

**UTTAR
PRADESH**

7TH COMMON REVIEW MISSION REPORT

**National Rural Health Mission,
Ministry of Health and Family Welfare**

INTRODUCTION

The Seventh Common Review Mission (CRM-7) team to Uttar Pradesh to review the implementation of the Reproductive and Child Health II Program (RCH-II) programme in the state visited the state and two of its districts **Pratapgarh and Mathura** from 8th-15th November 2013.

The team comprised of Government officials from various programme divisions, technical agency, development partners and representatives from the state; the list of names is given at Annexure-I. To gain a comprehensive perspective the team visited health facilities at all levels along with interactions with beneficiaries and community members, the list of facilities covered is given at Annexure -II

Key activities undertaken by the team during the visit were:

- Assessment of facilities for infrastructure, manpower and other resources and the services provided
- Review of records and reports
- Qualitative analysis through Focus Group Discussions (FGDs) and In depth interviews (IDIs) with beneficiaries, relatives of patients and service providers including Medical Officers , Program Managers , ANMs , AWWs and ASHAs.

The National briefing on 8th September'13 was followed by a state briefing session at Lucknow on 9th November, 2013 chaired by Mr.Amit Kumar Ghosh, Mission Director, National Health Mission, Government of Uttar Pradesh, the team was briefed about the progress, status of implementation of various programs, new initiatives being undertaken and the challenges being faced by the state.

The state visit was concluded with a debriefing session on 15th November, 2013 at Lucknow under the chairmanship of Mission Director, NRHM, UP. All Key health officials including Director Health Services, representatives from SIHFW, lead development partner & technical agency SIFSA, Consultants and officers from State Health Society and representatives were present in this meeting where the team gave a detailed presentation highlighting the achievements and the gaps observed in the two districts during the field visit along with a direction towards future course of action; MD NRHM and the state officials responded to these in detail and assured necessary action.

The team would like to acknowledge the facilitation of the review process by Government of Madhya Pradesh and specifically the district officials of the two districts visited and their responses to various issues raised by the CRM team.





BACKGROUND

Uttar Pradesh is the most populous state in the country with 19.96 crore inhabitants according to 2011 census. It covers an area of 2,40,928 Square km, equal to 6.88% of the total area of India making it the fifth largest Indian state by area. Hindi is the official and most widely spoken language in its 75 districts, 18 administrative divisions, 312 tehsils, 51914 Gram Panchayat, 822 development blocks and 107480 villages. The State is divided into four economic regions - Western Region, Central Region, Eastern Region and Budelkhand. In addition to 19 High Priority Districts (Faizabad, Sant Kabir Nagar, Hardoi, Barabanki, Pilibhit, Kheri, Sitapur, Bareilly, Gonda, Kaushambi, Kanshiram Nagar, Shahjahanpur, Siddhartha Nagar, Bahraich, Budaun, Balrampur, Shrawasti, Sonbhadra), state has identified 6 more- Kannauj, Mirzapur, Farukhabad, Allahbad, Rampur, Maharajganj

Demographic Profile

Indicator	Uttar Pradesh	Pratapgarh	Mathura
Total Population	19.95 Crores	32.09Lakhs	25.41 Lakhs
Rural Population	15.51 Crores	30.33Lakhs	18.26 Lakhs
Male population	10.44 Crores	15.91Lakhs	13.68 Lakhs
Female Population	9.51 Crores	15.82 Lakhs	11.73 Lakhs
Sex Ratio#	944	994	873
Literacy Rate#	69.72	73.10%	72.65%
Crude Birth Rate#	27.4	24.9	22.7

*Source: Census 2011

#AHS 10-11

Health Profile- Indicators & Infrastructure

Indicator	Uttar Pradesh	Pratapgarh	Mathura
Maternal Mortality rate	359	442	281
Infant Mortality Rate	53	88	45

Under-5 Mortality rate	73	113	60
Total Fertility Rate	3.4	3.4	3.7
Health Infrastructure			
District Hospital	152 (including DWH & Combined hospitals)	2	3
Community Health Centres	515	17	7
Primary Health Centres +APHCs	3692	71	4+25
Sub Health Centres	20521	360	205

OBSERVATIONS

There has been a considerable improvement during the mission period the MMR in Uttar Pradesh has decreased from 517 in 2001-03 to 345 in 2010-11 (Source:AHS). However, the State has still a long way to go to achieve the target of taking it to less than 100. In terms of IMR, State has progressed considerably from 76 in 2003 to 53 in 2012, although a lot more needs to be done to achieve the target of lowering it to less than 30. State has a high TFR of 3.4 (2011) which has been lowered from 4.4 in 2003, this is nowhere close to the target of 2.1.

