 against the total institutional deliveries of 379,736.
- Total reported institutional deliveries as(to estimated deliveries) is 379,736 (66 %), (HMIS-2012-13)

- 61902 mothers have benefited under Janani Surakshya Yojana (JSY) (2006-2013)
- 46 (39 Old + 7 New) MBBS Doctors are trained on Life saving Aesthetic skills (LSAS) and 123 (104 Old + 19 New) MBBS Doctors trained on Emergency care (EmOC) in 2012-13 (Nov). 81 MBBS doctors are trained in BEmOC.
- 1299575 total cases are attended to by the referral l transport system for delivery purposes, road-side accidents, referral from one health facility to another and other emergencies (from 2009-10 till September 2013)

Immunization

- Full Immunisation coverage increased from 59.1 % (DLHS II 2002 -04) to 59.6 % (DLHS III 2007-08)

Child Health

- 19 SNCUs- operational in each of 17 districts, 1 in Bhiwani, 1 in Jind, 1 in Mewat, 1 in m/Garg, 1 in Palwal, 1 in Panchkula, 1 in Ambala, 1 in Faridabad, 1 in Gurgoan, 1 in Hisar, 1 in Jhajjar , 1 in Kaithal, 1 in Narnaul, 1 in Rewari, 1 in Rohtak, 1 in Sirsa, 1 in Sonipar and 1 in Sonipat and 1 more in Yamuna Nagar, There are 66 NBSU which are functional.
- 318 New born corners established across the state
- IMNCI (Integrated Management of Neonatal and Childhood Illnesses) implemented in 19 districts
- 1 NRC is approved but it has not been made functional as in Nov, 2013. 1 NRC is under process for operationalization in Faridabad.

National Disease Control

- IDSP Unit is functional at state HQ and in 20 districts out of 21.
- Good progress in implementation of malaria control programme.
- Death due to malaria has reduced to 0 in 2013 from 1 in 2012.
- Death due to dengue has reduced from 11 in 2007 to 0 in 2013 (June)
- Death due to Japanese Encephalitis has decreased from 48 in 2007 to 0 in 2012

- Prevalence Rate of Leprosy is 0.26, 19 districts sustaining elimination level

Other Disease Control

- The State / districts have a large number of anemia cases detected though online anemia tracking method. The districts are doing good job of managing these cases with limited facilities.

ARSH Programme

- ARSH/Mitrata clinics established at District Hospitals of 21 districts and fixed day fixed hour AFHCs established and opened every Saturday at 91 CHCs and 2 PHCs; launched the WIFS (Weekly Folic Acid Supplementation); massive IEC campaign with over 14 lakh students consumed WIFS till October 2013.

Out Reach Services

- 6280 VHSNCs are constituted across the state

Mobile Medical Units

- 6 MMUs are operationalised and catering to the need of beneficiaries in inaccessible areas.

- 343 ERS 102 type Ambulances are deployed across the state for providing 2nd referral transport service.

Human Resource (Contractual)

- 217 contractual AYUSH Doctor, 174 AYUSH paramedical staff, 155 GDMO (other than PHC), 29 specialists (in position at CHC level), 30 specialists (other than CHC level), 428 paramedics, 1611 staff Nurses (at CHC and other than CHC), 2730 2nd ANM are in position as on 30th June, 2013.
- 12000 ASHAs in place with drug kits across the state.
- Total number of ASHA trained on 6th & 7th module in first and second round are 12038 and 12030

Community Participation /Monitoring

- Total number of MNGOs in the state has increased from 2 in 2005 to 10 in 2012.
- The process for Community Monitoring is yet to be initiated in the State.
- The citizen's charter on community participation is prepared and displayed on public domain but no Grievance Redressal Mechanism is set-up

The comparative analysis of data of Haryana and district Ambala and Palwal on various hygiene and health related indicators is captured in table 1.3 below

Table 1.3: Health & Social Indicators – State *vis-à-vis* Districts

Sr. No.	Indicators (%)	Comparative Analysis of health /related indicators			
		Haryana	Ambala	Palwal$	Remarks
1.	Improved Sources of Drinking Water	96.0	73.9	46.6	Need to improve access to drinking water to reduce cases of diarrhoea
2.	Couple using spacing method for > 6 months	13.4	4.6	7.5	Contraceptive acceptance needs to be increased in light of high unmet need -to improve and expand basket of FP services
3.	Total unmet need #	16.0	17.3	21.3	
4.	Percentage of Mothers who had at least 3 Ante-Natal care visits during the last pregnancy #	51.8	55.8	46.0	Ambala is doing relatively better than state in terms of RCH programme
5.	Institutional births #	46.8	55.3	39.2	
6.	Safe delivery	53.4	17.7@	6.5@	
6.	Children (12-23 months) fully immunized (BCG, 3	59.6	71.8	45.7	Coverage of immunization needs greater

	doses each of DPT, and Polio and Measles) #				focus in Palwal
7.	Children breastfed within one hour of birth #	16.5	17.3	12.4	Breast feeding needs greater attention in the state/district
8.	Women who have heard of HIV/AIDS (age group of 15-49)	66.6	79.9	56.2	Awareness on HIV/RTI among women is good
9.	Women who have heard of RTI/STI (age group of 15-49)	40.3	40.7	30.7	Awareness level needs improvement

Source: DLHS-III#; source of all figures are from DLHS-III unless specified otherwise; $(Faridabad figures is proxy as it was part of Faridabad); @Delivery at home assisted by a doctor/nurse /LHV/ANM (%)

1.4 PROGRESS OVER SUCCESSIVE YEARS AND CRMS IN HARYANA

The comparative progress over different CRM has been captured from 3rd CRM onwards as Haryana state got reviewed for the first time by CRM from 2009-10. The second CRM for the state was the 5th CRM and report has been included as substantive quantitative analysis was done and this has been used for assessment of progress during the subsequent CRMs.

Table 1.3: Progress across CRMs (1st to 7th CRM)

Areas of Development	3nd CRM (2009-10)	5th CRM (2011-12)	7th CRM (2013-14)	Remarks
Infrastructure				
No. of Medical College and Hospitals (both sectors)	---	3 (1 Govt. , (PGIMS Rohtak), 1 Govt. Aided (Agroha), 1 Pvt. (Mulana)	6 (2 Govt, 4 Pvt.) + 2 more colleges being established (1 at Mewat/1 at Karnal)	Total intake of is 700 in 6 colleges
No. of district hospitals	21	21	21	
No. of CHCs	93	111	109	Facilities have been planned as per requirement however these do not conform to IPHS norms
No. of PHCs	437	330	341	
No. of SCs	2465	2630	2572	
No. of ANM TC	8	8+42 (pvt.)		Need more training centres
No. of MPW (M) TC	2	2+7		

Human Resources				
Specialists (Total)	--	721	-	
O&G (at CHC level)	24	---	77	
Anesthetist	19	---	49	
Pediatrician	27	---	57	
Medical Officers at PHC /GDMO at CHC level	299 (R)/ 114	2239 (R)+ 113 (C)	2280 (T)	
AYUSH doctors	--	597 (T)	638 (T)	Increased in HR recruitments in last 2 years in various positions (*Source: PIP 2013-14 under 7th CRM column)*
Staff Nurse	490	2849 (T)	3481 (T)	
Pharmacists	---	812 (T)	947 (T)	
L.T	----	684 (T)	845 (T)	
ANM	2897	4609 (T)	5430 (T)	
MPW	1093 (R)	1871 (R)	2381 (R)	
Training				
Maternal health (total)				
SBA (ANM/AWW)	--	2076	3686 (SN/ANM)	Training achievements has increased over the years F-IMNCI figures are only for M.Os *Source: PIP 2013-14 under 7th CRM column)*
LSAS	--	27	58	
BEmOC	--	42	81	
Child Health (Total) (*since inception)*				
NSSK	-	4445	7087 (T)	
F-IMNCI	--	520	645	
IMNCI	653	6851 (T)	9300 (T)	
Family Planning				
Mini Lap	--	258	297	*Personnel trained as in Oct '2012 is 39 (PIP 2013-14)*

NSV	-	152	171	
Health Care service delivery				
Total No. of OPD services	15, 476,445	-	14,859,416	*Source: 2012-13(HMIS), excluding ANC cases*
Referral Transport (Total)				
Ambulance	0	335	343	ERS 102 Type
Programme Management				
Total no. of functional DPMUs		21	21	
Total number of functioning BPMUs	0	0	0	
Community Processes/Outreach				
ASHA (No. selected/ achievement rate)	13275 (95%)	13204	16,774 (93.18%)	ASHA selection and constitution of VHND has slowed
VHND	6282	----	6280	
Finance (in crores) (RCH/Mission Flexipool)				
Administrative approval (states contribution with NRHM Resource Envelop	237.28 (2009-10)	226.64 (2011-12)	256.03 (2013-14)	
Released including state share (Excluding funds routed through treasury)	107.87	195.01	134.16 (till 1st. installment 75% of BE)	
Utilization Rate (Excluding funds routed through treasury)	249.17	181.82	111.98 Up to 2nd Qtr)	

1.5. CHANGES OVER CRMS - *KEY OBSERVATIONS*

- Increased in production of health personnel with establishment of new medical colleges (both in government and private) and ANM training schools over the last 2 years.
- Substantial increase in human resource with recruitments for specialists, doctors, staff nurses, ANMs, L.T, pharmacists, MPWs including AYUSH medical officers.

- Health infrastructure in the State has improved in the last 4-5 years though there has been slight decrease in number of functional facilities in 2013-14. The State has upgraded many health facilities and constructed new facilities to meet its critical gap.

- SNCUs functional in 17 out of 21 districts. IMNCI training increased to cover 21 districts and categories of service providers trained as also increased in substantial numbers.

- Service delivery has improved over the years as evidenced in increase number of facilities and augmentation of human resources along with placement of systems.

- The achievements in training targets has also increased over the years

- The ASHA selection against the targets though has slightly decreased as compared to previous CRM. The VHND and activities have slowed down and no new VHNDs had been constituted.

1.6 FINANCIAL PROGRESS AGAINST THE APPROVED PIP

RCH-II

- The overall fund utilization against approved annual SPIP of **Rs. 133.23 crore**, is Rs**. 65.58 crore** up to 2nd Qtr of Financial Year 2013-14 i.e.51.08**%** utilization against approved PIP**.**

- Expenditure reported Maternal Health (Other than JSY) (57.43%) till 2nd Quarter of 2013-14 shows good level of utilization of funds.

- The State has reported (36%) utilization of approved PIP under PNDT Activities up to 2nd Qtr. of F.Y. 2013-14.

- The State has reported expenditure of less than 45% of the approved annual PIP under the heads Training (21%), ARSH (including School Health Programme)(19.99%), Family Planning Services (including Compensation and Camps) (34.59%), JSY (including ASHA incentives under JSY)(33.93%). The State should take necessary steps to improve utilization under these activities

Mission Flexi Pool

- Since the launch of the programme, out of the total release of Rs.534.79 crore under Mission flexible pool, the state has incurred expenditure up to 2nd Qtr of 2013-14 amounting to Rs 672.98 crore i.e. 125.84% of funds released to the State, which shows a diversification of fund of other programme to MFP .

- Out of the approved annual SPIP of Rs. 121.82 crore, the reported expenditure up to 2nd Qtr is Rs. 46.39 crore for the year 2013-14. 38.08% expenditure against approved PIP.

- The State had an overspent balance of Rs 162.99 crore as on 1st April, 2013 and Rs. 71.19 crore has been released during the year 2013-14. Expenditure reported by the state during the year 2013-14 has been Rs.46.39 crore

- The state has no budget and no Utilization under the activities of New Initiatives/Strategic Interventions and support services for the financial year 2013-14.

- The State has reported expenditure less than 45% of the approved PIP under the heads Untied Funds (17.33%), ASHA (34.12%), AMG(22.01%), Hospital Strengthening (1.13%), New constructions/setting up (37.81%), Monitoring and evaluation (HMIS) 37.50%) up to 2nd Qtr of 2013-14.

- The State has reported NIL Expenditure up to 2nd Qtr of 2013-14 under the activities of District Action Plans(including Block, Villages), Research study analysis.

Table 1.4: Utilization of Fund up to 2nd Qtr of 2013-14 (Rs in Lakh)

Activities	**SPIP**	**Utilization**	**% of utilization**
New Initiatives/ Strategic Interventions (As per State health policy)	NIL	NIL	NIL
Health Insurance Scheme	NIL	NIL	NIL
Untied Fund	717.85	124.40	17.33
Support Services	**NIL**	**NIL**	**NIL**

PART –II

2.1 INTRODUCTION TO CRM

NHM uses an intensive accountability framework through a three pronged process of (i) community based monitoring, (ii) external surveys and (iii) stringent internal monitoring on a regular basis. Common Review Mission (CRM) is a part of this intensive accountability framework and CRM Teams visit States regularly to review NRHM programme. This is the 3rd CRM visit to the State of Haryana.

AIM OF the 7th CRM:

- Review progress of National Rural Health Mission/National Health Mission with reference to the functioning of NRHM vis-à-vis its goals and objectives-identify the changes that have occurred in the last eight years and reasons for the current states and trend
- Review programme implementation in terms of accessibility, equity, affordability and quality of health care services delivered by public health systems including public private partnership (PPP).
- Review of progress against conditionalities and state's response to conditionalities.
- Review follow up of action on recommendations of last Common Review Mission.
- Note additional outcomes others than those envisaged under approved plans
- Identify constraints faced and issues related to each of the components outlined and possible solutions.
- Document best practices, success stories and institutional innovations in the state.
- To identify strategies and outcomes in the State in addition to the ones envisaged by the Mission, both positive and negative,
- Make recommendations to improve programme implementation and design.

2.2 COMPOSITION OF THE CRM TEAM TO HARYANA, OFFICIALS AND FACILITIES VISITED IN TWO DISTRICTS VIZ. AMBALA AND PALWAL

Composition of the CRM Team to Haryana , Officials and facilities visited in two districts viz. Ambala and Palwal are given in the following Tables

Table 2.1: CRM Team Composition

Sl. No.	Name of Official	Designation	Contact Details
1.	Dr. Tarsem Chand	Director (CEA)	Ministry of Health & Family Welfare,

		(CRM Team Leader)	Government of India, New Delhi-110001
2.	Mr. Raj Kumar	Director, (AYUSH)	Ministry of Health & Family Welfare, Government of India, New Delhi-110001
3.	Mr. Joytrimoy Nandi	Research Officer (NVBDCP)	Ministry of Health & Family Welfare, Government of India, New Delhi-110001
4.	Dr. Preeti Kumar	Project Director/Associate Professor	PHFI, Vasant Kunj, New Delhi
5.	Dr. Suchitra Lisam	Sr. Consultant	National Health System Resource Center (NHSRC), NIHFW Campus, Baba Ganganath Marg, Munirka, New Delhi-110067
6.	Dr. Gulfam Hashmi	Consultant (Regional Co-ordinator NRU)	Ministry of Health & Family Welfare, Government of India, New Delhi-110001
7.	Dr. Priyanka Agrawal	Consultant (RNTCP)	WHO, RNTCP for Punjab and Chandigarh
8.	Dr. Rajiv Shaurastri	Project Director	Population Foundation of India
9.	Mr. Vipin Joseph	Consultant (RCH- Monitoring)	Ministry of Health & Family Welfare, Government of India, New Delhi-110001
10.	Mr. Sahil Chopra	Consultant –NRHM	Ministry of Health & Family Welfare, Government of India, New Delhi-110001
11.	Mr. Vikas Sheemar	Consultant (NRHM-MIS)	Ministry of Health & Family Welfare, Government of India, New Delhi-110001
12.	Mr. Satyajit Sahoo	Consultant (FMG)	Ministry of Health & Family Welfare, Government of India, New Delhi-110001

A1. CRM Team to district Ambala

Name of the officer	**Designation**	**Organization**
Dr. Tarsem Chand	Director (CEA)	MoHFW
Dr Preeti Kumar	Project Director	PHFI

Dr. Gulfam Hashmi	Consultant	Regional Co-ordinator, NRU
Dr .Priyanka A	Consultant (RNTCP)	WHO
Mr. Sahil Chopra	Consultant (NRHM-I)	MoHFW
Sh. Satyajit Sahoo	Consultant (FMG)	MoHFW

A2. CRM Team to district Palwal:

Name of the officer	**Designation**	**Organization**
Shri Raj Kumar	Director (AYUSH)	MoHFW
Mr. Nandi	Research Officer	MoHFW
Dr. Suchitra Lisam	Sr. Consultant	NHSRC
Mr. Rajiv Shaurastri	Project Director	PFI
Mr. Vipin Joseph	Consultant (RCH- Monitoring)	MoHFW
Mr. Vikas Sheemar	Consultant (MIS)	MoHFW

Details of Facilities visited by Palwal /Ambala Team: **The name, level and person in charge of facilities visited is given in table 2. The visits were undertaken for a period of 5 days starting from 10th November to 13th November 2013.**

Table 2.2 : Details of public health facilities visited

Districts visited – Ambala and Palwal				
Sr. No.	**Name**	**District HQ**	**Name of DM**	**Name of Civil Surgeon**
1.	Ambala	Ambala	Mr. K.M. Pandurang	Dr. V.K Sharma
2.	Palwal	Palwal	Mr. Atul Kumar	Dr. Rajendra Prasad
Health Facilities visited in Palwal				
Sr. No.	**Name**	**Address / Location**	**Level (SC / PHC / CHC/other)**	**Name of the Person in Charge**
1	District Hospital - Palwal	Palwal	DH	Dr. Rajendra Prasad

2	Hodal CHC	Hodal, Palwal	CHC	Dr. Vipin MO, I/C
3	Hathin CHC	Hathin, Palwal	CHC	Dr. Manish MO
4	Mandkola PHC	Mandkola, Hathin	PHC	Dr. Anuj, DS
5	PHC Hassanpur	Hassanpur, Hodal	PHC	Dr. Manoj Kumar
6	SC Pondri,	Pondri, Hathin	SC	--
7	SC Gehlab	Gehlab	SC	-
8	SC Prithla	Prithla	SC	ANM- Smt. Mahendri
9	PHC Alawalpur	Alawalpur, Palwal	PHC	Dr. Parveen
10	SC Deeghot	Deeghot, Palwal	SC	ANM-Shakuntala Devi
11	SC Janoli	Allawalpur, Palwal	SC	ANM- Nikhelesh
12	DTC, Palwal	Palwal,	Training Center	
13	MMU	Palwal	-MMU site	
14	District Vaccine store	Palwal	DH	
	Health Facilities visited in Ambala			
1.	District Hospital	Ambala	DH	
2.	SDH	Naraingarh	SDH	
3.	CHC	Shehjadpur	CHC	
4.	CHC	Mullana	CHC	
5.	CHC	Chaudmastpur	CHC	
6.	PHC	Nahoni	PHC	
7.	PHC	Samlehdi	PHC	
8.	SC	Khodakhurd	SC	
9.	SC	Berpura	SC	
10.	SC	Lalpur	SC	

11.	SC	Dhanana	SC	
12	Villages	Tangedia and Lottan		

PART –III

FINDINGS OF THE 7TH CRM:

As mandated by the NRHM, an in depth study of major programme components including programme management, planning & design, governance, community ownership, monitoring & evaluation and health care delivery etc was carried out for the State of Haryana . The CRM team compared the progress over CRMs and studied the output expected over different periods of NRHM and tried to identify reasons for success and failures and to suggest changes wherever required to move ahead to the next phase of NRHM.

The CRM report has been divided into three parts, (i) State Initiatives, (ii) Observations (both State as well as District) and (iii) Recommendations. The following are the CRM Team's observations.

3.1 SERVICE DELIVERY:

3.1.1 State Initiatives:

The State has taken the following measures to improve quality and achieve integrated care through the following steps:-

- Facility Readiness Assessment initiated with support of MCHIP and USAID. Supportive supervision mechanism has been initiated with technical support from MCHIP-USAID
- Strengthening of labour rooms of all delivery points by establishment of septic and aseptic labour rooms, pre-natal and post natal wards, MTP/procedure rooms and availability of drugs and functional equipments, display of guidelines/protocols and infection prevention practices
- Establishment of web-based Maternal Death, Infant Death and Still Birth Reporting System (MIDRS)
- Accreditation process of SNCU by NNF has been initiated and self assessment scores being used
- NUHM for initiated with establishment of Urban Health Cell within SPMU, 2 urban FRUs functional at Faridabad, 56 urban ambulances proposed
- Infrastructure Development Wing (Engineering Cell) is established at the State level and headed by a Superintending Engineer, to support all civil construction works and to expedite maintenance of health facilities.
- Similarly the Collector & DM holds meetings with line Departments & executive agencies to review all civil works at District level (Palwal,)
- SIHF ISO certification 9001:2008 was achieved by SIHFW, Panchkula
- Towards strengthening of pre-service education in midwifery and nursing, assessment of 45 training centers (TCs) for nursing and midwifery in both public and private sectors is conducted with technical support from MCHIP-USAID through identification of gaps with respect to infrastructure, human resources, logistics and equipments/knowledge and skills of final year students

3.1.2 Observations:

A. Adequacy of Health Facilities:

- Though substantial improvement has taken place in the health infrastructure of the State in the consecutive five year plans, the adequacy falls still short of the state requirements.

Table 3.1: Health Facilities in the State during 10th & 11th Plan

Type of facilities	10th Plan	11th Plan (March, 2011)	Status as in October, 2013*
Health Sub-center	2433	2508	2572
Primary Health Center	411	444	341
Community Health Center	86	107	109
District Hospital	-	20	21

** PHCs got upgraded to CHCs; hence no. of PHCs has reduced in the current Five year plan period.*

- The State has upgraded many health facilities and also constructed new facilities to meet the critical gap.

District specific observations:

Palwal having population of 10 lakh has 1 District Hospital, 4 CHCs, 9 PHC's and 88 Sub Centres. There are 378 villages in 4 blocks of the district.

Table 3.2: Adequacy of health facilities in Palwal

Public Health Facilities – Shortfall as per Population Norms			
Types of Institution	**Functional as in March, 2013**	**Projected as per population Norms***	**Shortfall (Number/Percentage)#**
DH	0	1 (100 beds)	1
SDH	1	2	1 (50%)
CHC	4	8	4 (50%)
PHC	12	32	23 (71%)
HSC	88 (all)	192	104 (54%)

****-** as per IPHS 2010 norms; # considering only the existing /functional facilities (ongoing constructions are not taken into account)*

- In district Palwal, availability of health facilities falls far short of the required number as per the Census 2011 population norms. The shortfall (required vs availability) is highest for primary health centers which is 23 (71%); the bed population ratio is very low and stands at 192 for the entire district in the government sector. The DH has only 30 beds as against requirement of 100. Shortfall of health facilities is high for PHCs/SCs. Accessibility of public health facilities is an area of concern as health facilities available currently are not adequate, located away from farthest villages and out of reach to hamlets in remote and relatively backward area of Hathin, where home deliveries are also reportedly high.

B. Infrastructure Development:

- In terms of adequacy, the health infrastructure in the state has improved to a large extent. The State has upgraded many health facilities and constructed new facilities to meet the critical gap.