Service delivery has also seen an improvement. The Institutional deliveries have gone up from 24.5% (DLHS-III, 2007-08) to 40.1% (SRS) and 62.1% (CES, 2009). The Safe deliveries/ Skill Birth Attendance (Delivery by Doctor, ANM/Nurse/LHV) has increased from 30% (DLHS-III, 2007-08) to 64.2% (CES, 2009) and the unsafe deliveries: Deliveries by untrained functionaries have simultaneously reduced from 42.5% in 2005 to 35.5 % in 2010. (Source: SRS). Also, the 3 + ANC Coverage has increased from 21.9% (DLHS-III, 2007-08) to 38.2% (CES, 2009).

Part I- Strengths

Administration

- The districts have commendable leadership which is mainly attributed to the proactive District Collectors and Chief Medical Officers, who are receptive to new ideas and aspire for improvement and implementation of the programme.

Infrastructure

- The facilities visited were neat, clean and had a good upkeep across all levels of health facilities.
- The services including Out Patient, emergencies and delivery at delivery points were available round the clock.
- In district Mathura, two well-maintained modular Operation theatres with adequate equipments at District Combined Hospital and one Ophthalmic Modular Operation Theatre in District Male Hospital were available.
- In Pratapgarh, the Sick Newborn Care Unit and the Nutritional Rehabilitation centres at the District Womens Hoapital were well functioning.
- The cold chain was well maintained across all levels of health facilities.
- Adherence to infection prevention protocols at most facilities visited at Mathura
- Referral transport (108 Ambulances) were well functioning and the state is under process of introducing more vehicles for ensuring drop back facilities to the JSSK beneficiaries. The ambulances transport approximately 6 patients per day and till date approx 15 lakh patients have benefited from the service.

Programme Implementation

- Micro plan for immunization being generated and available
- Training Sites and the trained staff for PPIUCD has been increased in the state and counseling was also made an important part of the training; at DWH, Mathura PPIUCD inserted in more than 10% of deliveries
- RBSK – CM’s priority programme; adequate attention given, meeting and review undertaken by Chief Secretary for implementation.
- RBSK & WIFS programme has been integrated with the school health program in the state. The program is well functioning with regular screening and good record keeping in schools covered till date. Health cards were issued and maintained which was observed by the team in the school at Baraipur, Pratapgarh.
- The RNTCP program is functioning well in the state. Leprosy elimination level achieved across the state however surveillance is continued.
- No disease burden for Dengue, Chikungunia, Filariasis, Kala-Azar in the districts visited.
- Outreach Camps for Blindness control program being organized by NGOs at Mathura
- Essential Drug List and JSY, JSSK entitlements were well displayed at most health facilities visited.

Programme Management & Finance

- Supervisory staff and nodal officers for various programmes and activities are available from division to block level in adequate numbers.
- Good reporting and surveillance under IDSP at Pratapgarh was observed. Form P and L were being filled and analyzed with trends also being monitored.
- Facility based reporting under HMIS being done
- State level Quality assurance cell has been put in place and the Family Planning QA committee is functional at Mathura.
- E-transfer up to Block PHC level and Tally up to district is currently operational.
- RKS, Untied Fund, AMG funds generally available at all levels

Part II- Areas of Concern

ToR I- Service Delivery

▪ Delivery points-

- In the state out of 20,521 Sub centers; 3510 SCs are conducting >3 deliveries per month (17%), Out of 417 24X7 PHCs, 388 are functional as delivery points; conducting > 10 deliveries per month (93%)
- 95 FRUs (CHC and other FRUs excluding DHs) conduct >20 deliveries per month while 70 conduct C-Sections, All 81 DHs/DWHs conduct >50 deliveries per month while 69 of them conduct C-Sections and all the 9 Medical Colleges conduct C sections and >50 deliveries per month.
- In the districts visited facilities currently functioning as DPs were 26.25% (Pratapgarh) and 18% (Mathura) as compared to total facilities in the district. DPs were inadequate and not uniformly distributed in both the districts.
- There was a gross mismatch between service demand and availability of beds at Pratapgarh and a significant under utilization at Mathura
- Client perspective and attention to dignity & privacy missing at all DPs, including labor room and OT at Pratapgarh with no restriction to entry of the attendants accompanying the patients in the wards and labor room and bedside blinds and curtains in place especially in facilities with high caseload. However the situation fairly good at Mathura.

▪ Outreach services-

- Services are being provided to the the community at their doorsteps through Village Health & Nutrition Day and wherein immunization, ANC and PNC check are being provided to beneficiaries.
- Sterilization camps are also being organized which intimidated to the frontline workers who then mobilize the beneficiaries accordingly.

▪ Support Services-

- Sub-contracting for support services not in place;
- Central Sterile Service Department guidelines have been shared by state. The guidelines have directed the district to take up housekeeping service on a fixed uniform rate due to which the districts are facing difficulty to engage agencies for facilities with varying caseloads. Thus the guidelines are not comprehensive and needs improvement in terms of specifications as per technical protocols.
- Infection prevention & bio-medical waste management services outsourced and available at both places but adherence to protocols missing in Pratapgarh

▪ IEC/BCC-

- A state-wide IEC/BCC campaign “Hausla” (meaning ‘encouragement’ or ‘morale’ in English) has been planned, however no specific BCC strategy or plan was visible at district level during the visit. There were no specific

monitoring plans, indicators and outcomes for communication interventions either.

- The state has a separate BCC cell in the State Programme Management Unit but it needs to be revamped and revitalized with clear accountability to deliverables, for effective implementation of the programme.
- Limited funds have been earmarked for IEC and BCC activities for the state resulting in low visibility for the programme. Moreover, there is lack of understanding among programme managers on demand-side issues (which can be addressed through effective communication by service providers, for improved utilization of services).
- Communication is happening on an ad-hoc basis with no proper planning. Although Health Education Officers are in position, they lack basic understanding of BCC (including a mix of different communication methods, approaches and channels for communication) and the role of effective communication in bringing about behaviour change in the community.
- IEC prototypes are shared by the state and districts print the IEC material as per their requirement. However, visibility of the programme leaves much to be desired.
- On the positive side, at both Pratapgarh and Mathura, EDL, JSY and JSSK entitlements were displayed prominently and strategically at most of the health facilities visited. Citizen's charter was also displayed prominently at most of facilities visited.
- IEC activities were limited to wall paintings and posters at health facilities, with no focus on inter-personal counseling and communication by ASHAs, ANMs and other staff at health facility to generate awareness and demand for services in the community. Moreover, IEC material was very limited and at most places, it was not effective due to varied reasons -
 - In Kunda CHC, pamphlets with large amount of text were handed out to women post-delivery with no effort made to explain the messages. As a result, women were completely unaware of the messages it contained and its importance.
 - At maternity centres, messages on routine immunization and breastfeeding were painted but almost all the women interacted with had not read them. To make them attractive for the target audience, efforts should be made to make them more pictorial.
 - There was no IEC material on routine immunization at the BCHC and BPHC. At the District Hospital, the wall painting on the RI schedule in the immunization room had the old schedule (without the Hep B and JE vaccine). Moreover, ANMs administering RI to children were not giving out the 4 key messages to mothers/caregivers.
 - IEC materials were also placed on an ad-hoc basis - poster on ANC was put up in PNC ward at BCHC; a tin plate on IUCD was placed in the cold chain store. At one health facility, even the do's & don'ts displayed in the labor room were in English.