Table 3.2: Achievements in infrastructure development in Haryana

Type of Health Facility	Year	No. Sanctioned		Progress of New Constructions					
				No. Completed		No. Under Construction		No. Sanctioned but Yet to start	
		High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts	High Focus Districts	Non High Focus Districts
CHCs	Start of NRHM till 2012-13	0	19	0	7	0	12	0	0
	In 2012-13	0	0	0	0	0	12	0	0
PHCs	Start of NRHM till 2012-13	10	69	1	41	13	10	4	10
	In 2012-13	0	0	0	0	13	10	4	10
APHC/ Others	Start of NRHM till 2012-13								
	In 2012-13								
Sub-Centers	Start of NRHM till 2012-13	36	250	0	166	35	15	14	56
	In 2012-13	0	0	0	0	35	15	14	56

Table 3.3: Construction status of infrastructure in Haryana

Facility	No. of buildings sanctioned since start of NRHM till 2012-13	No. of New buildings completed /used since start of NRHM till 2012-13	No. of Ongoing Works	No. of buildings with Quality certification
SC	286	166	50	0
PHC	79	42	23	0
CHCs	19	7	12	0

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

- In Haryana, the completion rate of sub-centre (SC) construction and use as against total sanctioned numbers since start of NRHM in 2005-06 till the year 2012-13 is 58.1% (7 years)

- The completion of PHC construction and use as against total sanctioned numbers since start of NRHM in 2005-06 till the year 2012-13 is 53.1% in the last 7 years period

- The completion of CHC construction and use as against total sanctioned numbers since start of NRHM in 2005-06 till the year 2012-13 is36.8% in the last 7 years period

Table 3.4: Progress of NRHM in infrastructure development in Haryana from 2005 till March, 2013

Infrastructure	As on 01.04.2005	As on 30.06.2013
Blood Storage Units	0	27 (as in 2012-13)
Blood Banks (licensed and functional)	49	66 (do)
SNCUs	0	17
NBSU	0	66
NBCC	0	318
Total Number of Beds (Including Medical College Rohtak)	4761	10048 (including 1330 beds in PGIMS, Rohtak
Bed population Ratio (No. of beds per thousand population)	0.52	3.9 *

**Bed population ratio is 3.9 per 10,000 population in Haryana as per Census 2011*

Table 3.5: Status of infrastructure in Haryana, Ambala and Palwal

Health facilities	Haryana	Ambala	Palwal
District Hospitals (RHS 2012)	21	1	1*
Sub-Divisional/Taluka Hospitals (RHS/HMIS 2012-13)	22	2	0
Community Health Centres (RHS 2012)	109	4	4
Primary Health Centres (RHS 2012)	447	14	12
Sub Centres (RHS 2012)	2520	104	88
24x7 PHCs	274	Out of 14, 10 PHC	Out of 9,7 PHC are

		are functioning on 24x7 basis	functioning on 24x7 basis
Functional FRUs	41	1 DHs, 2 SDH out of 2 SDH and 0 CHCs out of 4 CHCs identified as FRU and are functioning as FRUs	1 DHs, 0 SDH out of 0 SDH and 0 CHCs out of 4 CHCs identified as FRU and are functioning as FRUs
New Born Care Units established a) SNCU b) NBSU c) NBCC	 15 47 148	 1 3 9	 1 2 6

*** DH in Palwal is under-construction.**

- In Palwal district, the construction has been ongoing for 22 public health facilities and up-gradation of existing PHCs and CHCs have been taken up in last 2-3 years (as in October, 2013). The pace of construction work is rather slow and PWD (B &R) is the construction agency; construction of 22 public health facilities (1DH, 2 SDH, 3 CHCs, 5 PHCs, 10 SCs) have been ongoing for last 2-3 years with completion rate of 40-90% of works at many facilities as per latest status report, October 2013.
- Construction of a 100 bedded District Hospital (proposed/approved in PIP 2010-11 had been ongoing in the campus of the General Hospital, Palwal since the last 3 years, undertaken by the Public Work Department, B&R (Palwal) through tender. Construction of a 50 bedded SDH was started in December 2012 and due for completion in Feb, 2014 in Hathin area within the campus of CHC, Hathin. The construction work of main building of CHC Alawalpur is completed and ready for takeover but due to issue related to boundary wall, it cannot be handed over.

- In Ambala there is ongoing construction, renovation, upgradation resulting in clean facilities with excellently appointed labour rooms, ANC and PNC wards, (except DH), laboratories etc. Ambala has 3 designated FRUs in the district including District Hospital out of which two are completely functional as per norms and the other SDH Naraingarh is not conducting C-Sections mainly due to shortage of specialists.

- Palwal has no functional level II (CHC/24x7 PHCs) providing basic emergency obstetric care with equivalent stabilization unit. The 2 CHCs out of 4 has stabilization unit, which is not fully functional (no in-patients) due to lack of trained M.Os or paediatrician at CHCs. Residential accommodation /quarters are not available for doctors in any of the facility visited; old quarters are available for grade II and III staffs in PHC Mandkola.

- In Ambala, out of 104 HSC, 71 HSCs have two ANMs, however only Subcentre Kesri was not having any ANM. 70 Subcentres are working in Government buildings, 30 Subcentres are working in Pnachyat buildings and 3 are in private buildings. Out of 14, 10 PHCS are functioning as 24*7.

- DH (Palwal) has 3 O.T (general, Eye, Obsteric/Gyne) but there is no blood bank in the DH. None of the CHC visited has O.T and has no blood storage unit which seriously compromised the functionality of CHC.

- Due to frequent power cut in CHC Hathin (Palwal), X ray could not be done in most of the time; 2-3 X ray done in a day on average. No generator provided to CHC.

- All equipments , supplies are available in labour room in CHC Hathin though these are under-utilized as delivery load is less (3-4 delivery per day on average).

- In Palwal, PHCs and SCs need further improvement in the quality of delivery huts. Mechanisms to ensure 48 hrs stay to be explored for deliveries happening in CHC/PHCs levels.

C. Utilization of Facility Based Services:

Table 3.6: Status of Health Care Service Delivery in Haryana

No of sub-centres with Second ANM (RHS 2012)	2481
No. of PHCs with 3 staff nurses	274
No. of PHCs functioning as 24x7 basis (RHS 2012)	315
No of CHCs functioning as 24x7 basis (RHS 2012)	76

Table 3.7: Delivery points in Haryana

Category of Centre	**Total**	**24x7 Status**	**FRU Status**
DH	21	21 (100%)	20
SDH	20	19 (95%)	11
CHCs	109	102 (94%)	7
PHCs	341	278 (82%)	0
Sub-centers	2572	473 (18%)	0
Total	**3062**	**892**	**38 + 2 Urban FRUs Faridabad=40**

- 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. There has been increase in number of 24x7 Delivery points and FRUs

- At present, 455 stand-alone Sub Centres functioning as Delivery Huts.

Table 3.8: Progress on key RCH service delivery in the state

Indicators (in %)	DLHS-III	CES (2009)	HMIS (2011-12)	HMIS (2012-13) Up to Oct., 2012
Any ANC	87.3%	89.4%	601919	342766
3+ ANC	52.4%	68.9%	492184 (81.77%)	272393 (79.47%)
Registration within 12 wks	55.1%	57.4%	307894 (51.15%)	172462 (50.31%)
Full ANC	13.3%	42.9%	--	--
Institutional Delivery	46.9%	63.3%	432255 (71.81%)	239319 (69.81%)
Safe Delivery	53.4%	69.3%	466533 (77.51%)	259721 (75.77%)
Home Delivery	52.6%	36.4%	**87381 (14.51%)**	**46423 (7.71%)**
% of C-sections out of total reported institutional deliveries	-	-	6.90%	8.30%
At Public	-	-	**16460 (3.80%)**	**12368 (5.19%)**
At Private	-		13374 (3.09%)	7507 (3.13%)
% of anaemic women out of total registered pregnancies	-	-	298334 (49.57%)	191655 (55.91%)
% of severely anaemic women out of total anaemic pregnant women	-	-	39589 (6.57%)	19909 (5.80%)

- Percent of C- section out of total reported institutional deliveries has increased from 6.90% in 2011-12 to 8.30% in 2012-13 (Nov'12); the increase is more in the public institutes and there is a marginal increase in private institutes.

Table 3.9: Increasing trends in Institutional Deliveries (CRS) in Haryana

Year	Govt. Inst.	Pvt. Inst.	Total Inst.	Non Inst.	Total
2006	83133	166464	249597	259373	**508970**
	16.30%	32.70%	**49.04 %**	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%	**67.03%**	33%	
2010	205086	197282	402368	142252	**544620**
	37.65%	36.22%	**73.88%**	26.11%	
2011	237067	198607	435674	127882	**563556**
	42.07%	35.24%	**77.31%**	22.69%	
2012	247153	202143	449296	114437	**563733**
	43.84%	35.86%	**79.70%**	20.30%	
2013 Jan. to Aug.	154182	122626	276808	51476	**328284**
	47.00%	**37.40**	**84.30%**	**15.70%**	

Table 3.10: Maternal Health Indicators (HMIS)

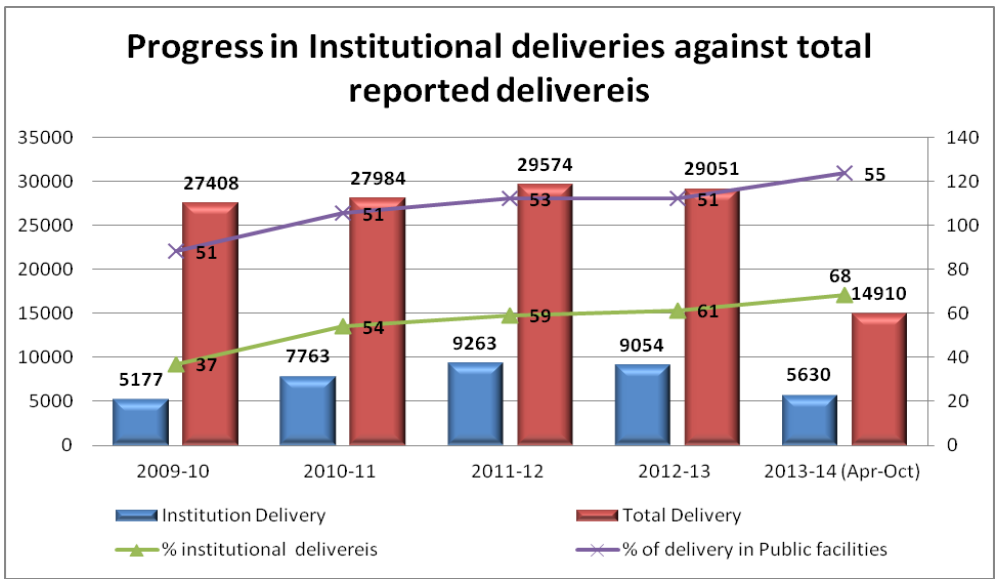
Indicators		**2011-12**	**2012-13**	**2013-14**
% age 1st Trimester registration to total ANC Registrations	Haryana	51	50.8	49
	Ambala	44.3	42.9	53.3
	Palwal	48.3	37.7	55.4
%age JSY registration to Total ANC Registration	Haryana	12.6	14.2	22.5
	Ambala	25.5	24.1	35.7
	Palwal	10.2	10.5	26.1
%age women given 100 IFA to Total ANC Registration	Haryana	83.9	70.1	97.1
	Ambala	92.1	88.6	99.1
	Palwal	72.1	56.1	80.7
%age Institutional deliveries to Total Reported Deliveries	Haryana	83.8	84.4	84.2
	Ambala	99.1	99.7	99
	Palwal	59.3	59.7	63.5
%age C-sections conducted at public facilities to Deliveries conducted at public facilities	Haryana	6.1	8.2	9.7
	Ambala	9	11.1	9.5
	Palwal	0.2	1.1	5.7

- In Haryana, home delivery has decreased from 2011-12 to 2012-13 from 14.51% to 7.71%

District specific Observations:

- In Palwal, institutional deliveries has increased from 37% in 2009-10 (public/private) to 68% in 2013-14 (April-Oct,2013). The deliveries in public institutes show an increasing trend in 2009-10 at 51% to 55% in 2013-14. In Ambala, institutional deliveries has shown consistent trend since last three year which is more than 99 %. The deliveries in public institutes show an increasing trend in 2011-12 at 59% to 66% in 2013-14. Out of total 125 health facilities (DH, 2 SDH, 4 CHC, 14 PHC, 104 HSC), 47 health facilities (DH, 2 SDH, 4 CHC, 10 PHC, 30 HSC) are reported deliveries in the last six months. In the 4 PHCs who have not reported deliveries in the last six months, is mainly due to shortage of Staff Nurses; However district has assured that Staff Nurse will be recruited at the end of November, 2013. None of the CHC in both districts is performing C-section due to lack of specialist and trained M.Os at these facilities.

Chart 3.1: Progress in institutional deliveries against total reported deliveries in Palwal



- In Palwal, 62 designated delivery points out of total 101 public health facilities (62%), but only 36 (41%)of designated delivery points are functional, 2 PHCs (Solra, Tappa) are not reporting any delivery for last 7 months (April-Oct'13).

- Palwal has 61% (4093) of total deliveries (6643) is taking place in facilities below DH; 38% of deliveries in public institutes are taking place in DH which is a huge proportion. The home deliveries are 63% in 2009-10 and come down gradually to 32% in 2013-14 (April-Oct) but the number is much higher is certain areas of Hathin, where nearly 40% home deliveries take place. None of the CHC is performing C-section in the district due to lack of specialist and trained M.Os at these facilities. There are 7 beds in PP war, had 3 post partum case and 1 is a PPIUCD case in DH.

- In Ambala, out of 6588 deliveries conducted from March 2013 to Oct 2013, 35% of the deliveries were conducted in District Hospitals which is a significant proportion. On an average 300 deliveries

are being conducted every month in 200 bedded District Hospital Ambala. In Palwal, on an average 400 deliveries take place at DH (Palwal), the institutional delivery rate is 60% in CHC Hathin. At SC Pritha, in last quarter (Aug-Oct'13); only 38% of new pregnancy are registered as there were only 20 new registration out of 54 targeted. The delivery load is very low at PHC, Alwalarpur (average 20 cases/month).

- In CHC Chaudmastpur (Ambala), only one bed was allotted for IPD admission. Though PHC Nohani was 10 bedded facilities, only one Staff Nurse was posted in the PHC and average delivery load per month was 3-5 in spite of having good labour room. Radiant warmer and suction pump was not functional and Staff did not know how to use it.

- In DH, Palwal there is a 14 bedded SNCU, where 4 sick neonates admitted of which 2 were out-born cases (home delivered). The NBSU though in place in CHC Hathin and Handol but are not admitting patients due to lack of paediatrician and trained M.Os at CHC. Breast feeding & KMC is in place in DH; though the post natal mother was not able to perform the kangaroo mother rightly. In the SNCU at Ambala, 12 out of 17 beds were occupied with children from hospital and referrals from outside. The HR (staff nurse) ratio was 6/10 .

- In Ambala, AYUSH is co-located with functional panchkarma unit. Patient inflow was found to be on an average as high as 150 per day, reflecting a good utilization . AYUSH doctors in the DH Ambala are not being currently used for monitoring national programs and school health programs., which was deemed appropriate. Records were maintained properly. Space for Yoga instructor and also for Ayurveda, Unani and Homeopathy Doctors and also for dispensing medicines is inadequate. Adequate space is being provided in the new building in the District Hospital likely to be completed soon. Similarly, in other CHCs/PHCs adequate space for AYUSH Doctors should be provided.

- AYUSH Doctors being engaged for School Health Programme are having Allopathic Medicines in their kits. There are proven medicines under AYUSH Systems for Anaemia and other diseases, such medicines may also be included in the kits of School Health Programme.

- There are Vacancies of AYUSH Doctors, Pharmacist/Dispenser in Palwal. These vacancies may be filled up on priority basis. IEC is needed to promote AYUSH in Health delivery system. AYUSH can provide affordable and quality Health care services.

- In Palwal, fixed day IUCD services, permanent sterilization, NSV, tubectomy and safe abortion services are provided on all days at DH, CHC. At the PHC/SC, there is no fixed day IUCD service. None of the PHC/SC is providing fixed day sterilization regular services. At SC Prithla, 7 IUCDs were inserted in September'13. The uptake of FP services is poor.

- In Ambala, PPIUCD insertions have increased tremendously in FY 2013-14 from 779 in FY 2012-13 to 693 till September 2013 (March-September). Fixed day IUCD services were available at PHC level and district wise annual calendar for camps at identified centres were in place.

- In Palwal, ultrasound is conducted at DH with payment of Rs. 400/ per case with an average of 25 cases per day; average X ray done is 40 per day. There is no 24x7 power back up for ultrasound and radiology department, except for MLC cases, no other routine tests are conducted during power cut. No CBC tests are conducted in CHC Hodal; All routine blood tests, LFT, Widal are done at CHC Hathin; 10 Hb tests are conducted for ANC cases per day on average; Laboratory services is good at PHC Mandkola in terms of quantity of tests and ranges of tests performed. In Oct, 2013, 32 diagnosed for TB; out of which 2 were sputum positive at PHC Mandkola Out of 72 total widal tests conducted in PHC Mandkola, 66 tests came out positive (the positivity rate is around 80% for widal tests in Hathin area)-

- In Palwal, Eye care and NCD like cancer, diabetes screening services are provided at DH; Eye camp is conducted for 3 days, started last 2 months; around 25 cases had cataract surgery the previous day at DH. Yoga instruction is given to around 30-40 patients on daily basis.

- Immunization services are provided at DH/other health facilities and on immunization day held at respective villages. Deep freezer, ILR, ice packs, vaccine carrier are available at cold chain point (DH/CHC/PHC); Cold chain is working properly in CHC Hathin; open vial policy is followed; date is also labelled properly; temperature is maintained; AMC is done regularly; extra freezer is also available at CHC Hathin (Palwal); preventive maintenance is done by RM (last visit was in Sep'12);

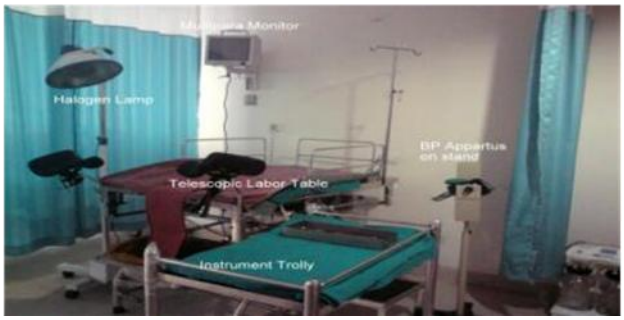
- Most of the EDL listed drugs are available at DH and at CHC/PHC visited and given free of cost to all patients admitted/treated at OPD. Local purchases are done through untied fund in DH. Some of medicine/ vaccine like Vitamin K is not listed in EDL and purchased locally (10-15 medicines per month of local purchases are made). There is need to include more drugs in the EDL. EDL is not displayed nor available in any of the facilities visited (CHC, Hathin, Hodal, PHCs visited). Online procurement system in which indent is made online 3 days prior and NAC given online from the Regional Warehouse located in Gurgaon.

D. Quality of Care:

State Initiatives:

- Implementation of Quality Intra Natal Care and Immediate Post Partum Care Standards through Supportive supervision mechanism has been initiated with technical support from MCHIP-USAID. Facility Readiness assessment initiated with support of MCHIP /USAID and all delivery points of 17 districts covered till now; Gaps analysis initiated and support provided to district to fill them

Figure3.1: Improved labour room infrastructure in DH Palwal



Observations:

- Cleanliness of facilities was good in both districts visited. All facilities had well displayed signages. However at Ambala DH, some of the signages, were in English. PHCs and SCs need further improvement in the quality of delivery huts. Mechanisms to ensure 48 hrs stay to be explored for deliveries at SCs. Service delivery especially outreach services for migrant populations at brick kilns need to be incorporated in district plans.

- In Ambala DH, the ANC and the PNC wards were not in optimal condition, with general overcrowding, and more than one patient on one bed. Lack of equipment such as drip stands for individual patients was also seen. In contrast, the bed occupancy was low in other wards.

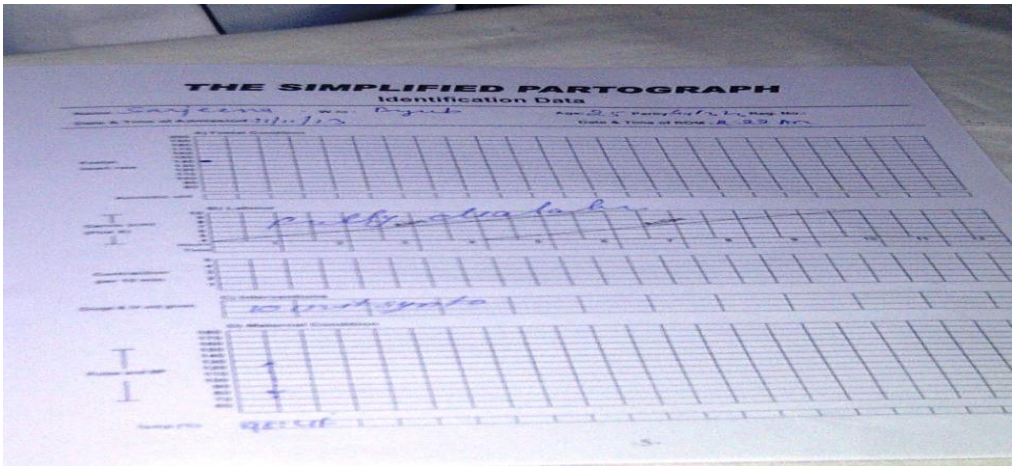
- In Palwal, against total pregnant women registered 66% of pregnant women have been reported with haemoglobin less than 11, of which 2% were found to be severe anaemic cases, of which only 9% had received blood transfusion. No injection iron sucrose is provided in DH.

- In Palwal, only 0.5% of complicated pregnancies are treated /attended at DH only as there is no other FRU and 1.5 % C-section conducted at DH, which is very low as against the expected numbers (Aprl-Mar'13, HMIS).

- Partograph was used in all labour rooms visited in Palwal; all labour rooms in DH/CHC/PHCs visited used a standard printed obstetric case record having partograph sheet, though record keeping is very poor; none of the investigation details are recorded. Incomplete patient files with improper plotting of partographs observed in 2-3 PHC/SC visited. Unsterilized and rusted instruments were being used in PHC Alawalpur and SC Prithla. Ambubags are all kept inside the bag and not placed on tray in SNCU and NBCC in DH, CHC. Emergency drugs are available at all labour rooms of CHC/PHC;

patients are referred after stabilization/ resuscitation at CHC Hathin. No labelling of drug/medicine kept in delivery tray.

Figure 3.2: A picture of a simplified partograph used in labour room at PHC, Palwal



- There is 98% registration of 1st ANC in HC Pondri (Palwal). At most sub-centers, SNs & ANMs are not doing HB and Urine testing though registers has reported otherwise as discussed with beneficiaries. Very poor records- no blood grouping, HIV, HBsAg, VDRL mentioned in the files at any PHC/CHC. Quality of Antenatal care needs lots of improvement as many patients are admitted at delivery points with severe anemia. There is no treatment of severe anemic cases either at CHC/DH as there is no blood bank/storage unit; only 10% of severe anemic patients receive blood transfusion. None of these patients received injection iron sucrose in the district hospital.

- There is wrong online reporting which does not match with records on registers maintained by L.T At one PHC Alawalpur, only 5 anemic cases are reported online (online tracking) from April-Oct'13 while the register of L.T reported 160 anemic cases (mild/severe) for the same period.

- Autoclaving highly compromised at almost all the Delivery Points. Unsterile delivery equipments are found on un- used delivery tray compromising the quality of care. Immunization waste disposal is good and managed as per guidelines in all facilities visited, wastes are treated at source; the pit is closed and locked**.**

E. Sub-contracting:

- Centralized Sterile Service Department is in place at DH, bio-medical waste management is contracted out in Ambala and Palwal for utilities such as BMW, water supply, sanitation, kitchen and power back up was found to be adequate across all facilities up to the PHC level, visited in Ambala/Palwal.

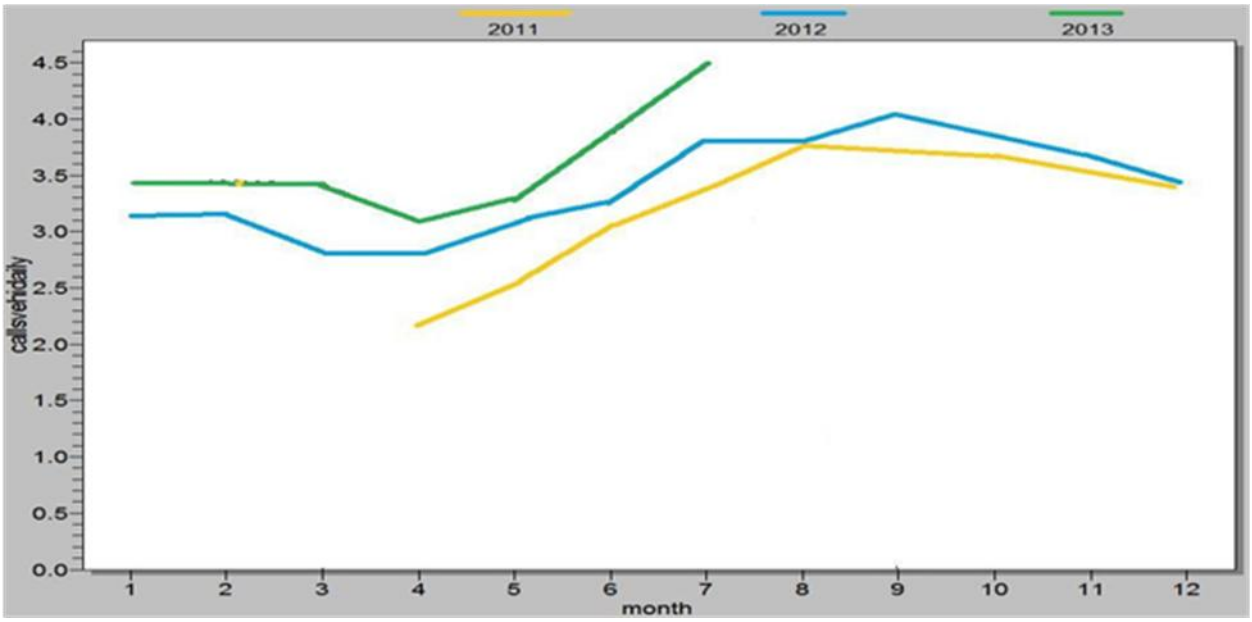
- The agency visits the CHC/PHC only twice a week; placenta disposal is not done properly; wrapped in plastic bag mixed with disposable cups and kept in toilet at CHC Hathin (Palwal).

F. Ambulance & Referral Services:

Table 3.11: 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
2011-12	366598	133548	14650	73275	16820
2012-13	403347	143046	18312	87047	19229
2013-14 (march 2013 to Oct'13)	223648	82338	10770	51786	17806
Total	1299575	483898	62274	273737	113031

Chart 3.1: Calls Per Vehicle Per Day (2011, 2012, 2013) in Haryana



- The calls per vehicle per day increased in 2013 as compared to previous two years (2012 and 2011). In 2012-13, there are 3-4 calls per day per vehicle in the initial months of the year and which increases to 5-6 in mid year.

Table 3.12: Availability of MMUs and basic ambulances in Haryana, Ambala and Palwal

Sl. No	Activity	Haryana	Ambala	Palwal
1.	MMUs	6	0 MMUs are operational	1 MMU is operational
2.	Basic Ambulances	348	24 (102) type vehicles are operational	15 (102) type vehicles are operational

Table 3.12 : Achievements (beneficiaries) of Mobile Medical Units in Haryana till Oct, 2013

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	5404
2010-11	47434	37451	10158	50	14280
2011-12	62568	14356	4574	51	4110
2012-13	65955	9516	8630	369	4790
2013-14 (March to Oct, 2013)	43184	6266	11482	1252	2444
Total	**257576**	**83818**	**36908**	**1722**	**31028**

- Ambala has 24 ambulances (21 BLS and 3 ALS). Dial 102 service in Ambala is working efficiently. Awareness among public is high about this service. Most of the pregnant women in District Hospital utilized Dial 102 service. EMTs were not present in any of the ambulances except in two Advanced Life Support ambulances. EMTs were not trained to utilize Defibrillator and Ventilator present in ALS which is an important service provided through ALS. Moreover, these two equipments were found to be non functional.

- GPS was not functional since one and half year which is imperative for rational utilization of ambulances.

- Signage of 'National Ambulance Service' was not found on any ambulance in Ambala. MMU is not available in Ambala.

Table 3.13: Pregnant women beneficiaries of Referral Transport in Palwal– 2009-2013

Pregnant women beneficiaries (Month-wise)	Beneficiaries in 2010	Beneficiaries in 2011	Beneficiaries in 2012	Beneficiaries in 2013
January	546	782	1038	1371
February	430	650	889	1236
March	437	746	793	1216
April	443	629	872	1199
May	493	736	872	1490
June	577	1052	925	1612
July	845	1364	1244	1982
August	1052	1501	1233	1904
September	975	1405	1234	1768
October	912	1447	1321	
November	831	1243	1133	
December	889	1136	1151	
TOTAL	**8430**	**12651**	**12585**	**11171**

- Overall, the number of pregnant women beneficiaries of referral transport has decreased slightly from 2011 to 2012. Trend of use showed peak utilization during the month from July to November months over the last three years.

- In Palwal, 102 emergency transport service is functioning well with high visibility. Review of registers show higher for number of patients brought to facilities as compared to drop back due to shortfall in vehicles. The 102 manager has automated call system of recording calls. Drugs are also found available in all ambulances checked. The key concern is that none of the AMT received trainings.

Recommendations (Service Delivery):

- Health facilities are grossly inadequate to cover the entire Palwal district population of 10 lakh, the general hospital designated as DH has only 30 beds as against requirement of 100. IFRU is required\for every 5 lakh population as per norms, so the district requires 1 additional FRU (1 existing DH/FRU). Though there are improvements in infrastructure development, Palwal fall far short of public health facilities as per requirements (Census 2011 /IPHS 2010 norms); so sanction of facilities (PHC/SC) is required in the coming years

- Expedite completion and takeover of facilities which are near completion. Meeting of CRM team with District Magistrate (Palwal) regarding construction status and take over from PWD (B& R) of few facilities should be followed up.

- Need more sanction of regular doctors/specialists at DH and other CHCs for improving the functionality of these facilities, which is under DGHS of Haryana. More staffs (doctors/staff nurses) needs to be recruited to fill up vacancies either on contract/ regular.
- Need to strengthen the facility below DH so that overload DH can be eased. Differential allocation of finances based on caseload, approved for state ROP is expected to make a difference in facility strengthening.
- Strengthen level II facilities to depressurize the DH by making non FRU functional through provision of multi-skilled training on LSAS, EmoC, deployment and supporting of these trained manpower to manage complicated pregnancy cases
- Facility development with focus on strengthening of level 1 category (SCs and selected PHCs), measuring availability of SBAs for home deliveries in areas with poor access to facilitate and home based new born care through ASHAs
- In Palwal, as home deliveries are higher (almost 35%)and uptake of FP services is poor in certain pockets, VHNDs needs to be organized regularly at hamlet level, with ASHA supporting and provision of ANC check up needs to be monitored by district programme supervisors, field level functionaries. Appropriate BCC strategy and IEC may be devised and targeted to muslim population with active involvement and participation of local religious leaders.
- Multi-skilling of M.Os for LSAS, CeMOC and EmOC to be improved as none of CHCs visited are conducting C-section in both districts. Hand-holding and mentoring of trained M.Os is required post training to instill confidence in the light of acute shortages of specialists in the state.

- Skill upgradation and assessment of skill competency of staffs is required as some nurses/ANMs were not able to demonstrate use of equipments (NBSU/KMC). Though infrastructure improvement of labour room is observed across most facilities, quality of services, is an area of concern.

- Mechanism to ensure 48 hours stay to be explored at facilities, at least in PHCs/CHCs where post partum women stay hardly for 6-7 hours after delivery. Training on use of partograph and closer supervision is required more so at SC level in both districts.

- MMU services may be initiated in Ambala for migrant and hard to reach populations at brick kilns – which requires a different strategy and planning for incorporation in district action plan. Training of manpower is required for efficient use of ambulances.

3. 2 REPRODUCTIVE AND CHILD HEALTH

3.2.1 State Initiative:

- Anemia Tracking Module (MIS) has been in place to track anemia in pregnant women
- Establishment of web-based Maternal Death, Infant Death and Still Birth Reporting System (MIDRS)
- Accreditation process of SNCU by NNF has been initiated and self assessment scores being used
- RBSK got launched in July 2013 with starting of activities in 3 districts through establishment of District Early Intervention Center (DEIC)
- A Remarkable initiative Anemia control programme for college going girls has been initiated with launching of SALAMATI-PRACHAR PROJECT, in collaboration with Pathfinder International India. The project activities pertain to assessment of health infrastructure in 2 blocks which got initiated in September, 2013

A. Antenatal Care:

Observations:

- Women reporting in health facilities are detected of anaemia by blood testing for HB By ANMs during ANC and Staff Nurses at Delivery Points , during night Hours , in case of non-availability of LTs.

- Reverse tracking of severely anaemic cases for improvement in services of ANM. Out of 87993 pregnant ladies admitted for delivery at government health facilities, 3403 (3.8%) was found to be severely anaemic and followed up till sub-center; peri-conceptional Folic acid tablets to women started in each district.

- Injectable iron sucrose therapy introduced in each district of the state and injectable iron added in EDL upto CHC level.

Table 3.14: Data of Anaemia Tracking Module (April 2013 to July 2013)

District	Total Women Reported	Severe Anaemic (<7)	Moderate Anaemic (7to9)	Mild Anaemic (9to11)	Non-Anaemic	Hypertension
Ambala	2874	139	1417	1259	59	97
Palwal	2156	222	1539	264	131	83
Haryana	**58464**	**4990 (8.5%)**	**34261 (58.6%)**	**16829 (28.8%)**	**2384 (4.1%)**	**3547 (6.1%)**

- The percent of severe anaemic cases is on higher side at 8.5% against the total women reported

District Specific Observations:

- ANC checkups being carried out at the sub centers and PHCs, CHCs. MCP cards are being filled up by the ANMs/SNs but the same is not carried forward at the time of delivery and post-natal follow up. The ANMs and other service providers need to be oriented on proper filling of the MCP cards during the monthly meetings at the block level. Line listing of severe anaemic women was being observed to be maintained.

Figure 3.3: An ANM at SC (tracking bag) and cot behind used for ANC check up

B. Child Care:

State Initiatives:

- To reduce IMR and U5 MR, state has introduced Facility based Newborn Care (FBNC) with establishment of 19 SNCUs across 17 districts. 3 more SNCUs are under process of establishment in SDH, Bahadurgarh, Jhajjar and GH-Jind. 52 NBSUs established in all districts. NBCC established in 192 CHCs/PHCs/Delivery huts on basis of deliveries of minimum more than 30 per month.
- More than 7000 children admitted in SNCUs in last one year. Online data entry initiated in all districts with functional SNCUs. 18 batches of FBNC trainings completed; 292 SNs, pediatricians and MOs trained in SNCU, FBNC trainings.
- Free referral transport services being provided to sick neonates.

- YASHODA Scheme introduced to address practices of pre-lacteal feeding, early start of complimentary feeding and infant milk substitute and early immunization. Presently (Oct, 2013), 150 YASHODA and 16 YASHODA supervisors are working at various hospitals.

Figure 3.4: An inborn neonatal unit, SNCU in DH (Palwal) and good practice followed

District specific Observations:

- Lone functioning SNCU at the Ambala DH is working in an excellent condition and with a good bed occupancy representing both inborn and outborn patients with protocols displayed and followed. The staff is oriented but the staff at SNCU needs to be more judiciously used. In the 17 bedded SNCU of DH, there were 12 sick neonates admitted of which 5 were out-born cases (home delivered). In the district hospital, neonates were admitted for septicaemia , preterm and LBW. In the year 2012-13, 375 patients were admitted and 347 (92.5%) treated and discharged while 22 (^%) referred and morbidity was 1.1% (4 Infants)

- In Palwal, in the 14 bedded SNCU of DH, there were 4 sick neonates admitted of which 2 were out-born cases (home delivered). In comparison to the previous quarter of this financial year (total admission 57), the number of admission has been improved in the second quarter and which is 141. In the district hospital, of the 4 neonates, 2 had septicaemia and 2 were preterm babies. The NBSU though in place in CHC Hathin and Hodal but are not admitting patients due to lack of paediatrician and trained M.Os at CHC.

- In Palwal, 1 NRC is approved but it has not been made functional as in Nov, 2013. 1 NRC is under process for operationalization in Faridabad.

C. Community level Care arrangements

State Initiatives:

- Under HBPNC, ASHA visits the home of beneficiaries 7 times, 1 birth preparedness visit and 6 visits as post natal visits upto 42 days

- Training of HBPNC for ASHAs for five days at block level completed in most districts where 11432 ASHAs got trained. HBPNC card used to capture home visits details, card uploaded in online software; 1.50 lac cards got uploaded in web-portal with identification of 781 mothers and 1027 new born with danger signs and referral to higher centers.

Observations:

- HBPNC visits for children born were recorded in ANM registers for PNC visits but complete visits for newborn care record was not seen in Ambala and Palwal.

- The training for the newly recruited staffs is yet to be initiated.

D. Immunization:

State Initiatives:

- State has initiated Intensified Routine Immunization Monitoring. Quality Assurance in Immunization constituted with closer monitoring and evaluation through RAPID and IFVs (Immunization Field Volunteers); implementation of Effective Vaccine Management.

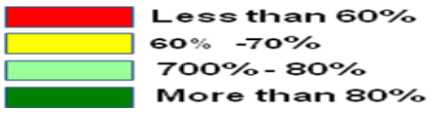
- Pentavalent vaccination has been initiated in the state w.e.f December 2012. Measles surveillance started in 21 districts. 2nd dose measles initiated in the state. Micro-plan review with HRA tagging is completed in all districts.

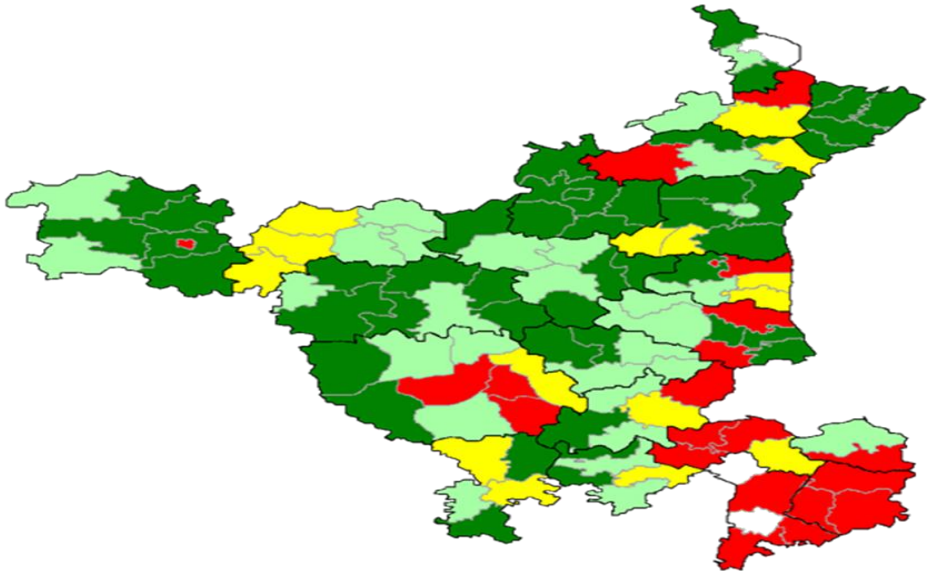
- No polio case has been confirmed for more than last three years in the state.

- Additional ASHAs for urban RCH centers have been provided to improve immunization in urban areas in most districts.

- To ensure coverage of more geographic and underserved population during 2012-13, 174622 immunizaton outreach camps have been held as compared to 158929 outreach camps held in 2011-12, which is 15693 more in number than last year. Immunization weeks held in all districts in April to August, 2013 for coverage of underserved areas. No. of outreach sessions have increased by 30,000 in 2012-13 as compared to last year.

Figure3.5: Block wise fully Immunized children (12m-23m); (Source IFV Monitoring, April-Sep, 2013)





District specific observations:

- In Palwal, immunization services are provided at DH/other health facilities and on immunization day held at respective villages. Deep freezer, ILR, ice packs, vaccine carrier are available at cold chain point (DH/CHC/PHC); Cold chain is working properly in CHC Hathin; open vial policy is followed; date is also labelled properly; temperature is maintained; AMC is done regularly; extra freezer is also available at CHC Hathin; preventive maintenance is done by RM (last visit was in Sep'12);
- Cold chain facilities in the district are well maintained in facilities of Ambala. Most facilities have a adequate power back up. No stock-outs for vaccines were found in the district but vitamin A was not found at Qurbanpur sub-centre.

E. RTI/STI Treatment:

Observations (State/district specific):

- Number of patients given RTI/STI treatement is 5028 in urban RCH centers in the state from April 2013 to September, 2013
- Total no. of new RTI/STI cases for which treatment was initiated is 413 in Ambala.
- The RTI/STI management is limited to the DH, Palwal and facility has effective cross referrals with ICTC. The staffs at RTI/STI clinic and ICTC at DH are well trained and well versed with the systems, processes and the tasks assigned to them. However, the documentation needs urgent attention, many of the registers observed to be unfilled and monthly reports were not being prepared based on the registers. Due to place constraints adequate privacy was not provide to the clients who access STI clinics. Absence of use of IEC materials during the counseling sessions is a matter of concern

F. Family Planning Methods:

Observations:

- State focused on spacing methods, particularly PPIUCD at high case load facilities
- Focus on internal IUCD at all facilities including sub-centers on fixed day

Table 3.15: Physical achievements of FP methods in Haryana

Item	Annual Target 2013-14	Prop. Target	Cumu. Ach. (Upto Sept,2103)	%age
Vasectomy	10000	5000	2446	48.9
Tubectomy	72000	36000	34395	95.5
IUCD Insertion (including PPIUCD)	264000	132000	77996	59.1
PPIUCD Inserted	10000	5000	10627	212.5
Oral Pills Cycles Distributed	1040000	520000	224215	43.1
C.C. Pieces Distributed	28440000	14220000	4027792	28.3

- During 2013-14, Ambala district has performed, 27 conventional vasectomies, 469 laproscopic sterlizations, 69 mini-laps, 51 post partum sterlizations, 550 IUCD out of 6% of them are PPIUCD. In Palwal, family planning services include the IUCD, OCP and condoms for spacing and sterilisation procedures. 48 vasectomies, 1139 tubectomy, 4617 IUCD out of 6% of them are PPIUCD in 2013-14 (Oct'13). Overall the effort to promote or motivate clients for adoption of contraceptives is weak. Post partum family planning has also not received its due focus.

F. Rashtriya Bal Swasthaya Karyakram (RBSK)

State Initiatives:

- RBSK launched in 3 districts of Haryana (Ambala, Panchkula and Karnal) and activities started from July 2013
- Club Foot Project taken up for treatment of children identified with Club Foot using Ponseti technique of which 120 cases were given treatment.
- District Early Intervention Center (DEIC) initiated in Ambala, Panchkula and Karnal and teams formalized and implementation mechanism established along with infrastructure development.

Table 3.16: Report of RBSK for year 2013-14 in Haryana

Sr. No.	ACTIVITY	No. of children
1	Total No. of children referred	8270
1a	No. of children referred to PHC	243
1b	No. of children referred to CHC	5144
1c	No. of children referred to DH/DEIC	2883
2	Total No. of children given treatment/ Under Treatment	7859
2a	No. of Children treated	3140
2b	No. of children under treatment	1058
2c	No. of children given on the spot treatment	3661

- Both the districts have initiated steps to activities with regard to Rashtriya Bal swasth Karyakram (RBSK), teams have been constituted at the block level and the training also completed. The district has initiated activities with regard to RBSK programme. Since the programme has not initiated in the district, the team could not review the performance of the RBSK programme in the district.

G. ARSH:

State Initiatives:

- Dedicated ARSH /Mitrata clinics established at District Hospital (21) and fixed day fixed hours AFHCs established, opened on Saturday at 19CHCs and 2 PHCs and training provided to 335 M.Os, ARSH counselor -21, identification of peer educators (14187)

- Anemia control programme initiated for college going girls taken up in government and government aided colleges with estimation of Hb of all girls followed by provision of IFA tablets for 3 months to girls with mild to moderate anemia, counseling and IEC on menstrual hygiene and referral services for severe anemia. SALAMATI-PRACHAR PROJECT launched in collaboration with Pathfinder International India in 2 districts (Mewat and Palwal). Project activities pertaining to assessment of health infrastructure in 2 blocks got initiated in September 2013.

- Weekly Iron Folic Acid Supplementation (WIFS) launched, held massive IEC campaign, helpline on WIFS established and over 14 lakhs students consumed WIFS tablets till September 2013.

Observations:

- Functional ARSH clinics have been established in all CHCs and PHCs of Ambala. However, in both the districts, the team has observed that clients / patients were not seen at these clinics during the team visit, Medical Officers have been assigned to perform counseling for adolescent people. ARSH Clinic which is located in the District Hospital is functional with a full time counselor. District has to initiate steps to increase the uptake of ARSH clinics in the districts.

- In Palwal district, 5 ARSH clinics have been established, however, only four are functional and the process of appointing counselors for the remaining clinic is in process.

- WIFS programme has been initiated in the district in the 246 schools, 1108 anganwadis in the district of Palwal.

H. JSY:

Table 3.17: No. of Beneficiaries of JSY in Haryana

Year	Total no. of JSY Beneficiaries
2007-08	48076
2008-09	57447
2009-10	63326
2010-11	63171
2011-12	65659
2012-13	61902
2013-14 (Up to Sept.-2013)	15710

Observations (state/district specific):

- According to the State officials, JSY is not felt as a need and disbursement of benefits is a tedious process.

- Further, the State feels that JSY benefits be given to all mothers in Mewat and Palwal irrespective of economic status and not in other parts of the state.

- In Palwal, rate of institutional delivery is 68%, which is observed to be low in comparison to other districts in the State. In the last five years, the number of beneficiaries receiving benefits of JSY has come down from 3810 beneficiaries in the year 2009-10 to 2573 in the year 2012-13.

- In Palwal,The officers appointed in the facilities have clarified that, in the previous years benefit of JSY was paid in cash or through Bearer cheque. After the instructions GoI for the payment through Account payee cheque or Direct Benefit Transfer, the payments to the beneficiaries have been stopped. However, some of the facilities have started paying JSY benefits as cash. During this financial year, only 212 beneficiaries have received JSY benefits till Oct, 2013

- Some of the facilities have informed that the Banks which are located near to the facilities are not ready to open accounts on a Zero balance basis. Regular advocacy with banks in this regard is required.

- Strict instruction to ensure payment to JSY benefits to the beneficiaries as per guidelines needs to be issued to all facilities. The mothers and ASHAs in the field have informed the team that many of them are yet to receive any benefits of JSY even after they have opened accounts with the help of ASHAs in the area.

I. JSSK:

Observations (state/district specific):

- Haryana has launched JSSK on 1st June, 2011. The positive aspect for the state is that OPD and free drugs scheme has been operational for over 2 years. In addition, State has introduced diet and referral transport facility under JSSK.

- Across facilities in Ambala and Palwal, low preparedness of facilities for ensuring the entitlements of scheme in terms of free diagnostics, 48 hours stay, grievance redressal system, which underscores the need to upgrade facilities to provide the desired free services. Under JSSK, free diet is provided; dry meal (tea, biscuits, milk half kg and apple) is given to any women admitted.

- In Palwal, there is free referral transport, free drugs and diagnostic tests. Women stay only for 5-6 hours at any facility where deliveries take place (DH, CHC, PHC). The team has observed that in some of the Sub Centres, Rs.100/- is paid to the husbands.

- In Ambala, diagnostics tests lead to out of pocket expenditure at facilities where availability of lab technicians is a constraint. Ultrasound facilities, though available at DH, is done from outside due to non-availability of sinologists and power cuts and long waiting time.

- The community was aware about the availability of transport facilities available for them. Majority of the mothers interacted with the team have availed transportation facilities to the facilities.

J. Maternal and Infant Death Review:

State Initiatives:

- Maternal and Infant Death reporting system initiated in the state. IDR initiated in 10 districts.

- State and district level review committees constituted and analyzed causes of deaths.

Observations (State/district specific):

- The reported maternal deaths has increased from 2009-10 to 200 in 2010-11 in MIDRS on account of better reporting in the system
- 11422 infant deaths and 6125 still births reported in 2012-13 and 3679 infant deaths and 2023 still births reported in 2013-14 (April to August 2013) in MIDRS.
- Bleeding is the most common causes of maternal deaths (12.4%) of all reported maternal deaths from April 2012 to March, 2013 for the state as per MDR Audit report next to other causes of deaths (81.4%). In Palwal, maternal deaths due to bleeding related causes are very high, 37.5% against total reported cases.