- There is no definite space for the FP counsellor at the district hospital for conducting counselling sessions; moreover the hospital with its huge patient load needs additional FP counsellors.
 - At the district hospital, the PPTCT area was a narrow corridor cramped with women waiting for their turn, a health education film was playing on TV placed high on the wall with low volume and no patient was even interested in watching.
 - Ferro has been outsourced for management of bio-medical waste, posters on use of dustbins for waste disposal has been put up but most of the staff interacted with at health facilities are not comprehending them; moreover the posters are not culturally contextual.
- Monthly meetings are presently only a platform for submission of reports. They could be better structured for strengthening on-job communication skills and capacity building of ASHAs and ANMs with active participation of BPM and MOIC.
- An integrated approach for BCC interventions was lacking. Social mobilization activities and advocacy initiatives are mostly being done by development partner organization/agencies in specific intervention areas. With BMGF being the state lead partner, effective coordination mechanisms need to be put in place for leveraging resources and strengthened programme communication at all levels.
- Ambulance & Referral Services-
 - 988 GPS fitted ambulances are functional under 108 service and 972 ambulances (Non GPS fitted) are operating in the State under 102 service. However, 102 call centres has not been established in the State.
- Mobile medical Units are currently non functional across the state.

ToR II- Reproductive and Child Health

- Planning
 - No comprehensive plan available at district and facility level for ensuring availability, adequacy and accessibility of EmOC, BEmOC, Family Planning, Child Health and Adolescent health services.
 - No initiative at block/community level for bringing home deliveries into institutional fold.
 - Initiatives for promoting various basket of choices for family planning needs strengthening at the strategy design level.
- Services& Quality
 - Essential services are being delivered in health facilities but technical protocols and quality parameters are grossly compromised. In the facilities visited, Labor rooms and NBCC are not adhering to technical protocols,

except at DWH and Combined Hospital at Mathura. SHC still continue to use 200 Watt bulbs as new born care corner.

- Partographs being made at DHs and few facilities down below; however correctness is an issue which needs improvement..
- Steps of AMTSL, management of PPH, components of ENBC, resuscitation steps and key technical protocols completely missing, staff which provides services are neither trained nor are being supported for technical skills.
- Inadequate EmOC services in both districts (C-section rate only 2% at Pratapgarh and 1.4% at Mathura); no plans in place for improving EmOC services
- Inadequate blood bank facility as compared to the delivery load in the facilities. Only 1 blood bank functional in each district - in Male Hospital;
- There are no New born Stabilization Units available and functional in any facility hence after newborn care corners the next referral is straight to the district hospital SNCU inspite of other level 3 facilities identified in the districts, as a result it poses a lot of burden to a single facility.
- CAC available upto district level, but availability of trained manpower and services below district level is an issue.
- Routine diagnostic services upto Block PHC while USG upto district level; emergency diagnostic not guaranteed at any level
- Weak outreach and home visits for ANC, PNC, identification of ARI, diarrhoea and malnourished children
- No line listing of severely anaemic women and identification of high-risk pregnancies being done at SHC/PHC
- Family Planning-
 - PPIUCD not initiated in Pratapgarh; available at District Women Hospital and combined hospital in Mathura
 - Fixed day FP services not available in both districts; however fixed day camp services for sterilization available at both places
 - Nischay Kits mostly available, however expired stock found in 1 ASHA kit in Mathura
 - Free supplies for FP commodities available in Mathura, missing in Pratapgarh
 - Except for IUCD-375, other FP commodities available at Mathura
 - Eligible couple registers not available/not updated
 - Lack of awareness and demand for FP commodities, especially among spouse and in-laws
 - No efforts for improving FP services and coverage
- Malnutrition- Only 1 functional and well maintained NRC at DH Pratapgarh, however admission through outreach referrals was only 14% indicating poor detection and referral by frontline workers.
- Community Level HBNC not yet implemented - ASHA training module (1st round, 6th module) underway