Table 3.18: Maternal Death Reporting & Audit (Progress in Haryana)

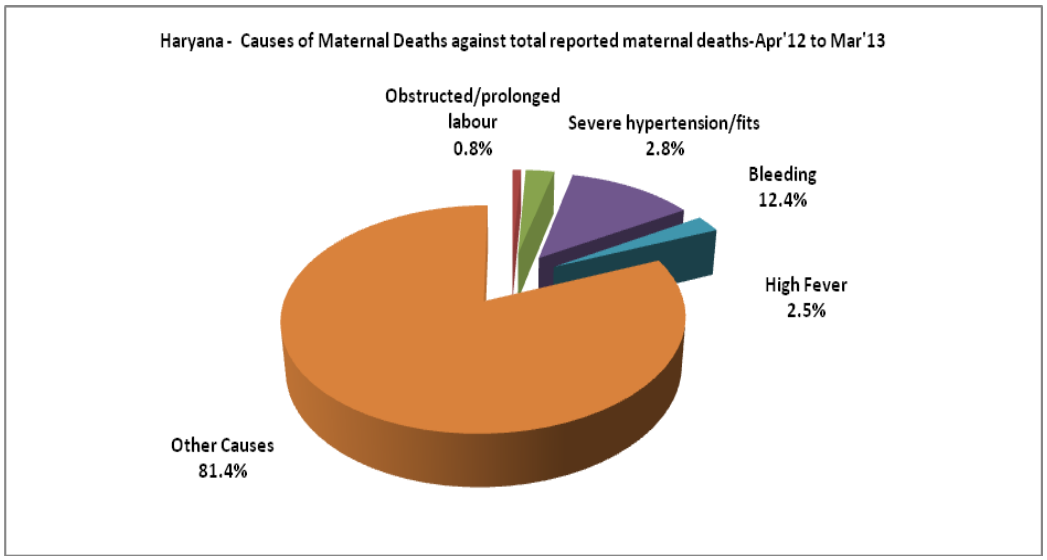
Estimated Maternal Deaths (SRS 2009)	826
Reported Maternal Deaths 2009-10	164
Reported Maternal Deaths 2010-11	200
Reported Maternal Deaths 2011-12	260
Reported Maternal Deaths 2012-13	383
Reported Maternal Deaths 2013-14	413

Table 3.19 : MDR Audit Report Review of Ambala and Palwal from April 2012- March, 2013

Items	Haryana	Ambala	Palwal
Total No. of Maternal Deaths Percentage against Reported Live Births (1000)	354 (77.10)	11 (67.77)	24 (97.02)
Causes of Maternal Deaths (% against total reported causes)			
Bleeding	44 (12.4)	--	9 (37.5)
Severe Hypertension & complications	10 (2.8)	---	2 (8.3)
High fever	9 (2.5)	1 (9.1)	1 (4.2)
Others (Hematemesis, Multiple Organ Failure, Suspected poisoning, HIV)	288 (81.4)	10 (90.9)	12 (50)

Obstructed/prolonged labour	3 (0.8)	--	--
Total	**354**	**11**	**24**

Chart 3.2 : Causes of maternal deaths against total reported maternal deaths –April 12 to March, 2013



- Ambala district has constituted committees to review all the maternal and infant deaths reported. During the year 2013-14, the district has a very good system of infant and maternal death reporting and counterfoils of all reported cases were available with all ANMs and facilities.
- District Palwal has constituted Maternal Death Review Committee (Chairmanship of CMO). During the year 2013-14, the district has reported a total of 33 maternal death have been reported and 16 of them have been reviewed and reported through the MIDRS, a reporting system for Maternal and infant Death Review System.
- During the financial, April- October, 2013, Palwal has reported a total of 689 Infant death under the MIDRS, including IFV/ ASHA entries. Even through the district has initiated Maternal and Child Death reviews, in some of the facilities, many of the deaths are not properly reported and reviewed, strict instructions in this regard to be issued to the facilities to report and review maternal/ infant deaths reported in the facilities. Field supportive visits needs to be ensured to the facilities where large number of death reviews are pending.

Overall Recommendations on RCH:

- Plan for ensuring optimal utilization of NBSUs in CHCs level –II facilities by posting of staff nurses (as required) and deployment of trained M.Os/specialists, hiring of contractual specialists may be undertaken.
- Number of sites for fixed day services need to be increased in the state, particularly in level III facilities. A roster scheduling providers to make visits for providing fixed days services needs to be prepared in Palwal and monitored closely for use of services from state.
- State should introduce intravenous infusion of Iron sucrose at DH Palwal as the percentage of pregnant women detected having severe anemia is relatively much higher.
- Quality of ANC check up and testing of Hb at SC level should be ensured with closer monitoring in Palwal as many beneficiaries' (ANC/young mothers) mentioned that Hb tests was not done even once though registers were maintained. Reporting online for ATM needs improvements as huge discrepancies have been observed in records of L.T for Hb test result.
- Strict instruction to ensure payment to JSY benefits to the beneficiaries as per guidelines needs to be issued to all facilities, particularly in Palwal district.
- Grievance redressal system need to be established and made efficient.
- Functionality of ultrasonograph should be ensured at DH, Ambala on priority basis.
- Monitoring of the JSSK scheme should be undertaken by state and district level nodal officials.
- More EMOC trained LMO to be trained and placed.

3. 3 DISEASE CONTROL PROGRAMME

A. National Vector Borne Disease Control Programme (NVBDCP)

Table 3:20: Disease situation in Haryana

Year	Malaria cases	Malaria Deaths	Dengue cases	Dengue deaths	Chikungunya cases	AES/JE deaths	Kala-azar cases	Kala-azar deaths	Microfilaria rate (%)
2011	33401	1	267	3	74	4	0	0	0
2012 (up to Oct 31)	26790	1	559	2	2	0	0	0	0

2013 (up to 06-11-2013)	13977	1	1301		0	--	2	0	

Table 3.21: Status of all four Vector Borne Diseases prevalent in Haryana

Disease		YEAR					Highly Affected Districts in year 2012
		2008	2009	2010	2011	2012 up to Oct. 31	
Malaria	Total Cases	35683	32272	18921	33401	26790	Hisar, Yamunanagar, Karnal, Sirsa, Mewat and Bhiwani
	Deaths	0	0	0	1	1	
Pf Malaria	Cases	1397	525	763	1133	533	Y. Nagar, Karnal, Panipat, Mewat
	Deaths	0	0	0	0	1	
Dengue/ DHF	Cases	1159	125	866	267	559	Gurgaon, Panchkula, Faridabad, Rohtak and Yamunanagar
	Deaths	9	1	21	3	2	
Chikungunya	Cases	0	0	1	74	2	Yamunanagar
	Deaths	0	0	0	0	0	
JE	Cases	0	1	1	12	1	Kurukshetra

Table 3.22: Status of Manpower (sanctioned & vacant) for NVBCP

Regular Posts	Required	Sanctioned	In Position	Vacant
Dy. Civil Surgeon (Malaria)	21	21	21	0
Assistant Malaria Officer	22	0	0	0
Biologist	21	17	11	6
Senior Malaria Inspector	133	44	24	20
Multi Purpose Health Supervisor	590	590	501	89
Multi Purpose Health Worker (Male)	3305	2544	1680	864
Lab. Tech. (Malaria)	472	212	192	20
Field Assistant	1	1	0	1
Entomological Technician	3	3	1	2
Field Worker	973	537	324	147
Insect Collector	68	23	9	14
Pump Mechanic	21	10	5	5

Observations (state/district specific):

- Malaria is not endemic in any district of the State but six highly affected districts are Hisar, Yamunanagar, Karnal, Sirsa, Mewat and Bhiwani. Dengue is not endemic in any district but highly affected district are Gurgaon, Panchkula, Faridabad, amunanagar & Rohtak. Gurgaon is the most affected district. Chikungunya is prevalent in 2 districts viz.; Yamunanagar, Panchkula. Acute Encephalitis Syndrome (AES) is not endemic in any district but affected district are Kaithal, Karnal, Kurukshetra, Yamunanagar Japanese Encephalitis (JE) is confined to district Kurukshetra.

- During 2012, 26819 positive malaria cases were reported with 2.12 percentage of P. falciparum infection and one death. The proportion of P. falciparum varied from .10 to 8.16 in Karnal followed by Palwal contributing 6.75 percent. The overall ABER was 10.96.

- During 2013 till September, 10419 cases of Malaria with 95 cases of P. Falciparum were reported. Post of State Entomologist (1), Zonal Entomologist (2) are lying vacant for last many years. As a result surveillance for vector borne diseases are not adequately and properly monitored to control vector borne diseases, particularly Malaria and Dengue.

- Palwal is endemic for Malaria. Malaris cases with Pf cases in the following table

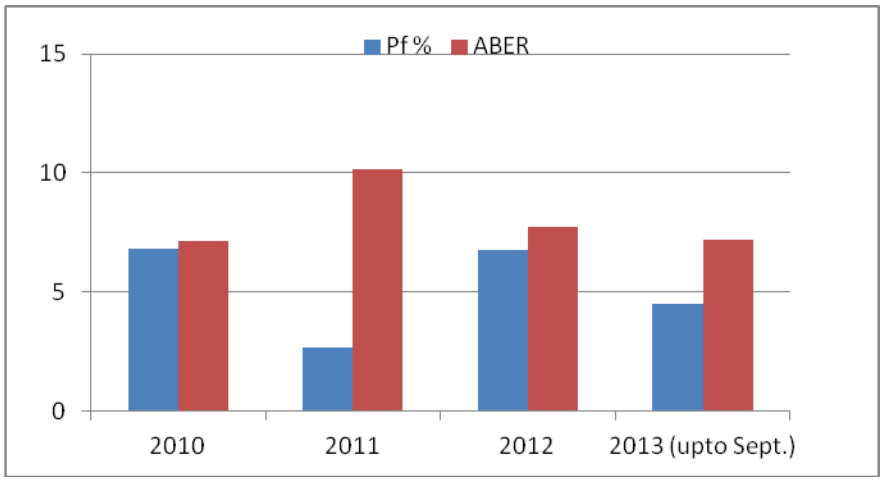
Table 3.23: Comparative Epidemiological Profile of Malaria in Haryana, Palwal

Year	Malaria cases (Haryana)	Malaria cases (Palwal)	Percentage Contribution	*P. falciparum* cases (Haryana)	*P. falciparum* cases (Palwal)	Percentage Contribution
2010	18921	280	1.47	764	19	2.48
2011	33401	489	1.46	1133	13	1.14
2012	26819	696	2.6	569	47	8.26
2013 (Upto Sep.)	2852	711	24.9	74	32	43.24

Table 3.24: Epidemiological Profile of Malaria in Palwal District

Year	**Cases**	**Pf**	**Pf %**	**ABER**
2010	280	19	6.79	7.12
2011	489	13	2.66	10.15
2012	696	47	6.75	7.75
2013 (upto Sept.)	711	32	4.50	7.2

Chart 3.3: Comparative graph between Pf% and ABER in Palwal



- In Palwal, only 4 MPHW were in position, while 22 posts are lying vacant since long. MPHW (M) was found lying vacant in CHC Hathin. About 20 villages with high endemicity due to Malaria were not under surveillance. Surveillance was started from August by appointing contractual surveillance worker for 5 months. Village wise enumeration of population at risk under CHC Hathin was not done.

- Cases were detected through perioidic mass and contact survey in one of the affected village Mehluka under Ransika Sub Centre of CHC Hathin. First P.falsiparum case was recorded in August and till 19th October 2013 22 P. falciparum cases were detected. The age wise breakup of P. Falciparum cases is as follows:

- PHC Hathin (Mewat region) has been highly endemic area. In the month of September 2013, an out-break of malaria was reported in Mehluka Village of Ransika Sub-centre. The month wise incidence was available only from the month of May as poor due to irregular visit under active surveillance.

- During the period from May'13 till Oct'13, 9 Sub-centers of Hathin PHC including Ransika Sub-centre has been reporting increasing trend of malaria.

- In Mehluka village, 5(Five) deaths due to fever were reported in September 2013. Out of five deaths due to fever, 4 (four) deaths were in children below five years and was a child of 12

(Twelve) years age. A mass blood survey was conducted in the village Mehluka, 694 blood-smears were collected and examined at Hathin PHC. The examination of blood-smears revealed SPR 14.4 & SfR 3.3 with proportion of *P. falciparum* 23.7 & 27.3 percent were with gametocytes of *P. falciparum*.

Table 3.25: Month-wise incidence of malaria in Mehulka village (Palwal)

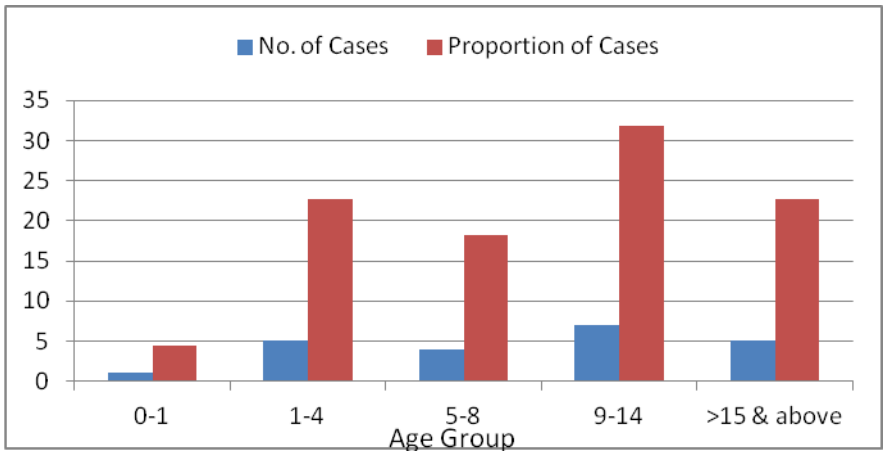
Month	Malaria Cases	*P. vivax* cases	*P. falciparum* cases
May	2	2	0
July	2	2	0
August	4	3	1
September	84	64	20
October	1	0	1
Total	**93**	**71**	**22****

Table 3.26: Age wise break-up of 22 *P. falciparum* cases in Palwal

Age Group	No. of cases	Proportion of cases	Developmental stages of Pf
0-1	1	4.5	PfG
1-4	5	22.7	
5-8	4	18.2	
9-14	7	31.8	
>15 & above	5	22.7	
Total	**22****	**23.65**	

*** Upto 19-10-2013**

Chart 3.4: Diagram showing age wise *P. falciparum* cases



- Detection of P.Falciparum infection in an infant in Sept 2013 was not taken into epidemiological warning in terms of local transmission. Out of 22 Pf cases detected at PHC laboratory, 6 were with gametocytes of P.falciparum, an indication of late detection in absence of surveillance, treatment and continuing transmission in absence of vector control measures. The state health authorities must fill up all vacant sanctioned posts under VBD including state and zonal entomologist with their respective component for monitoring vector surveillance vector susceptibility status to insecticides, yearly detection of trend of vector borne diseases and control, planning of vector control measures, reparation of action plan and procurement of logistics. ABER was less than 10 % in the year 2010 & 2012. In endemic PHC/District ABER must be raised by strengthening regular surveillance. Entire laboratory services under VBD, particularly for Malaria (case detection, accurate diagnosis of developmental stages of plasmodium species) need total revamp as technicians either were not trained or no reorientation training was conducted. Regional office of Health and Family welfare Chandigarh may access the training need and may accordingly plan training programs of Laboratory Technicians working in endemic districts (particularly Mewat region of Palwal, Mewat and Karnal.

- There was shortage of binocular microscope, quality staining material, glass wares. It needs a relook to reorganize the laboratory services under NVBDCP guidelines. During the visit of CRM team it was also observed that both examination of blood smears for malaria parasite and sputum of TB were being done with one microscope in an overcrowded room having inadequate ventilation. Stains used for Malaria microspore were JSB 192 and of bad quality.

- During the visit of CRM team to CHC Hathin, the recent drug policy chart was not found, even in District Hospital recent drug policy chart was found lying in a corner. Glasswares of laboratory of District Hospital Palwal, CHC Hodal and CHC Hathin were very dirty, use of filter paper was never heard of. District vector borne disease officer of Palwal district was not aware of epidemiological situation of disease. The responsibly is given to retired medical officer who is looking after all technical aspects of VBD. Kit of combination therapy for the treatment of P.falsiparum infection was available only for adults while more than 60% cases were detected in the age group below 15 years. Most of the medical officers of the district must be aware of recent anti malaria drug policy, management of Dengue fever and DHF and control, although no dengue cases were

detected in Palwal district till 11th November, 2013 since January 2013. The district has not reported incidence of filariaris, Kala azar and chikungunya and Japanese Encephlitis, potential resources and amplifying agents of JE were found in rural areas of CHC Hodal and CHC Hathin.

- Urban Malaria Control Schemes (UMS) is being implemented in Palwal town under the supervision of biologist. For regular weekly anti larval measures, 7 posts of superior field workers were sanctioned, out of which 6 are lying vacant, other vacant posts are insect collectors (1), field worker (3) and malaria inspector under UMS has been continuing on long medical leave. On ensuring from Biologist it was learnt that fogging operation has been conducted on regular basis although no definite data either on malaris or Dengue vector could be cross checked. Till October 2013, 26 cases of Malaria with P.vivax infection were detected.

- In 2004 13 cases of P.Vivax were detected in Palwal town under UMS, while in 2011 46 cases of P.vivax and one case of P. Falsiparum were reported from Palwal town under UMS.

There have been shortfalls such as:

- Zonal Entomological Component is not in position, which hampers proper vector surveillance;
- Domestic breeding checkers should be appointed on contract basis before Transmission Season so that surveillance can be strengthened and the help of Volunteers/Field Workers be taken in both urban and rural areas.

Urban Malaria Scheme (UMS)

UMS is being implemented in Palwal Town under the supervision of Biologist for regular weekly Anty-larval measures, 7 posts of Superior Field Workers (SFW) were sanctioned out of which 6 are lying vacant. Other vacant post were Insect Collector (1), Field Workers (3) and Malaria Inspected under UMS has been continuing on long medical leave. On enquiry from Biologist, it was learnt that fogging operation was being conducted on regular basis although no definite data either on Malaria or Dengue vectors could be cross-checked. Till October'13, 26 cases of Malaria with *P. vivax* infection were detected under UMS. In 2012, 30 cases of Malaria with *P. vivax* infection were detected in Palwal town while in 2011, 46 cases of Malaria with *P. vivax* and 1 case of *P. falciparum* were reported from Palwal town under UMS. It was observed that there was lack of coodrination between district health authorities, state programme officer and municipal bodies (UMS Towns) regarding anti-VBD activities in urban areas.

Epidemiological Profile of Dengue In Haryana & Palwal District

Incidence of Dengue is being monitored by Proactive 14 Sentinel surveillance hospitals with laboratory support. Till 6th September 2013, 1301 cases and 4 deaths were reported from the state of Haryana. No Dengue case was reported from Palwal district. Affected district were Gurgaon, Faridabad, Karnal, Panchkula & Yamuna Nagar. No Chikungunya case was recorded in the state till 6th September 2013.

The Dte. of NVBDCP had conducted vector surveillance in several towns of Haryana. The result of pre and post monsoon survey indicated high breeding indices and poor vector control measure.

Recommendation for NVBDCP:

- As the State is endemic of malaria, Dendue and JE, surveillance mechanism must be strengthened by filling up vacant post of MPHW, Malaria inspectors (UMS and rural), insect collectors, state and zonal entomologiosts with regular staff. District VBD must be functional in every sense for control VBDs. Vector surveillance may further be augmented in UMS Palwal.
- ABER in Palwal district was found less than 10% needs immediate correction for enhanced case detection and treatment.
- ASHA and ANM can be involved in slide collection from fever patients. Incentives for this purpose be considered. All health workers, medical officers must be familiar with drug policy for Malaria particularly for treatment with ACT. Adequate stock must be maintained for specific age group.
- State may devise action plan for Malaria control in endemic CHC/PHC with logistics procurement. Ad hoc approach may seriously be avoided.
- Regular monitoring vector population in CHC Hathin has become essential as there was huge potential of continuing vector breeding. Resting adults of vectors, An annularis An, culicifacius were found inside human dwellings with confirmed caese of P.falsiparum infection.
- Over and above, laboratory service must be reorganized. As the area was with potential of JE, vaccination for JE also be included under immunization programme.

B. Revised National Tuberculosis Control Programme:

- Implementation of DOTS under RNTCP is satisfactory with good decentralization of services and involvement of ANMS and ASHAs in Ambala and Palwal.

- Diagnosis of pediatric cases is sub optimal in Ambala. This may be due to the fact that the number of pediatricians is less in public sector in the district. In order to enhance case detection of paediatric cases, the State may consider TB as a part of disease screening under RBSK.

- HIV and TB testing facilities should be co-located in order to improve testing of HIV of all TB patients . In Palwal, no line list was maintained between ICTC and TB clinics, and the same has influenced cross referral between ICTC and TB clinics and identification of HIV-TB co-infection. District has to take immediate note on the matter. The laboratory services were integrated with general lab services and the lab services were co- located were ever the ICTCs functional.

- There was no district level HIV- TB co-ordination committee meeting to ensure effective co-ordination of HIV-TB activities in Palwal. The ICTC counselors were unaware about such meetings.

- Knowledge of paramedical staff in newer initiatives under RNTCP like notification, PMDT and TB/HIV is sub optimal. No state level training of MO and para medical staff has been done since 2010. Trainings are required at the state and district level to fill this gap.

- TB may also be included in the weekly IDSP reporting format since it has become a notifiable disease.

Table 3.27: Performance of RNTCP for Haryana, Ambala and Palwal

S.No	Indicators	2013-14	Ambala	Palwal	Haryana
		Targets	Achievements		
1	Case detection rate	70%	72%	59.5%	68.5%
2	Treatment success rate	85%	94%	90%	86%
3	MDR TB treatment success rate	50-60%	No outcome reported	Outcome awaited	42%
4	Treatment success rate among new TB patients tribal districts and Poor and Backward districts	88%	94%	_____	____
5	Number of cases to be put on treatment	Increasing trend		Yes	Yes
6	Default rate among new TB cases	<5%	1.6%	6%	4%
7	Proportion of estimated incident TB cases notified	60%		88%	74%
8	Proportion of TB patients with known HIV status.	90%	87% reported but not recorded in TB register	93%	80%
10	Proportion of districts TU aligned at block levels with health systems	25%	nil	-------	33%
11	Proportion of Key RNTCP staff in place as per approved ROP	90%	100%	95%	92%
13	Proportion of TB patients treated under RNTCP by a community DOT provider	50%	1.2%	15%	20%
14	Proportion of pediatric cases diagnosed out of new cases	8%	2.3%	5%	5%

Recommendations for RNTCP:

- There is immediate need to shift the criteria from A to C for Haryana, for improving the identification of MDR suspects. PMDT services are still centralized at district level and these need to be decentralized to DMC level.

- Supervision and monitoring needs to be strengthened. The quality of work in designated microscopy center is not being supervised and quality control of slide has to be ensured in Ambala.

C. IDSP:

Table 3.28: Progress of IDSP in Haryana over the years

Variables	2011-12			2012-13 (Avg. Upto Previous Month)			Target 2013-14		
Percentage of total districts reporting weekly data in 'P' form through portal.	100			100			100		
Percentage of total reporting units which are submitting weekly (S, P, L) Data on epidemic prone diseases through portal.	S	P	L	S	P	L	S	P	L
	36.21	41.98	33.65	70.19	75.17	69.23	100	100	100
Percentage of total outbreaks investigated and responded to by States/UTs by sending samples for testing in laboratory.	84			92			100		
No. of district public health labs strengthened for diagnosis of epidemic prone diseases.	2 existing			2(2 Referral lab)			5 District Priority Lab		
Percentage of Epidemiologists/Microbiologist/Entomologist (total) in position out of total number of sanctioned positions.	92			64			100		
Percentage of Data Manager in position out of total number of sanctioned positions.	90.5			68			100		
Percentage of Data Entry Operators in position out of total number of sanctioned positions.	90.9			86			100		

Table 3.29: Key performance indicators in Ambala

District	Sl. No (Delivery Point)	

Ambala	Percentage of Reporting units reporting >75% of times in last 12 weeks through IDSP Portal.	Reporting Format	S	P	L
		No. of identified reporting units	103	21	21
		% reporting	16.6	58.3	50
	No. of supervisory field visits by DSU officials/staff (Epidemiologists/DSO/Data Manager etc) in last year.	10 visits			
	No. of outbreaks in past 12 months investigated by Rapid Response Teams (RRT).	10 outbreaks			
	No. of outbreaks in past 12 months where appropriate samples were sent for laboratory investigations to District Lab/Referral Lab.	10 outbreaks (water samples and blood samples send to referral lab GH Ambala City)			

Observations (state/district specific):

- In Ambala, the reports are being analyzed to track seasonal trends. Epidemiological investigation of an outbreak of diarrhoea, which resulted in confirmation of cholera epidemic has been meticulously handled and recorded.
- There is no fool proof mechanism to check duplication of reporting other than line listing of cases.
- Daily reports are generated for reporting from all facilities – however, only 40-50% facilities report on an average. As per the training module for MOs, shared by the IDSP team, daily reports are to be provided only during outbreaks. Clarifications will be helpful to the IDSP team on this matter.
- In Palwal, Data Manager has joined during last month. Contractual HR is in position, but the IDSP staffs including District Epidemiologist & Data Manager are not trained. 100% public facilities are reporting under IDSP.
- Status of reporting through the IDSP portal- www.idsp.nic.in : Username ID and Password is not available for Palwal District, so online reporting is not done. Information is currently entered and submitted to state in MS Excel. The data is being shared with district administration and state in health review meetings.

Recommendations:

- Need for clarification on issue of duplication of reported cases in weekly records. Clarity required regarding daily IDSP reports.
- TB may be included in weekly IDSP reporting format, since it has become a notifiable disease.

D. NLEP:

Observations (State/district specific):

- Haryana has already achieved the status of "Elimination of Leprosy" i.e. less than 1 case per 10,000 of population fixed by WHO. The prevalence of Leprosy is 0.25 per 10,000 of the population (as on 30/11/2012.
- In Haryana, 21 Districts with 663 leprosy affected patients are on treatment as on 30/11/12. The thrust is on detecting hidden cases so that "Total Eradication" is achieved**.**
- There is only 1 highly endemic district (Panipat) for which special activities like capacity building of staff, awareness drive, enhanced monitoring and supervision with 1 person per block and validation of MB and child cases in the state.

Table 3.30: Performance of NLEP in Haryana

Indicators	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**	**2011-12**	**2012-13**	**2013-14 (Up to Sep. 2013)**
No. of new cases detected (ANCDR/100,000)	502 (1.83)	379 (1.52)	1.76 (451)	365 (1.39)	321 (1.27)	524 (2.03)	648	317
No. of cases on record at year end (PR/10,000)	474 (0.17)	319 (0.13)	464 (0.18)	375 (0.14)	337 (0.13)	532 (0.21)	0.26	0.27
No. of Grade II disability among new cases (%)	25 4.98%	11 2.9%	10 2.22%	4 1.10%	1 (0.3%)	3 (0.57%)	12	10

Table 3.31: Comparative analysis of Leprosy situation in Haryana up to November 2012

State/district	**Estimated population March 2012**	**Total new cases (2012-13)**	**ANCDR/100,000**	**Total Grade-III disabled cases (2011-12)**	**Percentage of Grade –II against New cases**	**Balance cases as on 30th Nov, 2012**	**PR/10,000**
Haryana	25817042	421.00	1.63	2.0	0.10%	663.0	0.2568
Ambala	1157587	16	1.38	0	0	27	0.23

Palwal	1059534	2	0.19	0	0	3	0.03

- Leprosy rate is low in Palwal. 1 case/ year was reported during 2010-11 and 2011-12 and 3 cases during 2012-13.
- No DPMR services is provided in Palwal though such services are available in Ambala.

E. NPCB:

Table 3.32: Progress under NPCB in Haryana

Physical Activities	**Targets 2012-13**	**Achievements 2012-13**	**Targets 2013-14**	**Achievements 2013-14 (up to Sep., 2013)**
Cataract Operations	147050	143336	150000	48678
Free spectacles to school going children	20920	7476	10000	2296
No. of cornea collected	------	157	------	14
No. of Keratoplasty done	------	74	------	------
No. of eyes collected	-----	-------	----------	171
No. of eyes pledged for donation	----------	----------	----------	7961

Table 3.33: Comparison of performance of cataract surgeries in Haryana, Ambala and Palwal

	Cataract achievement in 2012-13	**Cataract achievement in 2013-14**	**Free spectacles to School children 2012-13**	**Free spectacles to School children 2013-14**
Haryana	143336	48678	7476	2296
Ambala	8276	1324	481	40
Palwal	555	524	0	02

Observations (state/district specific):

- In Haryana, NPCB is run in partnership with NGOs/private sector.

- In Ambala, NPCB has good involvement of private sector. Out of the 1382 children found with refractive error, only 481 were provided with spectacles. In contrast to 17614 children screened in 2012, only 4383 have been screened in 2013-14 (Oct).

- In Palwal also, blindness control programme is run in partnership with NGOs. All cataract operations are done by NGOs and private sector. Due to lack of skilled manpower, operations are not taking place in public facilities. 1 Phaco machine was available in the DH, Palwal and found not in use. During the year 2012-13, the district has done Free distribution of spectacles to 288 children under IBSY (Indira Bal Swasthya Yojna). They have taken initial steps to ensure the facility cataract operations under the leadership of CMO.

Challenges are:

- Inadequate no of trained staff (Ophthalmic Assistants)
- Improper system for provision of glasses.
- Loss of follow up of screened Children.

3.4 HUMAN RESOURCES FOR HEALTH & TRAINING:

Observations (state/district specific):

- Since 1978, Haryana has been following the policies laid in Haryana Civil Medical Service Rules for recruitment, promotion, remuneration, transfers and Punjab Civil Medical Rules disciplinary actions for Medical Officers (MOs) and Senior Medical Officers (SMOs). A fresh recruit gets entry into services at the position of MO and after 11 years of experience gets promoted to the SMO cadre. As per the posting policy, doctors with post graduate qualifications may not get posted in the PHCs but at the CHCs designated as FRUs in the first phase. And the specialists may not get posted at non-clinical posts up to district level.

- In the revised Haryana Civil Services (Assured Career Progression) Rules, 2008, state has also made rural healthcare services mandatory for doctors to get promotions (ACP) post 31.08.2009.

- There is no specialist cadre in the state. Due to this, the specialists find it difficult to get the posting areas of their relevance with respect to their expertise, which further leads to attrition.

- Both, the Medical Officer and Paramedical cadre are managed by Directorate of Health Services. However, some matters like transfers and posting of MOs/SMOs need the nod of Finance Commissioner to take place. In the NRHM unit, separate cells for different divisions are in place but no HR cell has been formed as yet.

A. Generation of Human Resources:

Table 3. 34: Current availability of Medical and Nursing schools and colleges (2012-13) in Haryana

S.no.	Name of Institute	Annual Intake
Medical Colleges (6)		
1	Pt. B D Sharma Postgraduate Institute of Medical Sciences, Rohtak *(Govt.)*	200
2	Maharaja Agrasen Medical College, Agroha *(Pvt)*	50
3	Maharishi Markandeshwar Institute Of Medical Sciences & Research, Mullana, Ambala *(Pvt)*	150
4	Shree Guru Gobind Singh Tricentenary Medical College, Gurgaon *(Pvt)*	100
5	Gold Field Institute of Medical Sciences & Research, Ballabgarh, Faridabad *(Pvt)*	100
6	BPS Government Medical College for Women *(Govt.)*	100
B.Sc. Nursing Colleges		
1	Pt. B D Sharma Postgraduate Institute of Medical Sciences, Rohtak (Haryana)	60
GNM Training Schools		
1	General Nursing School, Bhiwani	20
2	General Nursing School, Hissar	20
3	General Nursing School, Karnal	20

- To address the HR gaps, MBBS seats have been increased from 100 to 200 seats and PG seats have been increased from 92 to 143 in the state. There are 2 more Medical Colleges being established at Nalhar (Mewat) and Karnal.

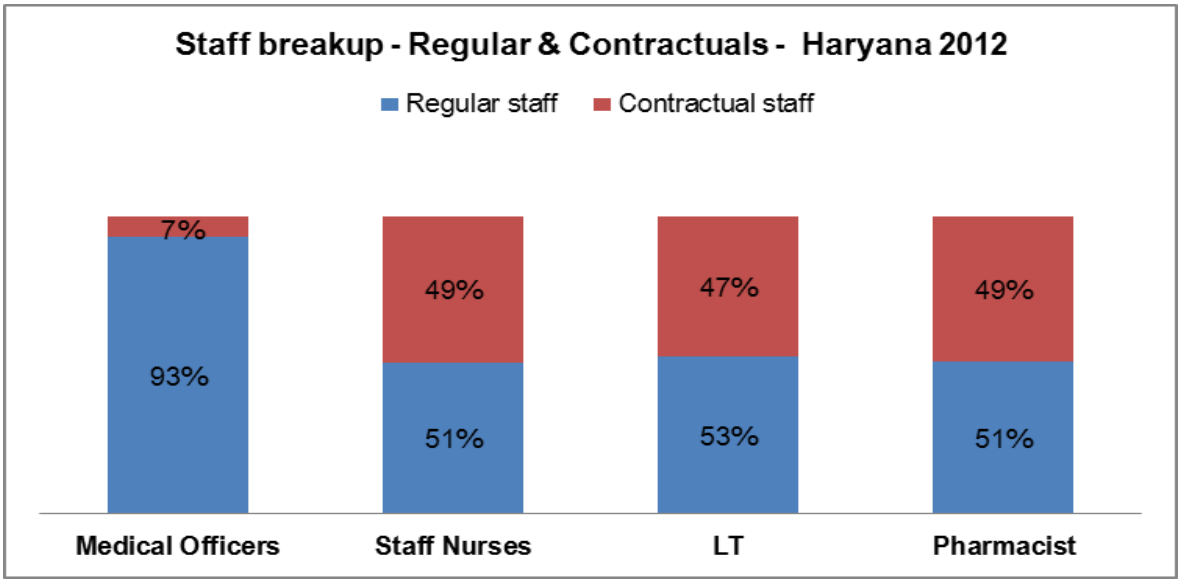
- District Palwal has no medical and nursing colleges in public or private sector. 1 GNM institute is under construction for last 2 years and due for completion in early 2014.
- Ambala, on the other hand, has 5 nursing schools and colleges offering nursing courses at diploma, UG and PG level as well as 1 private medical college in Mullana, Ambala, which has been recently established.

B. Availability:

Table 3.35 : Status of Human Resource in Haryana (2012-13)

Position	Requirement as per IPHS	Sanctioned strength (R+C)	In Position			Vacancy against sanction	Vacancy against IPHS 2010
			R	C	Total		
Specialists	1536	1306	520	0	520	786 (60.1%)	1016
Medical Officer	3120	2680	2142	138	2280	400 (14.9%)	840
Pharmacist	775	1220	672	275	947	273 (22.3%)	-
AYUSH M.O	--	812	483	155	638	174 (21.4%)	--
Staff Nurse	4440	4014	1510	1971	3481	533 (13.2%)	959
MPHW (M)	2608	3134	2381	0	2381	753 (24.0%)	227
MPHW (F)	5260	5733	2782	2648	5430	303 (5.2%)	170
Laboratory	945	1059	728	117	845	214 (20.2%)	100

Technicians							



A. Regular employees:

Medical Officers & Specialists: Post amendments in HPSC regulations, High Powered Selection Committee has been reconstituted for the recruitment of doctors which was earlier looked after by the HPSC. High Powered Selection Committee chaired by Director General Health Services Haryana, holds interviews and recommends the suitable candidates to the government.

- *Web enabled process* is being followed for notifying the candidates about their interview date/time & venue and result of the selected candidates. All such announcements are displayed on the website, to ensure accessibility of information to all candidates. *Waiting list* is also being kept after the selection process is over. If a candidate doesn't join within 15 days of receipt of application, the candidate next in the panel gets the call to join.

- Erstwhile, recruitments used to happen once in a year or 2 years when HPSC was holding the charge. But after DGHS has taken charge in 2008, recruitments are more frequently done. In the beginning in 2008, walk-in interviews were being conducted on 10th of every month. But now the recruitments are scheduled twice in a year since 2011. Before DGHS took the charge, 1156 appointments were offered to MOs from 1999 to 2008. Whereas DGHS has already offered 2368 appointments to MOs within the small span of 4 years since 2008.

- Even after these drastic reforms in recruitments, not much difference is visible in the backlog status of doctors. Out of the 2368 appointments offered since 2008, only 50% of MOs are retaining their services in the department.

Table 3.36: Sanctioned (S) and Vacant (V) of M.O and Paramedical regular staff

S.No.	District name	Regular Medical Officers

		Sanctioned	Vacant
1	Ambala	145	-
2.	Palwal	101	47
	Haryana Total	**2910**	**776**

- Palwal has the most acute shortage of doctors with 32% vacant posts.

Table 3. 37: Sanctioned (S) and Vacant (V) of M.O and Paramedical regular staff

Name	Pharmacist		Lab Technician		Opthalmic Assistant		Radiographer		MPHS (F)		Staff Nurse		MPHW(F)	
	S	V	S	V	S	V	S	V	S	V	S	V	S	V
Ambala	50	13	35	13	2	2	12	6	24	1	128	36	109	4
Palwal	28	16	1	1	5	1	9	3	17	8	28	11	90	13
Haryana	874	233	692	337	96	18	185	50	498	110	1875	333	2605	226

Palwal has the most acute shortage of Staff Nurses with 28% vacant posts,

- Considering just the shortage /gap (in-position against sanctioned posts), the proportion is relatively high (40% for staff nurses) and specialists, it is 90%. The gap in HR is bridges in the last 2-3 months with placement of contractual doctors/ANM/SN/Ayush MO.
- In the district hospital, Palwal 3 posts of SMOs are sanctioned, and all are vacant while out of 41 M.Os sanctioned, only 19 posts are filled up. Out of 8 posts of deputy Civil Surgeon for DH, only 3 are filled up of which only 1 has MD qualification. All 4 anctioned posts of programme managers are filled up.
- In the district, out of 45 posts of staff nurses sanctioned at 4 CHCs and 9 PHCs, 40% (18) posts were filled up,
- All the four positions of specialist are vacant in each of the CHC visited. All CHC visited had 2 MOs with 1 LMO (Ayush) and no post of SMO is filled up in any of the CHC.
- Out of 2 sanctioned posts of M.Os in each PHC, only 1 is filled up. Out of 9 sanctioned posts of SMO/MOs, only 2 are filled up at CHC Hathin.
- For TB, the posts of TB health visitor and HIV-TB DOT supervisor at district level are all filled up. At the District T.B center, Palwal the post of L.T is vacant. The post of District TB, Medical officer, pharmacist, radiographer is not sanctioned.
- Posts of ASHA Block coordinator are filled up for each CHC except at CHC, Hathin

B. Deployment:

- State has devised its own staffing norms for doctors, nurses and paramedical staff based on delivery case load. State also reckons HR gaps for FRUs and the other facilities on the basis of these norms.

- There are 20 facilities currently functioning as FRUs in the state, out of which 6 are not conducting C-section deliveries. Following table shows the number of FRUs per district along with details pertaining to HR gaps for facilities not conducting C-section deliveries.

Table 3.38: Deployment of specialists at FRUs in Haryana (2012-13)

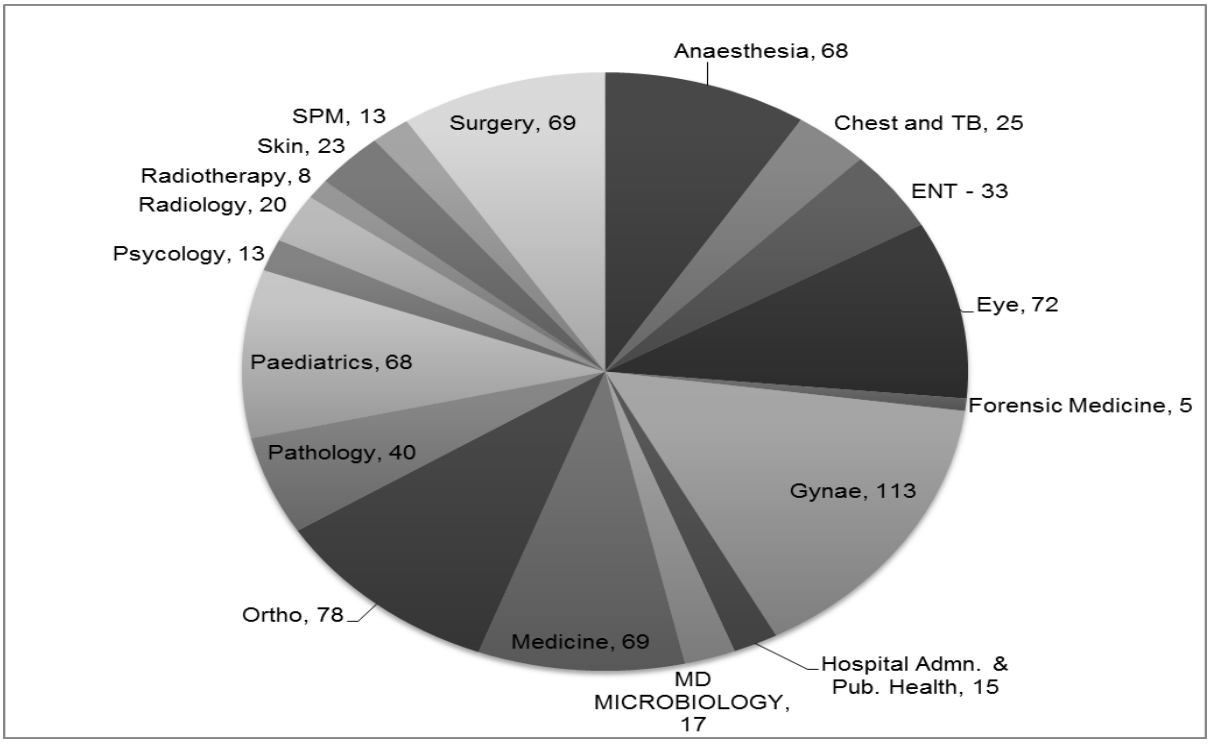
District name	Designated FRUs	FRU not conducting LSCS	Lacking specialist (Anaesthetist-A, Paediatrist-P, Obstretecian-OG)
Ambala	3	-	
Bhiwani	2	SDH Dadri	1-P, 1-OG
Faridabad	2		
Fatehabad	2		
Gurgaon	2	SDH Sohana	1-P
Hisar	2		
Jhajjar	2		
Jind	3		
Kaithal	1		
Karnal	2		
Kurukshetra	2		
Mewat	1	DH Mandikhera	No LMO
Narnaul	2	CHC Mahendergarh	1-A, 1-P, 1-OG
Palwal	1		
Panchkula	2		
Panipat	2	CHC Samalkha	1-A, 1-P, 1-OG
Rewari	2	CHC Bawal	1-A, 1-P, 1-OG
Rohtak	2		
Sirsa	2		
Sonepat	1		
Yamunanagar	2		

- State has also proposed to deploy AYUSH LMOs in the facilities where it is finding difficult to retain MBBS MOs. Remuneration for AYUSH LMOs affixed at Rs 20000 per month. AYUSH LMOs are to conduct deliveries, provide RTI/STI and IUD insertion services at the facilities.

Table 3.39 : Status of EmOC training upto September 2013 in Haryana

District	EmOC trained	Resigned/ Doing PG etc	Posted at FRU	Certified	Performing	Non Performing
Ambala	10	1	7	7	7	-
Palwal	2	0	1	2	1 (1 is on CCL)	-
TOTAL	12	1	8	9	8	-

Chart 3.40: Pie-chart showing the distribution of specialists in Haryana



- Manpower shortage was also found in the SNCU in DH- Ambala, where only 6 out of 10 SN positions were filled. At the time of the visit, 12 out of the 17 beds were occupied. The team was informed that the 4 vacancies were due to the re deployment of SNCU staff to other units in the hospital to assist with the increased workload. At the SHC level, efforts have been made to ensure the availability of two ANMs at each facility.

- Rational deployment of staffs is an issue in Palwal, as there are acute shortages of specialists, doctors in the district. None of the specialist are available at CHC and many specialists posts are not filled up at DH, Moreover the deployment of staffs like ANMs also needs to be looked into as there are sub-centers having 2 or more and performing lowly in terms of not conducting any delivery, no VHND, low outreach and OPD load (2-3 cases per day average) and covering population of 5000-6000 only (eg. Pritha and Pndri SC)
- SC Pondri has 2 ANMs (1 regular and 1 contractual) for serving a population of 6056 in 4 villages. Considering the less work-load at SC (OPD of 2-3 cases) and limited outreach (no VHND session ever conducted)

C. Workforce Management:

- As per the posting policy, a doctor once placed at a particular place shall have to serve there for at least 3 years. Even after that, s/he shall not get transferred, provided his work is satisfactory and s/he wishes to continue in the facility.

- At the time of joining, promotion or transfer request, MOs are asked to fill three choices for posting. And attempt is then made to post them in their preferred area of posting. This also helps in attracting the doctors from the neighboring states.

- State has good road connectivity linking the rural areas to the cities/towns, which is why people prefer to visit District Hospitals (DH), whenever in need. Considering DHs to be the most preferred facility for treatment by the people, state has increased the specialists posts at the DHs. This has served in the interests of specialists not willing to move to rural areas.

- NRHM Haryana offers a remuneration of Rs 80,000 to the specialists posted in difficult areas and Rs 50,000 to the MOs posted at SNCUs. On the other hand, MOs as fresh recruits get a consolidated salary of around Rs 39,000. In addition, State has made a credit marks system, according to which the MOs having served in rural areas gets the weightage in PG examination.

- In a wake to address gaps in health service delivery, state has also recommended extension of retirement age of doctors from 58 years to 60 years. State has also recommended engagement of specialists on contractual basis for 2 years after their recruitment.

- State has no computerized system of tracking real time information on Human Resource. However, as per the transfer policy of HCMS Doctors I & II, Civil Surgeon shall submit consolidated report of relieving/joining of doctors and engagement of contractual specialists to update computer records in Head Quarters on fortnightly basis.

- **Regular staff**: Transfers & posting of Medical Officers are overseen by Directorate as a whole but need the nod of Finance Commissioner to take place. State has all policies for recruitment, transfers, posting and promotion. To get promotion, a Medical Officer is required to do at least 2 years of rural service in all phases of his/her ACP.

- **Contractual Staff**: Annual contracts are given to the contractual staff, which get renewed based on their performance appraisal at the district and state level. There is no scope for promotions. No transfers are done for contractual staff. Contractual staff is preferably employed at the facilities where the chronic vacancies exist. Terms of reference, job responsibilities for all categories of contractual staff are available in the state.

D. Management Cadre

- **Regular cadre:** At the state level, Director General of Health Services heads the directorate. There are different Establishment wings looking after establishment issues of different category of personnel, each headed by a Deputy/Addl/Joint Director. All positions in the DGHS office are filled either by the cadre of Medical Officers or Senior Medical Officers barring one post of Additional Director, which is filled by senior HCS officer.
- **Contractual cadre:** The state doesn't have State Programme Manager. Director (Admin & Procurement) and Director (MCH, BCC) report to Mission Director. Under the Directors, Joint

directors have been assigned various subdivisions who get the support from the consultants of those respective subdivisions.

- **State Institute of Health and Family Welfare:** SIHFW looks after coordination of all RCH training in the state. It is led by a Principal and assisted by a team of faculty and a group of Consultants, viz. (Consultant RO, Consultant Medical and Consultant Management).
- **State Health Systems Resource Centre:** SHSRC serves as a technical support unit to NRHM Haryana. It is headed by Executive Director and comprises a team of Junior Consultants, Consultants and Senior Consultants.