- Death Reporting/Audit- Maternal deaths under reported, poor review quality (external auditor in Pratapgarh an AYUSH doctor, not skilled and competent for conducting MDR); even the collector was dissatisfied with MDR review/reporting quality and infant DR not yet initiated in the districts visited.
- Immunization- Full immunization -72.6% in Pratapgarh, 20% in Mathura (AHS 2010-11), 72.1% in Pratapgarh, 49% in Mathura (as per monitoring data of WHO, UNICEF, MCHIP, MI, Govt.)
 - Well maintained cold chain, vaccines available, micro plan are being generated and available
 - RI cards are not duly filled-up by ANM; either lost/not available with beneficiaries
 - Wastage of vaccines is not being assessed.
 - Due list information is captured on loose sheets, as a result follow-up and tracking is not being done
- ARSH- ARSH clinics not implemented in any of the districts visited. The menstrual hygiene also not yet implemented in both districts. WIFS implemented in schools going children so far; it is yet to be extended for out-of-school children
- Under RBSK the record keeping was found to be good in the schools visited. Children were being screened and treatment and referral for diseases was found to be satisfactory. However, improvement is needed for treatment and referral of deformities and disability and the follow-up of identified cases needs to be strengthened.
- Essential Drugs-
 - Inj. Methergin being used as uterotonic at few places; labor being augmented by Inj. Oxytocin
 - Inj. Oxytocin not available at most places in Pratapgarh, however adequate availability in Mathura
 - Other essential drugs available at Pratapgarh but not at Mathura
 - IFA and ORS supplies mostly available; Zinc available at few facilities
- JSSK & JSY
 - JSSK free entitlements for pregnant women being implemented but entitlements for infants require strengthening.
 - At Pratapgarh, user fees were being charged from everyone including pregnant women.
 - 108 services generally used for bringing women to DPs in Pratapgarh; only 10-20% women availed services in Mathura
 - The drop back facility is very poor in both the districts visited (32% in Pratapgarh, 28% in Mathura)
 - In Pratapgarh, Out-of-pocket expenses reported by beneficiaries on diagnostics and at few places in Mathura, out-of-pocket expenses by beneficiaries on drugs/diet/blood/consumables; beneficiaries was also reported.

- Bearer cheques for JSY being issued at discharge at district level facility; however an average delay varying from 15 to 30 days below district level was reported during interactions with beneficiaries.
- Adequate JSY record keeping was generally observed across facilities however a couple facility JSY records did not have receiving signatures of the beneficiaries in spite of cheques being distributed.
- Disturbing complaints at facility and community level of informal payments being demanded for delivery, IV fluids etc.
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Recommendations

- Comprehensive planning for all DPs to be assessed on priority in terms of (along with timeline for gap filing) –
 - ✓ Infrastructure
 - ✓ HR and training
 - ✓ Equipment & drugs
 - ✓ Residential accommodation
- All DPs must be assessed for all services related to RMNCH+A
- Critical services like PPIUCD, Quality delivery services, ENBC and resuscitation, ARSH clinics, Safe Abortion Services, MDR, IDR, etc must be undertaken
- Service providers at all DPs should be quickly oriented on technical protocols and guidelines on priority for building their capacity to deliver quality RMNCH+A services.
- More number of facilities for EmOC needs to be operationalized and already operational facilities need performance monitoring
- Blood bank, BSUs requirement should be linked with functional and proposed Level 3 delivery points
- Sterilization of labour room, OT, autoclaving of equipments are crucial activities for ensuring infection prevention
- Infection prevention protocols like training adherence to practices, segregation, transportation and BMW should be linked and must be ensured at all delivery points
- All high volume delivery facilities should have a nodal officer designated among the existing staff as Quality Control Officer, so as to follow the practices on day to day basis
- MOUs for contract services should have clauses to ensure that protocols designed and defined by GoI/State are built-in. Termination clauses of contract should be clearly laid down.
- Periodic clinical and prescription audits at high load facilities should be undertaken
- Maternal death review should be undertaken by qualified personnel and review findings must be linked with programmatic gaps so that corrective actions can be taken
- Ultrasound and auto analyzers should be placed at all district hospitals
- Convergence between 108 and 102 services needs to be ensured with both vehicles being linked to centralized call service and GPS tracking

- Free entitlements under JSSK for infants and neonates should be monitored on regular basis and can be a default indicator for the success of JSSK implementation
- User charges for JSSK beneficiaries should be immediately waived off
- JSY payment should be account payee and must be issued at the time of discharge
- Requirement of photographs and other documents can be reduced and ASHAs be oriented for bringing all necessary documents at the time of delivery
- Grievance redressal system needs to be strengthened for eliminating out of pocket expenses incurred by beneficiaries or their attendants.
- Fixed day FP services should be implemented at all delivery points
- PPIUCD must be ensured at district level and all FRUs providing EmoC services
- Sterilization camps being organized should be conducted throughout the year instead of being season specific
- Sterilization protocols in these camps must be ensured for improving quality of sterilization
- Eligible couple register should be updated on priority
- Outreach services like VHND, immunization sessions should be held comprehensively at all AWC or other designated places as per micro plan generated
- Growth monitoring of infants & children through convergence with ICDS needs strengthening with referral linkage
- Follow up visits for ANCs as per the due list should be generated through MCTS
- IPC through ASHA, ANM, AWW and HEO needs strengthening
- Community processes for PRIs, community, ASHA and other stakeholders needs more orientation and close follow up for effective outcome
- Coverage for out of school children under RBSK should be initiated
- ASHA on HBNC module needs to be expedited for implementation of HBNC visits
- Line listing and follow-up of severely anemic women to be ensured at all SHCs and PHCs
- Regular Zinc and ORS supply must be ensured at all SHCs
- All supplies to health facilities must be linked with demand and utilization of drugs
- Supplies like IV Sucrose, IV fluid must not be pushed to SHCs
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ToR III National Disease Control Program

Integrated Disease Control Program

- Facility reporting and field level surveillance report available at Pratapgarh; however B/L MOICs not aware about surveillance process and facility level reporting (as reports are being generated by concerned staff and sent to district)
- At Mathura, the same is missing due to non availability of HR

National Vector Borne Disease Control Program

- No disease burden on JE, Kala-Azar, Dengue, Chikungunia and filariasis in both the districts.
- Not an endemic area for Malaria but the slides for cases of fever are being prepared and examined.

Revised National Tuberculosis Control Program

- Well run RNTCP program and Cure rate is achieved in both the districts and Drugs are available both for 1st and 2nd line.
- ASHAs are aware and have a major contribution as DOT provider.
- State has registered an increasing trend of cross referrals (2010- 5%, 2011-13%, 2012 -26%, 2013- 32%)
- Proportion of TB-HIV co-infected patients receiving HIV care and support has shown an increasing trend (2010- 24%, 2011-44%, 2012 -50%, 2013- 61%)
- Under RNTCP around 600 old posts and around 250 new posts vacant across the state
- Detection rate is at plateau in both the districts.
- 76% of the Tb cases is being reported through Nikshay
- Detection of Paediatric Tb cases is having a declining trend (from 7-to 5%) against the national average (10-15%) indicating program weakness.
- INH prophylaxis is almost negligible in both the districts despite availability of drugs
- Only 11% of facilities are co-located (DMC with ICTC), which shows an increasing trend

National Leprosy Elimination Program

- State has achieved elimination of leprosy and is maintaining elimination at state level, basic surveillance for detection of new cases is continued
- Both Districts visited are low endemic and have achieved the level of elimination

No other national programs under NCD flexipool is being implemented in both the districts

National Prevention of Blindness Control Program

- Only one eye camp at Pratapgarh however NGO run camps are being organized at Mathura.
- In Mathura, 4196 (out of 4206 cases) operated for cataract were IOL; while in Pratapgarh it was 2352 (out of 2751 cases)
- School health camps for detecting visual errors now merged with school health program under RBSK.

- Target for distribution of spectacles is being achieved however the spectacles are not being given to all children identified with refractory errors.