E. Training & Capacity Building:

State has a dedicated institute, i.e. State Institute of Health and Family Welfare to look after the coordination and monitoring of RCH training in the state. Based on training need assessment, SIHFW prepares a training plan annually which covers all major heads under RCH. Table shown below comprises information on number trained so far against the targets:

Table 3.41 : Training targets and achievements in Haryana

S.No	Name of training	Category of personnel	Load Current year (2012-13)	Total trained in 2012-13	Cumulative achievement since 2005
1	SBA	ANM/ LHV	684	483	2872
2	SBA	SN	508	391	1779
3	RTI/STI	LTs	270	217	461
4	RTI/STI	MOs	210	159	546
5	RTI/STI	SNs/PHNs	330	283	561
6	EmOC	MO	48	26	122
7	LSAS	MO	20	11	50
8	IMNCI	MOs			163
9	IMNCI	ANMs/ LHVs	675	396	1455
10	Immunization				6435
11	F-IMNCI for	Mos	160	51	1138
12	IMNCI Trained	SN	768	412	1127
13	NSSK Trg	MO/SMO/Peadiatrician, Gynecologist etc.	896	452	3057
14	NSSK Trg	ANM	768	569	4116
15	Contraceptive Update	District RCH program officer, Gynecologists and 10 Gynecologists from private sector, Sister Tutor ANM TC and GNM TC & 1 IMA member	420	214	214

Table 3.42: Training on child health (targets vs achievements) in Haryana

Name of Training	Training Load 2013-14	Total Achievement till Sep' 2013	Cumulative Achievement

IMNCI	675	284	10994
F-IMNCI	1008	372	2930
NSSK	2112	1034	8601
IYCF	2100	0	
Yashoda Training IYCF Councelor	168	5	308
HBPNC Supervisory Training	90	171	5064
HBPNC Software Refresher Training	558	0	321

Table 3.43: Training load, achievements for 2013-14 in Haryana

Name of Training	Training Load 2013-14	Total Achievement till Sep' 2013	Cumulative Achievement
MINILAP	54	6	386
Laproscopy	24	0	108
NSV	68	0	290
Alt. IUCD	1045	17	6000
Contraceptive Update	200	158	
PPIUD Insertion	220	208	577
B-EmOC+PPIUD	230	5	-

- LSAS and EmOC trained doctors are well deployed by the state in the FRUs where there is lack of specialists.
- Ambala has an excellent training facility - DTC, located in the campus of the DH, with well appointed rooms, kitchen facilities for the students, AV equipment etc. There is also an ANM training centre in the campus. At the time of the visit, no trainings were in session.

- In addition, the DH serves as a training centre for BeMOC trainings. The team met two trainee doctors at the time of the visit. Feedback from the trainers and trainees, on the training curriculum and duration, clearly reveals that the duration of the training is insufficient for the BeMOc trained doctors to perform caesarean sections independently, especially in sub district level facilities, where expert help is not available to manage complications. However, all LMOs (trainees) who had felt that the training was sufficient to enable them to manage all uncomplicated deliveries and many of the complicated ones too.

- Palwal has a nodal officer (Deputy Civil Surgeon) for training and training calendar is prepared as per the district health plan in consultation with respective state programme managers at Panchkula, SIHFW and CS along with MOs in-charge of all CHCs/PHCs.
- Training infrastructure is not available for Palwal. There is no District Training Center, trainings of all programmes are conducted in DH. If batch is more than 25, room is hired in Dharamsala or hotel.
- The trainings of ANMs on SBA, NSSK has achieved the targets for the year 2013-14. None of the M.O has received any training in CHC/PHC in 2013-14. 19 M.Os got trained on NSSK out of 50 M.Os targeted for training in 2012-13. As per the Palwal district training plan for 2013-14; 5 batches of staff nurses and 5 batches of ANMs/LHVs are to be trained on SBA. Each batch has 4 participants for 21 days duration. Achievements of SBA training is almost 50% as 20 SN out of 44 targeted staff nurses got SBA trained in 2012-13. As in 31st October, 2013; only 8 SN are SBA trained out of 20 SN targeted. The training target for ANMs is 100% for SBA training in 2013-14.
- All 906 ASHAs working in the district received training on Module I-V as in October 2013. 50% of ASHA (489) received training on HBPNC round 1st out of 906 ASHAs while 436 ASHAs received trainings on HBPNC round 2nd.
- In Ambala, 'On the Job' training is being provided to staff at some facilities by their supervisors and MOs and even written test for SNs has been conducted by an MO at a facility in Ambala. The team evaluated knowledge and skills of ANMS and ASHAs at the centres visited and found them to be well versed with RCH protocols and comfortable with use of BP instruments and Hb meter, weighing machines etc.

Recommendations on HRH & Training:

- Human Resource Information System (iHRIS) is required by the state to track real time information on HR tracking and proper deployment of trained and untrained staff.
- Increased coherence between DGHS Office and NRHM Office in terms of information sharing.
- Increase in seats in Govt Medical colleges with the compulsory rural service bond of some duration.
- SPMU should have a dedicated HR cell to look after the HR issues of the contractual staff.
- State should make a separate cadre for specialists.
- Lessen disparity between the salary of contractual and regular staff.
- Concept of Paying clinics, as mentioned in the Haryana Civil Medical Services Rules may be brought into the application. With this, the MOs will be able to do private practice for which they have to give a share to the government.
- Creation of adequate number of regular posts for health facilities

- Establishment of ANM/GNM TCs for production of health personnel. Need to put in place a system for giving local area preference for deployment of health workers (SN/ANM) Special attention on Hathin block of District Palwal for ensuring HR recruitment and deployment and using adequate incentives sanctioned for that region.

- Sanction of more regular posts for specialists and doctors is required for a poor performing district like Palwal. Rational deployment of specialists and doctors across Haryana district is the top priority and fair transfer norms should be followed . Multi-skilling programs for M.Os may be undertaken and handholding system either at functional CHC/DH within or outside Palwal may be planned out.
- Increased coherence between DGHS Office and NRHM Office in terms of information sharing. Compulsory rural service bond of some duration in remote and difficult to work areas must be fully implemented as per ACP 2008.
- The health personnel posting in remote areas like Hathin (which was earlier part of Mewat district) should be given difficult area allowance as per notification issued; process should be expedited for implementation of incentive scheme for these staffs (for both regular/contractual); Contractual staffs are comparatively getting higher pay than regular staffs. A differential incentive scheme should be devised (graded) and fixing of basic incentive regardless of performance should be in place. As per the facility performance/case load, the incentives may increase also taken into account the work-load of each staff.
- Increasingly there has been a resurgence of malaria in many districts of Haryana with growing burden of seasonal outbreaks of JE, dengue, etc. ASHA workers and ANM need to be trained in slide collection and incentive for this task may be provided. There may be need to revitalise the position of MHW (M) by filling the vacancies.
- Since no state level training of MO and para medical staff in RNTCP has been done since 2010, training are required at the state and district level to fill this gap.

3.5 COMMJUNITY PROCESSES AND CONVERGENCE

3.5.1 Observations (State/district specific):

A. Panchayat Raj Institutions:

- *Sarpanch* and the ANM and AWW are the joint signatories of the VHSNC account and *Sarpanch* is the president and ANM is the Vice President while ASHA is member secretary of the VHSNC. Main activities pertaining to sanitation campaigns, drainage clearing, sprinkling of lime, provision of pits for bio-waste disposal, spraying of insecticide, distributing chlorine tablets, sprinkling of bleaching powder, kerosene and chemical for mosquito larvae control, IEC activities such as slogan/ message wall writings, banner mobilization rallies, awareness generation on health related issues, arrangement of resources necessary for prevention and control during epidemics etc. needs closer supervision.

- The role of Anganwadi centers towards distribution of nutrition supplements, growth monitoring and immunization of the village children was largely found lacking.
- During the year the untied fund of Rs. 3,000/- was released to the VHSNCs per committee. The heads under which the funds could be utilized were informed to the committees. Guidelines for utilization of VHSNC funds were provided to the VHSNCs.
- VHSNC issues pertains primarily to maternal health,
- All reports are complied and sent to PHC for consideration and for seeking resolution to any issues which need inter departmental consultations between the Health department, PRI and other department related to the matters.
- The role of is carried out by the *Swasthya Kalyan Samiti (SKS)* in Haryana and is in existence for all the health facilities. At the PHC level the Medical Officer is the Chairperson, the Dental Surgeon is the Member Secretary while a member of the Block Samiti, Sarpanch, two AWW, two ANMs and two ASHAs are the members of the Samiti. The SKS gets an annual fund of Rs. 1,37,500/- which includes Annual Maintenance Grant and untied fund. Till last year this funding was for Rs. 1,75,000/- per annum.

B. VHSNC:

- 6280 VHSNC/VLCs formed for 6955 revenue villages. VHSNC/VLCs formed at the *Gram Panchayat* levels. Aanganwadi Worker and Lady *Panch* (i.e. Head of VHSC/VLC) designated joint Account Holders.
- VHNDs are planned for every fortnight and in the district, against the planned 1058 VHND sessions 686 were held as follows -
- For children - Immunization (both polio and routine), dispensation for IMNC checkup drugs, referrals to higher facilities, nutrition, growth monitoring and play school level education for children.
- Coordination is lacking between the WCD, Public Health and the Health departments, though of late the efforts have been stepped up.
- Being monitored at PHC & CHC level on last working day of every month when the MOs and PO from the WCD-ICDS department coordinate and review the status and performance of the VHNDs in their respective regions.

C. ASHA Training & Performance:

State Initiatives (steps for strengthening ASHA programme):

- State Community Processes Resource Centre established at State HQ
- District & Block ASHA Coordinators/Community Mobilizers, and ASHA Facilitators appointed in the field. CUG Numbers provided to all ASHA in the State.

- RAPID Assessment & Supportive Supervision conducted in 15 Districts.
- ASHA Grievance Redressal Mechanism established at NRHM State HQ. ASHA Helpline No. 8288014141 established at NRHM State HQ. ASHA Grievances Redressal Cells formally constituted in 7 Districts.
- Performance based incentives increased substantially, over the years.
- Self Appraisal Forms and Field Diary provided to each ASHA. Performance of each ASHA being appraised at SPMU/DPMU regularly.
- Almost 3000 non-performing ASHAs replaced and approx. 120 zero performing ASHAs left in entire State.
- Monthly Workshops for DAC/BACs conducted for their Orientation and capacity buildings.
- 12000 Drug Kits and HBNC Kits provided to well performing ASHA.
- Trained *Dais* also being used as ASHAs in Mewat district.
- 472 ASHA Facilitators designated at the level of PHCs.

Table 3.44: Target and achievements for selection of ASHA in Haryana, Palwal and Ambala (Oct, 2013)

State/District	Target	Achievement	%
Haryana	18000	16774	93.18
Palwal	885	866	97.85
Ambala	945	684	72.38

Table 3.45: Training status of ASHA in Haryana and districts upto October 2013

State/ District	I	II-IV	V	HBPNC Round-I	HBPNC Round-II
State	18110	17669	15492	12038	11331
Palwal	866 (100%)	866 (100%)	866 (100%)	604 (68.74%)	590 (97.68%)
Ambala	651 (95.17%)	651 (95.17%)	651 (95.17%)	568 (83.04%)	523 (92.07%)

Table 3.46 : ASHA appraisal for annual/average monthly payments

ASHA Appraisal for Annual/Average Monthly Payments

Financial Year	Budget Utilized (Rs. in Lakh)	No. of ASHA In-position	Per ASHA Annual Payments (In Rs.)	Per ASHA Average Monthly Payment (In Rs.)
2006-07	56.85	7940	715.99	59.66
2007-08	114.34	11108	1029.35	85.78
2008-09	217.66	12152	1791.15	149.26
2009-10	340.07	12753	2666.59	222.22
2010-11	716.11	12861	5568.07	464.00
2011-12	1285.44	13787	9323.57	776.96
2012-13	1779.14	14622	12167.56	1216.75
2013-14 (Upto August)	1087.23	16774	6481.64	1080.04*

Observations:

- Palwal has 906 ASHAs of which 39 have dropped out and 867 are active ASHAs. In areas where marginialized communities are living ASHAs have been selected from those communities only. "Reaching the Unreached Module" has been used for orientation of the ASHA Facilitators who are required to supervise, monitor and mentor the ASHAs coming under their jurisdiction.

- Palwal has 906 ASHAs and all of them have been trained till Module 5. Of these 486 ASHAs have completed HBPNC round 1 and 436 have completed HBPNC Round 2. There has been a drop out of about 39 ASHAs during the year. Trainings on Modules 6 and 7 have not yet been initiated in Haryana. However the training of all the ASHAs on Modules 6 and 7 will be completed in the current financial year.

- The State has got approval in the PIP-2013-14 to train all the 906 ASHAs under Module 6 and 7 in the current financial year. Out of a total of 25 District Trainers and 2 District Master Trainers, who have received the National Training for Module 6 & 7. Procurement of both the Drug Kits and equipment kits have been made as per approved PIP-2013-14.

- Under the WIFS program, ASHAs in districts where the Menstrual Hygiene Scheme is under implementation provide sanitary napkins and Iron Folic tablets to beneficiaries. In Palwal, 17 ASHA Facilitators were selected and deployed. The ten point Performance Monitoring System for ASHAs is in place and is being implemented.

- Supply of drug and equipment kits - Drug kits had been provided to all ASHAs. Similarly, detailed guidelines for provision of drug kits to all currently engaged ASHAs have been made available to

them. In the current year, purchase of ASHA Drug Kit and Supplies have been completed. HBNC Kits which containing Watch, Thermometer, Weighing Scale, Baby Blanket and a kit bag along with required drugs (like Cotrimoxazole, Syrup Paracetamol, Gention Violet etc.) are being supplied to ASHAs trained on HBPNC.

- Process of payments and incentives received by ASHAs (process of payment, different types of incentives, the average monthly take home amount). Ssystem of electronic transfer of ASHA performance based incentive payment has been introduced since the last year. Average monthly take home for ASHAs ranges from Rs. 1500-Rs. 2000.

- Incentives for Institutional delivery @ Rs. 200/- per case required to be approved in the current RoP, as withdrawal of this incentive is promoting resentment among ASHAs. Spacing Incentives for Family Planning is needed to be revised i.e. Rs. 500/- per case; as interval of 2 and 3 years not motivating ASHA. First three installment may be given on Bi-annual basis @ Rs. 100/- each and last Bi-annual payment may be @ Rs. 200/- . Incentive for RI is also needed to be revised, i.e. Rs. 150/- per Session; as in populated villages ANMs are conducting Session on >3000-4000. 02-03 ASHA mobilizes community, incentive get divided.

- **Availability of ASHA restrooms – ASHA ghar in health facilities, if any –** Not yet initiated in the state. Asha Facilitator, ASHA Coordinators and ANM support the functioning of the ASHAs.
- The payment made to them is insufficient and it is hard to work at such low incentives. The additional incentive of Rs. 200/- which was paid earlier on attaining the level of Rs. 1,500/- incentive, has been removed leading to resentment. For promoting institutional deliveries the incentive applicable to the ASHAs for BPL cases should apply to APL cases as well. The cooperation of ASHAs with ANM and aanganwadi workers also need improvement.

D. Community Monitoring:

- There is no community participation, involvement and ownership at any level in Ambala and Palwal. District Vigilance and Monitoring Committee is established in 2012 in Palwal but no meetings records was available so is the case in Ambala.

E. Convergence:

- For Polio programmes, immunization program and review of VHND, associate line departments are invited to the health facilities every month, however their participation requires more focus and intensity from the line departments.
- Assess the convergence in planning, implementation and monitoring – Lacks focus and integration. Coverage of water and sanitation programs in the district - specifically, involvement of VHSNC's and ASHAs in water and sanitation activities – ASHAs and ANMs attempt to focus on the water and sanitation issues but the required impetus and support from the related line departments is lacking.

Recommendations:

- Sensitization of PRI Members and other Stakeholder for VHSNC activities and VHND Celebrations
- Reporting on 10 Performance indicators of ASHA to be implemented
- Need for greater convergence of field level functionaries; improve ASHA helpline and grievance redressal mechanism.
- ASHA kits use should be closely monitored and replenishment mechanism to be explained. Streamline mechanism for equipment replenishment.

3.5 INFORMATION AND KNOWLEDGE MANAGEMENT:

State Initiatives:

- **Anaemia Tracking System:** In addition MCTS, the state has initiated a separate line listing software of anaemic cases. As per the reporting system of the total pregnant women registered under the system 10% of them are severely anaemic.

- State has started a reporting System called District Health Information System (DHIS) an own format as an alternative to the HMIS reporting system by adding some more indicators with regard to RCH programme in the monthly reporting format of HMIS. All the facilities including sub centres have started reporting on that format and the data entry is being done at the CHC level facilities by the information assistants. Absence of a check on correctness and completeness of the data which have been uploaded on the online system is observed in the district.

- Many of the indicators were not properly reported and discrepancies were observed between the manually prepared reports and the online reports. Information assistants have been appointed up to the level of PHC and all the posts were filled in the facilities visited by the team.

- Computer and internet facilities were been provided upto all CHC level facilities where the data entry is happening.

A. HMIS/DHIS, MCTS:

Observations:

- The State has started reporting different online reporting systems implemented by the State. At present following online reporting systems are functional in the district Health Management Information System (HMIS)/ District Health Information System(DHIS), Maternal and Infant Death Report, SNCU, Procurement ,Referral Transport, Anaemia Tracking, MCTS, Human Resource, Supportive Supervision, Nikshay.

- For effective implementation State had **appointed District Monitoring & Evaluation officers** in the districts in order to achieve the goal of quality reporting from the districts.

- **CUG numbers are distributed** to ANMs, ASHAs & Information Assistants for better internal linkage and for effective utilization of ASHA mechanism in order to strengthen outreach. State had started **Helpdesk cum Call centre** as per GOI guidelines for verification of Beneficiaries and Health service providers.

- Though MCTS has been implemented the state, the State officials have opined that the state is not convinced with the objective of the system, since the MCTS has not contributed in the service delivery, especially in the immunization activities. It has been observed that, of the existing 88 Sub centers in the district of Palwal, only 74% of them are regularly reporting on MCTS, which need an urgent attention.

- State effectively implemented **MCTS programme in rural area**, more than **90% pregnant women are registered** in the portal. In child registration 75% of children are registered.

- The registration of pregnant women and children is observed to be less in the district of Palwal. As against the total ANC registration reported in the district till September, 2013, only 47% of the mothers has been registered in MCTS and system and which is only 40% of the information on children as against total live births reported. Poor progress in updating information of pregnant women and child is a matter of concern. Information on 25% of the mother and 9% of children is updated on a regular basis, which results in poor use of MCTS. The team has also observed that none of the facilities in the district started generating work plans for the ANMs/ASHAs.

- The State has to ensure that the proper update of services delivery is happening on the MCTS system to enable the system to generate work plan as well as to ensure quality service delivery and follow up pregnant women and children.

B. Use of Data:

- Use of MIS data or any information at any level of the programme management observed to be minimal. Some of the general observation of the team with regard to monitoring evaluation activities in the district are as follows;

    - In majority of the facilities, registers were maintained manually and that leads to problems in correctness of the data uploaded on the website.
    - It has been observed that, no verification of data is performed before entering data into the DHIS. The team has found discrepancies in the data submitted by the facility and the data entered in the DHIS. For e.g. Data pertaining to deliveries taken place in CHC Hodal during the second quarter of this financial year was shown as 'nil' in the DHIS, however, the facility has reported 344 deliveries in their manual reports. Immediate attention is required from the district level officers to rectify problems in correctness of information.

- Even though State has initiated validation in the data entered by the facilities, wrong data is entered. The team has found that the information entered with regard to OPD and IPD is reflected wrongly in the DHIS.
- The number of incident reported under different reporting system is not captured in the DHIS. For eg; In the district of Palwal a total of 33 Maternal deaths have been reported, however, only 7 of them have been reported in the DHIS.
- Quality of the information fed by the facility in to the DHIS was observed to be poor and it was also observed that no supportive supervisory visits from the district level are initiated yet for the information management. The district needs to initiate scrutiny of information submitted by the facility and initiate visits to the poor performing facilities for handholding.
- An absence of monthly review meeting for DHIS reports is observed by the CRM team in the facility. The District officials have to ensure that review meetings are happening at the CHC level to review the performance based on the DHIS data as well as for the quality information.
- Absence of review meeting and monitoring system of different reports at the CHC and district level observed to be as a serious matter of concern.

Recommendations

- The district has to initiate that supportive supervision activities to ensure quality reporting to the upper level. The CHC level officers including information assistants need to be given indepth training/ orientation on the use of data which are generated through different reporting system in the district.
- Data quality should also be a part of the checklist of the all supportive supervision activities in the State, which will help the state to ensure complete and correct reporting.
- Use of different reports generated through the system must be used to review the programme reviews at the State as well as district level.
- Strengthening of MCTS should be given high priority and strict instructions need to be issued to all facilities for registration and update of MCTS data on a regular basis.

3.6 HEALTH CARE FINANCING:

State Initiatives/Good practices:

- State has appointed Concurrent auditor throughout the State and the concurrent audit has been completed up to I Qtr of 2013-14.
- The State is collecting the compliance report on the observations of Statutory and concurrent auditor from Districts.
- The State & District are following e-transfer system up to CHC & Sub Centre level which is a good practice.
- The State had conducted one day training on model accounting and Tally ERP 9 in the month of September 2013, which was very effective. Such type of training needs to be conducted at the DHS level also.

Observations:

Table 3.47: HR Status under Financial Management in Haryana

S.No.	Position	Sanctioned	In Position	Vacancy
1.	Director Finance	1	1	0
2.	State Finance Manager	1	1	0
3.	State Accounts Manager	1	0	0
4.	District Accounts Manager	21	20	1
5.	District Accounts Assistants	222	214	8

- There is shortage of Accounts person in PHC level. Only one accounts assistant is handling (3-5) PHCs i.e accounts of all PHCs under one CHC. So one accounts assistant could not able to maintain the books of accounts of all PHCs regularly. Currently there are 8 post vacant of accounts assistant in the State.

- **Trending of the State/District on the absorption of funds. Activity Heads with low and high Expenditure. Reasons for low expenditure.** The State has incurred 77.97% in 2010-11, 84.48% in 2011-12 and 74.66% in 2012-13 under RCH Flexipool and 90.23% in 2010-11, 100.47% in 2011-12 and 82.42% in 2012-13 under Mission Flexipool. The low expenditure has been observed in, Child Health, Family Planning, Training, Planning, Implementation and Monitoring, Hospital Strengthening. However the expenditure trend under ASHA, Infrastructure & Human Resources, and Referral Transport has exceeded more than 100% in 2012-13. (Annexure –A)

- **For the Financial Year 2013-14 up to IInd Qtr. the trend of expenditure of SHS Haryana is as follows:**

RCH-II

- The overall fund utilization against approved annual SPIP of **Rs. 133.23 crore**, is **Rs. 65.58 crore** up to 2nd Qtr of Financial Year 2013-14 i.e.51.08**%** utilization against approved PIP**.**

- Expenditure reported Maternal Health (Other than JSY) (57.43%) till 2nd Quarter of 2013-14 shows good level of utilization of funds.

- The State has reported (36%) utilization of approved PIP under PNDT Activities up to 2nd Qtr. of F.Y. 2013-14.

- The State has reported expenditure of less than 45% of the approved annual PIP under the heads Training (21%), ARSH (including School Health Programme)(19.99%), Family Planning Services (including Compensation and Camps) (34.59%), JSY (including ASHA incentives under JSY)(33.93%). The State should take necessary steps to improve utilization under these activities

Mission Flexi Pool

- Since the launch of the programme, out of the total release of Rs.534.79 crore under Mission flexible pool, the state has incurred expenditure up to 2nd Qtr of 2013-14 amounting to Rs 672.98crore i.e. 125.84% of funds released to the State, which shows a diversification of fund of other programme to MFP .

- Out of the approved annual SPIP of Rs. 121.82 crore, the reported expenditure up to 2nd Qtr is Rs. 46.39 crore for the year 2013-14. 38.08% expenditure against approved PIP.

- The State had an overspent balance of Rs 162.99 crore as on 1st April, 2013 and Rs. 71.19 crore has been released during the year 2013-14. Expenditure reported by the state during the year 2013-14 has been Rs.46.39 crore which indicates diversification of fund from other programmes to MFP.

- The state has no budget and no Utilization under the activities of New Initiatives/Strategic Interventions and support services for the financial year 2013-14.

- The State has reported expenditure less than 45% of the approved PIP under the heads Untied Funds (17.33%), ASHA (34.12%), AMG(22.01%), Hospital Strengthening (1.13%), New constructions/setting up (37.81%), Monitoring and evaluation (HMIS) 37.50%) up to 2nd Qtr of 2013-14.

- The State has reported NIL Expenditure up to 2nd Qtr of 2013-14 under the activities of District Action Plans (including Block,Villages), Research study analysis.

Table 3.48: Trend of Expenditure of Palwal for FY from 2010-11 to 2012-13

PALWAL			Rs. In Lacs
RCH FLEXI POOL	PIP	Expenditure	% of Expenditure
2010-11	161.70	122.23	75.59
2011-12	304.57	245.55	80.62
2012-13	382.55	305.43	79.84

Mission Flexible Pool	PIP	Expenditure	% of Expenditure
2010-11	350.39	278.36	79.44
2011-12	261.76	187.99	71.82
2012-13	306.59	339.46	110.72

Table 3.49: Trend of Expenditure of Ambala for FY from 2010-11 to 2012-13

AMBALA			**Rs in Lacs**
RCH FLEXI POOL	PIP	Expenditure	% of Expenditure
2010-11	229.91	192.27	83.63
2011-12	411.93	386.44	93.81
2012-13	484.00	407.09	84.11

Mission Flexible Pool	PIP	Expenditure	% of Expenditure
2010-11	481.28	445.31	92.53
2011-12	300.82	290.74	96.65
2012-13	389.21	396.19	101.79

Table 3.50 : Statement Showing Fund Status of District Palwal and Ambala as on 30.09.2013

Rs. In crore

District	**Opening Balance as on 1.04.2013**	**Funs Released under NRHM**	**utilisation till 30.09.2013**	**% of utilisation**	**Closing Balance as on 30.09.2013**
PALWAL	0.92	6.30	3.45	47.78	3.77
AMBALA	1.62	7.07	4.05	46.61	4.64

- Both the District Health Society of Ambala & Palwal had incurred overall satisfactory utilisation of fund from financial year 2010-11 to 2012-13 and up to II Qtr of 2013-14.

Table 3.51: Difference in PIP up to Sept 2013 Amount Reported by SDH and DHS, Ambala

Rs. In Lakh

Programme	PIP 2013-14 as per State	PIP 2013-14 as per District	Difference
RCH Flexipool	448.48	136.68	311.80
Mission Flexiblepool	305.55	225.49	80.06
Immunisation	43.46	41.93	1.53
TOTAL	797.49	404.10	393.39

Table 3.52: Difference in expenditure up to Sept,2013 Amount Reported by State & District Health Society Ambala.

Rs. In Lakh

Programme	Expenditure 2013-14 as per State	Expenditure 2013-14 as per District	Difference
RCH Flexipool	211.80	210.86	0.94
Mission Flexiblepool	126.63	124.11	2.52
Immunisation	13.42	13.38	0.04
TOTAL	351.85	348.35	3.50

- **Factors responsible for difference in PIP & utilization of funds between State & District:**
  a) Difference in PIP, because the additional approval to the District Health Society has not been communicated to the DHS, Ambala up to II Qtr.
  b) Delay in financial reporting from the sub district level units.
  c) Full strength of financial staff not in position.
  d) Delay in submission of SoE from the outside agencies such as PWD etc.
  e) Only one accounts assistant is handling (3-5) PHCs i.e accounts of all PHCs covering under one CHC.
  f) Disbursement of funds to the facilities having high unspent balances.

- There are two programs running under Non Communicable Disease Programmes in the DHS. 1. **National programme for prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)** , 2. **National Programme for Health Care of Elderly (NPHCE)**. The grant received under NPHCE during 2011-12 is Rs.41.92 Lakh and during 2012-13 Rs.41.76 Lakh, whereas the expenditure reported is only Rs.13.39 Lakh for the financial year 2011-12 and 2012-13. The unspent balance up to 31.10.2013 is Rs.96.22 Lakh.

  Similarly under NPCDCS Programme fund received during 2011-12 is Rs.1.90 crore and expenditure made during 2012-13 is only Rs. 19.60 Lakh and during 2013-14 is only Rs.20.09 Lakh. The unspent balance up to 31st Oct 2013 is Rs.1.51 crore.

The Audit Report has not been submitted for NCD Programme for the financial year 2012-13 till date.

Audit Procedures:

- **Statutory Audit:** The State has conducted the Statutory Audit for the financial year 2012-13 and has submitted the audit report for the F.Y. 2012-13. The Statutory Audit Reports for Non Communicable Diseases for the Financial Year 2012-13 is awaited from State.

- **Concurrent Audit:** The State has implemented the Concurrent Audit System in 2013-14 which is a good practice implemented by the State. The report for the same was also made available for the I Qtr of 2013-14 in Ambal district and was awaited in District Palwal. However, the consolidated Concurrent Audit Report of Qtr I of Haryana was not sent by the State to the Ministry. The action taken by the Districts on the reports of Statutory and Concurrent Auditor was also made available by the District Health Society.

- **Delegation of Financial Powers:** The delegation of financial powers had been done at all levels.

- **E-Transfer of Funds:** The State is transferring the funds through e-transfer to all the District Health Societies and up to PHC level.

- **Group Bank Account**: As per financial management guidelines there should be group bank account at all levels. There should be one main account and from the main account the fund should be transferred to the account of each programme. The SHS and DHS are not following this as a result diversification of funds happens.

- **Implementation of Tally ERP 9:** Tally ERP 9 is being used in Ambala District Health society. Below DHS all 4 CHCs and 14 PHCs, 2 SDHC, 1 GH, are maintaining their books of accounts manually. In CHCs and PHCs no separate computer for Accounts person. In DHS Ambala the books of accounts National Disease Control Programmes (NDCPs) was manually maintained. Tally software was installed in upto the CHCs in the district of Palwal , however, huge backlog of entry has been observed in the facilities.
- In Palwal, In some of the facilities, it has been observed that, proper procedures for procurement including quotation has not been followed.
- JSY payment was paid through bearer cheque and cash in the district of Palwal. In some of the facilities, the JSY benefits have been transferred to the ANMs account, thereafter cash payment has been done to the beneficiaries by the ANMS in the area. This is against the guidelines of GoI with regard to the payment of JSY benefits. State has to take necessary initiatives to ensure Direct Benefit Transfer (DBT) to the beneficiaries.
- Supportive supervision from the district to the facilities is essential to strengthen the financial management and reporting system of facility. The team has observed that, in both of the districts, none of the district officers have visited any of the facilities for the financial management activities . Many of the accounts assistants are not well versed with the health care financing, health

programmes and its proper financial reporting; adequate supportive supervision and hand holding will help to improve the quality of financial management. Close monthly monitoring and review system of financial performance of the facilities, with a high focus on utilization, documentation, reporting etc. at the district level needs to be strengthened.

Expenditure against Untied Grants, AMG and RKS Grant

- The State had reported low expenditure against **Untied Grants (17.33%)**, **AMG (22.01%)** and **Corpus Grants (44.75%)** up to September, 2012. The position of the trend of expenditure of the districts visited is given below:

Table 3. 54: Expenditure trend of Programme Untied Funds, AMG, RKS. Rs. in Lakh

DHS AMBALA	2012-13			2013-14 (up to II Qtr)		
PROGRAMME	pip	Utilization	%age Utilisation of PIP	pip	Utilization	%age Utilisation of PIP
Untied Funds	15.24	14.37	94.31%	34.39	5.59	16.25%
Annual Maintenance Grants	17.32	15.25	88.04%	15.30	6.38	41.70%
Corpus Grants to HMS/RKS	21.96	24.55	111.81%	25.00	12.72	50.88%

Table 3.55: Expenditure trend of Programme Untied Funds, AMG, RKS. Rs in Lakh

DHS PALWAL	2012-13			2013-14 (up to II Qtr)		
PROGRAMME	pip	Utilization	%age Utilisation of PIP	pip	Utilization	%age Utilisation of PIP
Untied Funds	11.49	7.97	69.36%	23.56	0.53	2.25%
Annual Maintenance Grants	11.96	13.11	109.62%	12.25	0.46	3.76%
Corpus Grants to HMS/RKS	16.80	19.05	113.39%	20.00	4.10	20.50%

- The utilisation of under AMG & RKS up to II Qtr. of 2013-14 for DHS Ambala was satisfactory it was low under the activity of Untied Funds. In the financial year 2012-13, the utilisation for the above three programmes were satisfactory.

- The DHS Palwal has incurred excess expenditure more than PIP under the activities of AMG & RKS for the financial year 2012-13. Up to II Qtr of 2013-14 the expenditure under the above three activities were very low.

Training Measures and Monitoring Activities Undertaken:

- A one day Training in Financial Management had been organized by the State,in September 2013 , upto the PHC level at Panchkula. Since last 5 years no other training on financial management has not been conducted by the State.

- There is lack of training sessions planned below the District level. Therefore, the District Health Societies should organize the training programmes at the CHC/PHC level on quarterly/half yearly basis.

Recommendations

- State may implement customized Tally ERP-9, up to PHC level.
- State and District Health Society should organize the financial management & Tally training programmes at the CHC/PHC level.
- The State should create group bank account up to CHC level so that fund of one program will not get diverted.
- The State should create posts and appoint Accounts/Finance person up to PHC level.
- Trainings after appointment of accounts person need to be fast tracked.
- District Accounts Manager may also plan to visit at least two CHCs/PHCs in a month for supervising the working of Accountant.
- Director Finance / State Finance Manager must visit at least two districts in a month for monitoring and improving the financial management system.
- ARSH – single signatory is operating the ARSH Accounts in DHS (Ambala) which is not appropriate as per financial management guidelines.

3.7 MEDICINE AND TECHNOLOGY

State Initiatives:

- Setting up of separate corporation for procurement of medical equipments, drugs etc namely Haryana Medical Services Corporation, Ltd.
- An online Asset Management Software is developed for proper management of medical equipments
- Preparatory work has started for launching the free drug supply across the state, based on a Centralised Procurement and Decentralised distribution model.
- State in the process of establishing Haryana Medical Services Corporation Ltd, in which all health institutions including AYUSH and medical education have to place order through HMSC. Heads of Departments shall deposit 85% of budget amount in account of HMSC and balance 15% to the institutions for emergency purchase. HMSC to make the payments to the suppliers after quality assurance.

District Specific Observations:

- **Facility Supply**: The central drug warehouse in Ambala serves as a point of distribution for multiple districts. Marked improvement in the facility level infrastructure for storage and inventory management, especially at the District hospital and the CHCs of Ambala. Designated storage space for drugs, with well organised storage racks and systematic inventory management mechanism is in place. Most storage facilities were well maintained, with adequate ventilation, temperature and damp control mechanism.

Figure 3.6: Drug Store DH- Ambala

Figure 3.7 Drug store - rear picture DH - Ambala

- Computerisation and e-indenting is currently available up to the PHC level in Ambala and Palwal. In Palwal, the DH, CHC, PHC receives supply directly from the warehouses.
- **Receipt of demand from facilities**: Each facility is sending its demand on a Specified Performa to the Ware House Manager by e-mail / physical means. On the basis of receipt of demand the Warehouse which located in Gurgaon, checks the balance Passbook entitlement of that particular facility and issue the stock demanded without making any alteration and record the available stock reported.
- **Distribution of supply to facilities:** Once the supply to be issued is finalized the warehouse issues a transport order to the empanelled transporter/courier for transport to the facility. A system of indenting starting from PHC onwards and inventory control management system. Medical Officers of the facilities visited maintained their individual OPD register indicating the name of patient, diagnosis, name of medicines prescribed and advised investigation. In Ambala, most of the essential drugs are fairly widely available in public health system in the district facilities. The EDL has been recently expanded from about 300 drugs to more than 800 drugs with the inclusion of drugs for tertiary level care. EDL for different facility levels has been prepared and distributed to the facilities. The flow of drugs at the DH was the highest with

about 19 distribution and delivery points. The flow of drugs decreased from the SDH to the SC level. Indent of drugs are made through online system.

- It was observed in Ambala (DH) that 5 indents in the store house showed a high receipt of drugs, with only 1-3 drugs not available. However, stock registers at the DH revealed stock outs of some essential drugs, including ringer lactate, DNS, Dexamethasone. This shortage was being covered through a system of local purchase to address the patient's needs in many cases from untied fund. EDL was not available at prescription point that is with the doctors. However in Ambala, EDL was well displayed in waiting areas of many facilities at CHC/SDH/PHC. No STG book was found for use in an OPD. EDL was not displayed nor available in some the facilities such as (CHC, Hathin, Hodal). Online procurement system is in place which indent is made online 3 days prior and NAC given online from the Regional Warehouse located in Gurgaon for facilties in Palwal.

Table 3.57: Ambala district - Prescription analysis

Facility	Total No. of drugs	Average No. of non generic prescribed from outside in a prescription
DH - 7 prescriptions	Average no - 4.3	1.1
CHC - 13 prescriptions	Average no - 4	1.5

- Medicine kits for Sub- Center in Palwal are being procured separately by the State HQ. Instructions regarding minimum shelf life of medicine and principal of FEFO and FIFO were adhered to as outlined in the enclosed note. Doctors were prescribing the medicines from the stock only and adhered to EDL. Medicines are being prescribed & dispensed for 3 days only. Principal of FEFO (First to Expire, First Out) was adhered to. FIFO is observed in most facilities in Ambala and Palwal.

- Records available at the facilities were manually maintained and the team has found that in CHC Hathin, there is a huge discrepancy between the stock registers and the physical availability of drugs. Urgent attention is needed in this regard to ensure right use of drugs. Drugs are being prescribed as generics and from the EDL, non-generics continue to be prescribed. Though no OOP is being borne by pregnant women, many other prescriptions, at all levels of facilities had at least one prescribed drug purchased from outside in Ambala and Palwal. However, drug availability has greatly increased at all levels of facilities. Exit interviews with patients, especially at CHCs in Ambala and Palwal revealed that patient satisfaction in terms of free drugs availability was cited as the reason for visiting the facility.

- Diagnostics were found to be available for free to all RCH patients in most facilities visited. However, patients were found to be paying for diagnostics, including for ultrasound at the DH facility, where the machine was found to be out of order for the past two months. There is also a out of pocket cost to the patient through user charges in OPD slips, admission costs, as well as charges for diagnostics and surgical procedures in both districts.

AYUSH DRUGS:

- The team found that around 100-150 patients visit the AYUSH OPD in DH - Ambala. Drugs were found to be available to the patients. However, drugs were not available in Ayurveda. In homeopathy, though the drugs were available, adequate dispensers such as plastic bottle and globules were not available.

Table 3. 58: Ambala district - Pharmacist status

	2010-11		2011-12		2012-13		2013-14	
Staff	Sanction	Filled	Sanction	Filled	Sanction	Filled	Sanction	Filled
Pharmacist	50	37	50	33	50	40	50	40

3.8 NATIONAL URBAN HEALTH MISSION:

- NUHM initiated with establishment of Urban Health Cell within SPMU, 2 urban FRUs functional at Faridabad, 56 urban ambulances proposed

Observations:

A. Urban Slums

- *Status of mapping of urban slums*
  - SPMU Haryana has prepared and submitted the PIP for 29 cities/ towns under the NUHM for the year 2013-14.

- *Availability of primary health care in slums including health infrastructure managed by State Government or Urban Local Body or PPP arrangements for service delivery*
  - 37 Urban Dispensaries, 11 Polyclinics, 11 functional Urban Health Centers are already extending their services in urban areas. Health Care service provisioning for the identified key focus urban areas has been envisaged to be rolled out through a network of 151 Urban Primary Health Centers. In addition 15 more Urban Health Centers have been proposed.

- *Availability and adequacy of outreach sessions in urban slums*
  - Organizing out-reach camps for providing health care services to vulnerable and marginalized population is one of the strategies which has been included while drawing the City Health Plans.

- *Community level structures like CBOs existing in urban slums for health care service delivery*
  - State has the presence of CBOs which is managed by Directorate SUDA, popularly called as Neighbour Hood Community (NHC) and Community Development Structures (CDS). Such

structures are been planned to be federated for MAS activities in slums, wherever operational.

- *Constraints felt by health care providers in urban slums*
  - Data on the vulnerability aspects of migrants like regional and language disparities leading to their power of collective bargaining and their lack of trust in the health care system.
  - Precise information on living conditions and spread of slums/ KFAs is required for appropriate planning. implementation and monitoring

- *Initiative for providing health care for the most vulnerable, homeless, street children , rag pickers, migrants workers etc.*
  - Provision of camps and out-reach sessions has been made for proper targeting of the vulnerable.

B. National Urban Health Mission (NUHM)

- *Level of readiness for National Urban Health Mission including preparation of city and state level PIPs and establishment of programme management structures.*
  - At the state level the Governing Body of State Health Mission has been suitably expanded and the Urban Health Cell has been established. The cities/ towns have made plans based on existing information and data and have accordingly provided for health care facilities and HR. They have also provided for baseline data collection in the State PIP submitted to the MOHFW for appropriate planning and targeting.

- *Involvement of Urban Local Bodies in delivery of primary health care*
  - The ULBs have been taken on board in respect of the Urban Health program and have contributed in the preparation of the city plans.
  - Strategy of capacity building (CB) of stake holders, elected members and officials have been planned and incorporated.

- *Availability and adequacy of health manpower , equipment & drugs in urban health facilities*
  - During the current year the major thrust is on the renovation and converting existing urban health centers into Urban PHCs and accordingly provisions for health manpower, equipment and drugs has been provided.

- *Coordination and implementation of key national level programmes- JSY, JSSK, Disease control programme, NCD etc. in urban areas.*
  - Intra departmental convergence within the health sector is emphasized as a strategy and the benefits of national health programmes/ schemes/ entitlements would be provided for under the urban health program.

- *Involvement of coordination between different governance agencies, municipalities, state departments etc.*
  - With the expansion of the State Governing Body by inclusion of relevant line departments will ensure convergence and coordination between different governance agencies, municipalities, state departments etc.

District specific observations (Ambala Findings -From other departments towards NUHM):

ICDS

- Only 16 AWs in 42 slum areas
- No priority for adolescent girls
- Ration Supply: inadequate
- Follow up training of AWWs: No special training has been given to detect SAM/MAM

Education

- Require ration card for availing cash benefits
- No special teachers for identifying vulnerable group children (Only DED interns)
- Schools are not planned in the close proximity to urban slum areas

School Health

- Students to special educator: Poor proportion
- Regular Teachers are not being trained to identify children with special needs

RBSK

- No coordination with physiotherapy department.

In Ambala Health department:

- No ownership/responsibilities of MC and State Health Department to provide services
- No monitoring and evaluation in place to make sure the delivery of services to these areas
- Lack of Identity Proof exclude migrants from availing the benefits of schemes like Apne Beti Apna Dhan and LADLI.
- Absence of Grievance redressal ; Left outs are not reached actively

Urban Health Facilities in Ambala:

- For the population of near to 4 lakhs (42 slums) there are only 4 Urban Health facilities, no delivery Point in Ambala for urban areas; HR : 1 ANM for 15-20 thousand population.
- Speciality Services: Even at SDH Am.C and Naraingarh there are no Gynec/Obs/surgeon and Paediatrician. No Radiologist in civil hospital,
- Infrastructure: Rented buildings, difficulty in finding buildings within the slum areas.
- Funds: No SKS/ untied funds for URCH.

- Drugs and Equipments: Shortage of medicines for new born and elderly. Stethoscope and BP apparatus was not provided to the medical officer.

Figure 3.8: Urban slum, Ambala

In Ambala district, key issues are:

- Roles and responsibilities of ULBs to provide public health services to urban vulnerable population.
- Challenges faced by ULBs in providing water/sanitation services to slum population
- Priority areas and process of planning for UH.
- Type of convergence required to improve health services for this group.
- Expected contribution of centre, state and local Bodies.
- Institutional platforms for joint monitoring systems for ensuring convergence.

Challenges faced by Service Providers in slum Areas:

- Refusal for Immunization (Pentavalent)
- Lack of motivation for adopting family planning methods.
- Inconvenient timings
- Floating population

Recommendations:

- Strengthening of convergence between ULB and State Health Department.
- Developing ownership for reaching and providing services to vulnerable population.
- Developing facilities in close proximity to slums (School, AW, UHC)

- Provision of identity proof (Ration card/BPL card)
- Joint Monitoring System should be there
- Ensure Community Participation.

3.9 GOVERNANCE AND PROGRAMME MANAGEMENT

State Initiatives:

Observations (state/ District specific):

A. Programme Management:

- Palwal is in the process of making institutional arrangements with development of NUHM framework for implementation at various levels. The NUHM is yet to roll out in the coming months with establishment of urban PHCs and PHCs in urban areas of the district. Meetings are being held for establishment of new structure with identification of urban slums and location for creation of such facilities. The challenge in process of restructuring PMUs and integration of NRHM and NUHM structures are mainly in area of manpower a...

- There is fixed meetings plan and carried for review of programme in clinical areas among regular cadres though informal meetings between DPMU staffs and regular staffs. District level support supervisory teams are made for various programmes and district officials are aware of the monitoring visits formats shared from state headquarter. Out of 10 sanctioned posts at DPMU, 9 are in position. At BPMU, only 1 was vacant out of ....The post of 1 computer assistant is vacant. Performance appraisal format developed by state is used at the time of renewal of contract before the end of financial year. For staffs working for the last 5 years, a 5% increment per annum is given and for those, the percentage of increment as fixed by the state is given. All the staffs received ToR at the time of joining. Any kind of grievances related to administrative issues is put up to Civil Surgeon or Deputy Civil Surgeon. Salaries of staffs of contractual staffs are released by Deputy Civil Surgeon and Civil Surgeon. There has been no capacity building initiatives and trainings programme on planning and management areas, conducted for the DPMU staffs. The DPM has received training related to software. There is no financial devolution of DPMU at district level.

B. Institutional Mechanism:

- SKS (Swasthya Kalyan Samiti)/RKS is established at district hospital and at few CHCs. However, there is participation of Zila Parishad though community participation in functioning of SKS.
- In Ambala, supervisory tools are being actively used; however, there is need to review the action taken on these reports, especially at the lower levels of facilities (SC and ASHA). In Palwal, though deputy civil surgeon (3) of them at General Hospital is aware about the supervisory

checklists and number of visits to be made on monthly basis, in reality regularity of such visits is a major issue. The last visit of Dy. CS was made in January 2013 to a health sub-centre as recorded in tour register.

- The frequency of supervisory visits is not structured and not based on performance of facilities except for child heath/immunization related indicators, in which close monitoring is taking place on ground level. The DPMU is also involved in supportive supervision. 28 supervisory visits was made to facilities in the month of September, 2013.

- There is no block level planning and preparation of health action plan and participation of community is lacking at any stage of planning. There is no grievance redressal cell established for DPMU.

- Some innovations which are practical and widely adopted, include stamping in registers of severe anemic patients and high risk pregnancies and should be continued

- Many of the ASHAs were not aware of ASHA helpline. Similarly, on dialing in the helpline number, it was found to be ineffective

C. Accountability:

- There is no social audit, other accountability mechanism for health as well as community monitoring mechanism in place in the district. There is no community participation, involvement and ownership at any level in Ambala and Palwal. District Vigilance and Monitoring Committee is established in 2012 under the chairmanship of Honorable Member of Parliament, of which Civil Surgeon is member.

D. Regulations:

State Initiatives:

For effective implementation of PC & PNDT Act,

- Residence ID proof is made mandatory for ultrasound of pregnant ladies except emergency.
- Toll Free no. of 102 has been started for registration of complaints under PNDT
- Incentive to informer paid upto Rs.20,000/-in each district to disclose illegal activities; in five districts same has been implemented
- Best Village scheme is introduced for provision of monetary incentives and state award for village gram panchayat with best sex ratio
- Registration of veterinary ultrasound machines and infertility clinics.

Table 3.59: Implementation of PC & PNDT Act in Haryana

Activities	Apr., 13-Sept., 13	Cumulative (till Sept., 2013)
Regd. USG Clinics	52 (2Govt.)	1449 (63 Govt.)
Regd. GCC	0	73

Regd. Genetic Labs	0	3
Inspections	1196	17297
Seize/Seal	18	234
Suspension/Cancellation	18	407
Court Cases PNDT	4	94

Observations:

- The registration of clinical establishments has not started yet in the district.

PART-IV

4.1POSITIVE S/STRENGTHS

- Towards strengthening of pre-service education in midwifery and nursing, assessment of 45 training centers (TCs) for nursing and midwifery in both public and private sectors is conducted with technical support from MCHIP-USAID through identification of gaps with respect to infrastructure, human resources, logistics and equipments/knowledge and skills of final year students

- Anemia Tracking Module (MIS) has been in place to track anemia in pregnant women. High Risk Pregnancy stamps and marking with red pen in the ANC register is being used to highlight the severely anaemic patients. **Reverse tracking of severely anemic cases for improvement in the services of ANM.** Out of 87993 pregnant ladies admitted for delivery at govt. health facilities, 3403 (3.8%) found to be severely anemic and were followed up till sub-center level and instruction given to ANMs and ASHAs for treatment and follow-up; **Injectable Iron** also added in the EDL up to CHC level

- Quality improvement and strengthening of labour rooms of all delivery points by establishment of septic and aseptic labour rooms, pre-natal and post natal wards, MTP/procedure rooms and availability of drugs and functional equipments, display of guidelines/protocols, use of partograph – improvement observed in almost all facilities visited.

- Implementation of Quality Intra Natal Care and Immediate Post Partum Care Standards through Supportive supervision mechanism has been initiated with technical support from MCHIP-USAID.Facility Readiness assessment initiated with support of MCHIP /USAID and all delivery points of 17 districts covered till now; Gaps analysis initiated and support provided to district to fill them

- Quality improvements in immunization programmes and outreach sessions are well organized due to availability of due-lists, efficient cold chain, availability of trained HR, good record keeping. Measles Surveillance has been initiated in all 21 districts with technical support from NPSP-WHO. Till date 4026 Health Workers, 1655 Vaccine Cold Chain Handlers, 1315 Medical Officers and 26776 Front Line Workers has been trained in Immunization. Measles 2nd dose initiated; Quality Assurance in Immunization constituted and closer monitoring and evaluation of immunization programme through RAPID & IFVs, implementation of Effective Vaccine Management.

- Supportive Supervision system is in place, done in close collaboration with PGIMS Rohtak Haryana. It involves recording observations in inspection registers and follow up action, baseline and follow up during quarterly visits by external monitors (6 days in a month) from local medical college, NRHM HQ and state training institute. The first round happened in May 2012 to August,2012; the second round during October 2012 to December 2012 and RAPID rounds in 15 districts and third round in May, 2013. In first visit, of drugs, equipment , infrastructure and Gaps in the Knowledge & practices were observed. Second visit revealed considerable strides in the information education and communication materials, drugs availability & record keeping. Knowledge practices and Skills improved. State performance rose to 56 points in comparison to 35 points of 1st visit (59% improvement). Third visit revealed marked improvements in IEC, drugs & equipment availability.

Confidence, knowledge practices and Skills showed massive improvement. The state performance rose to 74 (33% improvement). Overall improvement in 3 rounds has been ***121%***.

- Establishment of web-based Maternal Death, Infant Death and Still Birth Reporting System (MIDRS)
- To redress the practices of pre-lacteal feeding, early start of complimentary feeding and infant milk substitute as well as for early immunization of the new-born, the Yashoda Scheme (MOTHER AND NEWBORN AIDE) had been started in the state to reduce IMR and U5MR. Presently 150 Yashodas and 16 Yashoda Supervisors are working at various hospitals to reduce IMR and U5MR
- Accreditation process of SNCU by NNF has been initiated and self assessment scores being used
- RBSK has launched in July 2013 with starting of activities in 3 districts through establishment of District Early Intervention Center (DEIC)
- Anemia control programme for college going girls has been initiated with launching of SALAMATI-PRACHAR PROJECT, in collaboration with Pathfinder International India. The project activities pertaining to assessment of health infrastruture in 2 blocks got initiated in September 2013.
- Centralized Drug Procurement and distribution Policy is implemented in the FY 2013-14 w.e.f. 1st July 2013. It has a clear mandate to distribute drugs and consumable across all health facilities with adherence of quality and uninterrupted supplies. Through the Centralized Procurement of Drugs policy, warehouse at strategic locations has been set up, provision of infrastructure support, Online Software "Drug Procurement Management Unit (DPMU)" developed by NIC Haryana along with empanelment of Drug Testing Labs for quality check.
- Department is setting up a separate corporation for procurement of medical equipments, drugs etc. namely Haryana Medical Services Corporation, Ltd. An online Asset Management Software is being developed by UNDP for proper management of medical equipments. The purchase policy of State Govt. was decentralized till recently. Most of the drugs and consumables are procured from rate contract of DS&D, CPSU, ESI etc.
- NUHM for initiated with establishment of Urban Health Cell within SPMU, 2 urban FRUs functional at Faridabad, 56 urban ambulances proposed

4.2 CHALLENGES/WEAKNESSES

- Decentralized planning does not take place, only district level planning is in place. Programme Management Units/structure is not established at block levels due to which, the planning and monitoring does not take place form block level.
- There is no social audit, other accountability mechanism for health as well as community monitoring mechanism in place in the district. There is no community participation, involvement and ownership at any level in Ambala and Palwal. District Vigilance and Monitoring Committee is established in 2012 in Palwal but no meetings records was available so is the case in Ambala.
- Surveillance system, Case detection and treatment vector control measures are relatively weak in Palwal. PHC Hathin – outbreak of Malaria detected late due to poor active surveillance, due to lack of manpower in the field.

- Support mechanism for ASHAs is weak and very few ASHA facilitators are in place. The role and responsibilities of intermediate level functionaries such as LHV, ANM coordinators and ASHA facilitators need to be better defined and their services utilized optimally. ASHA helpline is not working effectively and many of them are not aware of it. ASHAs are not aware of the replenishment procedure and complete set of drug kits is not provided.

- Activities of VHSNC were minimal. VHSNCs though formed are poorly functioning. Though multiple records of VHNC activities were available in Ambala, they were mostly records of funds released. VHND – routinely organised but activities were found to be limited to immunization activities. Involvement of PRI is minimal in VHSNC activities. Utilisation of VHNC funds was found to be a one time activity, such as purchase of equipment. Many accounts had records of large unutilized amounts.

- Computerisation and e indenting is currently available only at DH and CHC level. However, some CHCs continue to use manual indents and reporting, while PHCs have to initiate the process. Gaps are due to non availability of pharmacists and DEOs at these levels.

- The SNCU is not optimally utilized due to lack of adequate staffs (pediatrician or trained M.Os and staff nurses) to provide services round the clock. At CHCs visited in Palwal, there were no in-patients admitted in NBSU due to lack of manpower.

- No facility is able to retain the women following delivery for the required 48 hours under JSSK due to lack of facilities for keeping in-patients. It is an accepted practice to discharge patients' early following delivery, particularly normal deliveries due to unavailability of support facilities for admitting in-patients, even at CHC/PHCs level.

- Incentives for Institutional delivery @ Rs. 200/- per case required to be approved in the current RoP, as withdrawal of this incentive is promoting resentment among ASHAs. Spacing Incentives for Family Planning is needed to be revised i.e. Rs. 500/- per case; as interval of 2 and 3 years not motivating ASHA. First three installment may be given on Bi-annual basis @ Rs. 100/- each and last Bi-annual payment may be @ Rs. 200/- . Incentive for RI is also needed to be revised, i.e. Rs. 150/- per Session; as in populated villages ANMs are conducting Session on >3000-4000. 02-03 ASHA mobilizes community, incentive get divided.

- Diversification of fund happens on account of maintaining group account where fund does not gets transferred to account of each programme; there are no Group bank account at any levels. Unavailability of accountant at each facility results in non-maintenance of books of account in PHC at regular levels. Only one accounts assistant is handling (3-5) PHCs i.e accounts of all PHCs under one CHC. The pending UCs has also increased in last 2 years on RCH-II and Mission Flexible pool.

4.3 OVERALL RECOMMENDATIONS/ SUGGESTED ACTION PLAN:

Table 3.60 : Areas of improvements and timeframes for Haryana, district specific

Sr. No.	Areas of Improvements	Immediate Action (1-3 months)	Short-term Action (4-6 months)	Long term Action (7 months -2 year)	Remarks
1.	**Infrastructure Development**				
	Sanction of more health facilities			X	
	Expedite completion/taking over of nearly completed facilities which are currently under construction	X			-In Palwal, construction of 22 (1DH, 2 SDH, 3 CHCs, 5 PHCs, 10 SCs) had been ongoing with completion rate of 40-90%,
	Support facilities at delivery huts (PHC/SCs) needs improvements- especially NBCC and other facilities (running water, electricity supply, signages) needs improvements		X		
	Service Delivery				
	Mechanism to ensure 48 hours stay to be explored at facilities, at least in PHCs/CHCs where post partum women stay hardly for 6-7 hours after delivery		X		
	Closer monitoring in correct use of pantograph is required; SCs (Ambala) were not using partograph through improved supportive supervision and training	X			
	SNCUs needs to be fully staffed (with placements of pediatrician or trained M.Os and required number of staff nurses for quantitative and qualitative		X		

	improvements)				
	MMU services in Ambala could be utilized for migrant and hard to reach population. District plan should be inclusive of strategies for reaching out to migrant workers		X		
	IDR/MDRs needs closer review by senior officials with analysis of causes of death and follow up actions	X			
	RBSK-AYUSH drugs may be included in RBSK drug lists		X		
	Use of ambulances needs improvements for maternal health (currently it is underutilized) and functionality of GPS needs to be strength	X			
	Improving quality of data reporting on Anemia Tracking Module through identification of high risk areas of severely anemic & necessary action.	X			
	Human Resources for Health				
	Increase in seats of medical colleges for MBBS/P.G , establishment of ANM/GNM TCs for more production			X	
	Implementation of compulsory rural service bond as per ACP 2008, rotatory rural postings, financial incentives for rural/remote postings for increased availability of HR in rural areas Differential incentive scheme should be devised (graded) and fixing of basic incentive regardless of performance should be in place. As per the facility performance/case load, the incentives may increase also taken into account the work-load of each staff.		X		Staffs in remote areas like Hathin (which was earlier part of Mewat district) should be given difficult area allowance as per notification issued; process should be expedited for implementation of incentive scheme for these staffs (for

					both regular/contractual);
	Create a specialist and public health cadre		X		
	Creation of adequate number of regular posts for health facilities and adequate number of facilities as per norms		X		Sanction of more regular posts for specialists and doctors is required for a poor performing district like Palwal. Rational deployment of specialists and doctors across Haryana district is the top priority and fair transfer norms should be followed
	Filling up of vacant posts against sanctions for staffs through contractual (SN/pharmacists)		X		
	Need to rationalize the HR deployments as per facility work-load and FRUs -local area selection and postings for ANM/SN.		X		
	IHRIS (Human resource Information system) should be introduced to track real time information on HR related issues for rational deployments and other administrative purposes		X		
	Disease Control Programme				
	Regular monitoring of vector population in is required.	X			Huge potential of continuing vector breeding, resting adults of vectors, Annularis culicifacious found inside human

					dwellings with confirmed cases of P.Falsiparum infection
	Laboratory services to be reorganized and vaccination for JE to be included under immunization programme	X			
	TB should be part of disease screening under RBSK to ensure case detection of paediatric TB cases. HIV-TB testing facilities should be co-located to improve HIV testing for all TB patients. Trainings of M.Os and paramedical staff is required (which has not been done since 2010). TB may be included in weekly IDSP reporting formats		X		
	Immediate need to shift criteria from A to C for Haryana for improving identification of MDR suspects. PMDT services to be decentralized at DMC level.		X		
	Medicines and Technology				
	Supply Chain Management though is progressing well, but need to ensure replacement of manual indents to e-indenting till PHC level, EDL lists should be available at all prescription points. Generic drugs use to be improved and EDL lists may be revises for inclusion of more drugs (emergency) like Vitamin K.				
	Community Processes & Convergence				
	ASHA/Community Process need for greater convergence of field level functionaries; improve ASHA helpline and grievance redressal mechanism; Provision of complete set of ASHA drug kits and replenishment should be given		X		

	ASHAs and ANM need to be trained in slide collection and incentives to be given. The MHW (M) should be revitalized by filling up posts		X		
	Sensitization of PRI Members and other Stakeholder for VHSNC activities and VHND Celebrations.	X			
	Reporting on 10 Performance indicators of ASHA to be implemented.	X			
	Supportive Supervision				
	Data quality should be part of checklists and HMIS/DHIS data should be used for periodic review of programmes	X			
	Health Care Financing				
	State to implement customized Tally ERP-9 upto the PHC level and organizing the financial management and Tally training programme at CHC/PHC level		X		
	Create posts and appoint Account/Finance person upto the PHC level and trainings to be fast tracked		X		
	Signatory for ARSH account (Ambala) should be as per the guidelines		X		
	Information and Knowledge Management				
	Supportive supervision visits should be in regular intervals with prioritization of poor performance facilities after HMIS data analysis on services/KI, emphasis on accurate reporting and documentation	X			
	Registration and update of MCTS data to be regularized	X			
	Governance and Programme				

	Management				
	Increase coherence between DGHS and NRHM office in terms of information sharing and posting of consultants at DGHS for improved capacity and coordination is required		X		

PART –V (ANNEXURES)

Annexure A: Total functional delivery points in public health facilities of Haryana

Up to, Oct. 2012 Date: 14.12.2012

S.No	Indicator	Number
1	**Total No. of SCs**	**2630**
a	No. of SCs conducting >3 deliveries/month	275
2	**Total No. of 24X7 PHCs**	**315**
a	No. of 24X7 PHCs conducting > 10 deliveries /month	161
3	**Total No. of any other PHCs**	**28**
a	No. of any other PHCs conducting > 10 deliveries/ month	0
4	**Total No. of CHCs (Non- FRU)**	**97**
a	No. of CHCs (Non- FRU) conducting > 10 deliveries /month	84
5	**Total No. of CHCs (FRU)**	**8**
a	No. of CHCs (FRU) conducting > 20 deliveries /month	8
b	No. of CHCs (FRU) conducting C-sections	5
6	**Total No. of any other FRUs (excluding CHC-FRUs)**	**13**
a	No. of any other FRUs (excluding CHC-FRUs) conducting > 20 deliveries /month	13

b	No. of any other FRUs (excluding CHC-FRUs) conducting C-sections	10
7	**Total No. of DH**	**21**
a	No. of DH conducting > 50 deliveries /month	21
b	No. of DH conducting C-section	20
8	**Total No. of District Women And Children hospital (if separate from DH)**	Nil
a	No. of District Women And Children hospital (if separate from DH) conducting > 50 deliveries /month	Nil
b	No. of District Women And Children hospital (if separate from DH) conducting C-section	Nil
9	**Total No. of Medical colleges**	5
a	No. of Medical colleges conducting > 50 deliveries per month	*4
b	No. of Medical colleges conducting C-section	4
10	**Total No. of Accredited PHF**	
a	No. of Accredited PHF conducting > 10 deliveries per month	
b	No. of Accredited PHF conducting C-sections	

i. Provide the status in a soft copy.

ii. Upload on State/UT NRHM website, the name wise list of the above facilities which are delivery points.

iii. Name wise list of all delivery points to be sent in soft copy e.g. Names of all sub-centres conducting >3 deliveries per month; names of all DH conducting > 50 deliveries per month; names of all DH conducting C sections, etc.

iv. * Medical College Mewat has not reported

Annexure- B:Progress on Key MH Indicators:

MMR	RGI(2004-06)	RGI(2007-09)	AHS(2010-11)
	186	153	-

Indicators (in %)	**DLHS-III**	**CES (2009)**	**HMIS (2011-12)**	**HMIS (2012-13) Up to Oct., 2012**
Any ANC	87.3%	89.4%	601919	342766
3+ ANC	52.4%	68.9%	492184 (81.77%)	272393 (79.47%)
Registration within 12 wks	55.1%	57.4%	307894 (51.15%)	172462 (50.31%)
Full ANC	13.3%	42.9%	--	--
Ins. Delivery.	46.9%	63.3%	432255 (71.81%)	239319 (69.81%)
Safe Delivery	53.4%	69.3%	466533 (77.51%)	259721 (75.77%)
Home Delivery	52.6%	36.4%	87381 (14.51%)	46423 (7.71%)
% of C-sections out of total reported	-	-	6.90%	8.30%

institutional deliveries				
At Public	-	-	16460 (3.80%)	12368 (5.19%)
At Private	-		13374 (3.09%)	7507 (3.13%)
% of anaemic women out of total registered pregnancies	-	-	298334 (49.57%)	191655 (55.91%)
% of severely anaemic women out of total anaemic pregnant women	-	-	39589 (6.57%)	19909 (5.80%)

Achievements

Activity	Up to 2011-12 (cumulative)	In financial year 2012-13 (till Nov)
No. of fully functional FRUs	34	35
No. of fully functional 24x7 PHCs	308	315
No. of Blood bank licensed and functional	64 (Pvt. + Govt.)	66 (Pvt. + Govt.)
No. of Blood Bank non-functional due to any reason	4	5 Pvt.
No. of Blood Storage Units licensed and functional	25 (Approved by SDC)	27 (Approved by SDC)
No. of Blood Storage Units non functional due to any reason	15	17
No. of VHNDs held	102267	52182
No. Trained in LSAS	39 (31 old + 8 New)	46 (39 Old + 7 New)
No. Trained in BEmOC	163	81
No. Trained in EmOC	104 (89 Old + 15 New)	123 (104 Old + 19 New)
No. Trained in SBA	1192	607
No. Trained in MTP	300	20
No. Trained in RTI/STI	965	631
No. of Maternal Deaths reported	360	219
No. of Maternal Deaths reviewed	360	219

Annexure C: Financial Progress of NRHM

Rs. In Lakh

S.No	RCH Activity	2010-11			2011-12			2012-13		
		PIP	Utilization	%age Utilisation of PIP	PIP	Utilization	%age Utilisation of PIP	PIP	Utilization	%age Utilisation of PIP
A.1	Maternal Health	841.59	598.04	71.06%	1085.97	1085.15	99.92%	2983.49	1729.79	57.98%
A.2	Child Health	352.39	101.46	28.79%	742.61	430.35	57.95%	484.79	177.84	36.68%
A.3	Family Planning Services	1069.61	541.07	50.59%	1204.25	603.51	50.12%	1877.54	753.26	40.12%
A.4	Adolescent Reproductive and Sexual Health/Arsh	40.65	12.10	29.76%	241.14	127.35	52.81%	362.55	264.63	72.99%
A.5	Urban RCH	1097.06	913.73	83.29%	920	905.7	98.45%	920	1102.20	119.80%
A7	PNDT ACTIVITIES				90.16	41.76	46.32%	92.36	62.10	67.23%
A.9	Innovations/PPP/ NGO	80.6	144.10	178.78%			0.00%	0	0.00	0.00%
A10	Infrastructure & Human Resources	2043.59	1615.73	79.06%	4625.72	4405.01	95.23%	4885.66	5414.51	110.82%
A.11	Institutional Strengthening	39.78	3.12	7.83%			0.00%	0	0.00	0.00%
A.12	Training	825.94	525.98	63.68%	797.09	628.83	78.89%	1387.98	864.84	62.31%
A.13	BCC / IEC	191	124.11	64.98%			0.00%	0	0.00	0.00%
A.14	Procurement	1510.44	1763.04	116.72%			0.00%	0	0.00	0.00%
A.15	Programme Management	617.08	426.37	69.09%	680.01	547.11	80.46%	2374.88	1104.83	46.52%
	purchase of fixed assets		21.70	0.00%			0.00%	0	0.00	0.00%
	Total	**8709.73**	**6790.55**	**77.97%**	**10386.95**	**8774.77**	**84.48%**	**15369.25**	**11473.98**	**74.66%**

Rs in Lakh										
S.No	Mission Flexipool Activity	2010-11			2011-12			2012-13		
		pip	Utilization	%age Utilisation of PIP	pip	Utilization	%age Utilisation of PIP	pip	Utilization	%age Utilisation of PIP
B1	ASHA	732.40	1037.76	141.69%	596.09	590.79	99.11%	1319.86	1744.72	132.19%
B2	Untied Funds	1021.94	936.60	91.65%	1021.90	433.87	42.46%	435.40	401.36	92.18%
B3	Hospital Strengthening	200.00	66.22	33.11%	64.38	94.30	146.48%	175.30	87.23	49.76%
B4	Annual Maintenance Grants	531.00	427.73	80.55%	375.70	326.02	86.78%	385.03	398.96	103.62%
B5	New Constructions/ Renovation and Settingup	2037.84	2620.98	128.62%	1469.00	2469.00	168.07%	4522.35	3068.85	67.86%
B6	Corpus Grants to HMS/RKS	558.00	509.74	91.35%	563.00	508.61	90.34%	510.59	536.03	104.98%
B7	District Action Plans (Including Block, Village)	0.00	0.00	#DIV/0!	10.00	0.00	0.00%	21.00	0.00	0.00%
B8	Panchayti Raj Initiative	0.00	0.00	#DIV/0!	25.00	0.44	1.76%	75.83	30.91	40.76%
B9	Mainstreaming of AYUSH	400.00	314.82	78.71%	371.36	489.29	131.76%	851.14	759.05	89.18%
B10	IEC-BCC NRHM	300.00	537.68	179.23%	621.08	379.41	61.09%	558.60	427.60	76.55%
B11	Mobile Medical Units (Including recurring expenditures)	39.09	18.34	46.92%	43.49	25.35	58.29%	44.95	24.76	55.09%
B12	Referral Transport	1560.20	874.04	56.02%	1513.43	1837.24	121.40%	1257.16	1401.91	111.51%
B13	School Health Programme	100.00	1.05	1.05%	0.00	0.00	0.00%	0.00	0.00	0.00%
B14	Additional Contractual Staff (Selection, Training, Remuneration)	2525.96	2195.76	86.93%	0.00	0.00	0.00%	12.10	3.00	24.81%
B15	PPP/ NGOs			#DIV/0!	0.00	49.33	0.00%	1009.60	785.52	77.80%
B16	Training	98.04	4.46	4.55%	0.00	0.00	0.00%	0.00	0.00	0.00%
B17	Incentives Schemes	150.00	96.09	64.06%	0.00	0.00	0.00%	165.98	155.74	93.83%
B18	Planning, Implementation and Monitoring	605.59	296.10	48.89%	495.64	345.65	69.74%	682.24	332.34	48.71%
B19	Procurements	600.00	739.33	123.22%	2126.80	1940.25	91.23%	3118.51	2404.06	77.09%

B20	PNDT Activities	0.00	2.44	0.00%	0.00	0.00	0.00%	38.00	9.98	26.26%
B21	Regional drugs warehouses	196.55	258.44	131.49%	181.97	138.26	75.98%	99.60	42.85	43.02%
B22	New Initiatives/ Strategic Interventions (As per State health policy)	473.90	193.08	40.74%	307.04	217.20	70.74%	52.32	3.46	6.62%
B23	Health Insurance Scheme	0.00	0.00	0.00%	0.00	0.00	0.00%		20.72	0.00%
B24	Research, Studies, Analysis	0.00	0.00	0.00%	0.00	0.00	0.00%			
B25	State level health resources center(SHSRC)	230.92	14.42	6.25%	0.00	0.00	0.00%			
B26	Support Services	52.68	5.77	10.95%	38.58	0.00	0.00%			
B27	NRHM Management Costs/ Contingencies	0.00	18.14	0.00%	0.00	0.00	0.00%			
B.28	Other Expenditures (Power Backup, Convergence etc)	0.00	25.89	0.00%	0.00	12.94	0.00%			
	purchase of fixed asset	0.00	5.85	0.00%	0.00	12.71	0.00%			
	Total	**12414.11**	**11200.71**	**90.23%**	**9824.46**	**9870.67**	**100.47%**	**15335.56**	**12639.05**	**82.42%**