ToR IV Human Resource and Training

- Availability
 - 37% vacancies amongst regular staff seen in Mathura District.
 - High vacancy rate seen among critical staff. For instance, vacancies of SNs (regular staff) are 75% in Mathura and 72% in Pratapgarh. Majority of the staff nurses are hired on contractual basis and efforts for filling up regular positions needs to be accelerated.
 - Critical gaps seen in rational deployment of HR. In Mathura, there is no provision for second ANM at sub centre.
 - Shortage/ non-availability of specialists, especially at below district level. (e.g. gynec, pediatricians, anesthetist) which affects delivery of RMNCH+A services.
 - It was mentioned during interaction at the district level that all cadres of all medical officers (including specialists) have been merged as a general cadre
 - At district level, Non availability of Specialists below district level, where available their pairing is not rational; no plan for filling these gaps through skill based training
 - AYUSH doctors to be more effectively utilized (e.g. for supportive supervision, Family Planning etc) with clear demarcation of roles at PHC and below level.
 - While there has been increase in the HR in the various facilities, during the visit to the facilities, corresponding increase in service utilization in terms of patient load (IPD/OPD) was not very visible.
- Deployment:
 - No rational plan for deployment of HR in critical areas like Labour Room, SNCU, Family Planning services etc. after getting trained in these skills.
 - Rotation of staff nurses in labour rooms. Non rotational posting orders still not in place.
 - No rationalization of load between laboratory technicians hired through various programs (e.g. RNTCP and NRHM). Mismatch between investigation load seen. LTs not comprehensively oriented, as a result the regular LTs doing routine tests are over burdened whereas LTs from vertical programmes are grossly underutilized. Need for integration and multi-skilling of Lab Technicians and other paramedics to improve availability of diagnostic services.
 - Gross inadequacy and mismatch between service delivery units (LR, SNCU, NBCC, FP etc) and availability of trained HR
 - Mismatch between skills and placement. For instance, two doctors had multi-skilled training but were not posted at EMoC facility. Also, there appears to be no plan on how to fill these gaps through skill-based training.

- No performance related incentives to HR across levels.
- Workforce Management
 - A performance appraisal format is available for contractual staff. However, the same is not appropriately designed. The nature of information captured and its subsequent use for decision making needs to be reviewed.
 - Daily performance sheets for doctors are too lengthy which are neither analyzed at district level nor linked with total performance of the facility and its output - stand alone proforma not serving its optimal utility
 - Presently, these reviews are being conducted on a monthly basis. The same could be rationalized.
 - Further, while performance of contractual staff is being monitored at the facility level, it is unclear how the attribution of results is being done at an individual level. Staff productivity to be monitored.
 - Mechanism for marking daily attendance of all doctors (regular staff) through daily attendance sheets is underway across the state. These performas are compiled at the state level, but these need to be analyzed and linked to the performance of the facility and district.
 - At certain facilities, despite availability of all specialists (anesthetist, orthopaedic, surgeons) no surgeries being undertaken; no performance monitoring of health facility.
 - Designated work of employees (FP counsellor & BF counsellor, HMIS & MCTS data entry operators, DPMs, DCMs and BPMs, HEOs and Computer/ARO) is not being monitored
 - Reports of Informal payments by lower cadre staff leading to out of pocket expenses despite JSSK, JSY.
- Training And Capacity Building
 - No rational & comprehensive plan for calculating training loads from delivery points or functioning facilities followed by need based capacity building.
 - Centralized data at district level on the number of persons trained under various trainings was not readily available and had to be computed on request. (see table below). Moreover, no systems established either for any follow up or monitoring performance of the trainees.
 - No road map for strengthening of pre service teaching and training of ANMTCs & GNMTCs in place and no steps taken for improving faculty positions. In ANMTC, Mathura, Training infrastructure, including HR inadequate. Position of all 3 tutors (regular staff) are vacant.
 - Inadequate capacity-building efforts coupled with the lack of a rational workforce policy hampers quality of services provided.
 - Majority of ANMs are not SBA trained (district level issue) – in cases where she is trained – its outdated – ANM last trained 4-5 years ago

- Key concern: HR data figures provided to the team (in hand written formats or different versions of various documents) do not tally.

RECOMMENDATIONS

- HR planning and management must be strengthened at all levels. HR mapping and analysis should be done at state and district level. Based on this, a comprehensive HR Strategy for regular and contractual staff at all levels should be prepared and implemented.
- The state must fill up their vacant regular HR positions. Huge vacancies under state health services needs to be filled on priority and walk in interviews involving NHSRC or GOI representatives can be organized to fill the existing vacancies.
- Rational deployment and gap filling through skilled based trainings and regular recruitment should be initiated on priority. Along with this, redistribution of HR from non-functional or less utilized facilities to a functional and high volume facility to be undertaken.
- All HR working in critical service area like labour room, OT, SNCU, CSU must not be rotated to other departments and such necessary orders should be issued.
- An incentive mechanism for doctors, nurses and other cadres – regular and contractual – to be developed and implemented on priority. Incentives can be provided for hard to reach/remote/difficult areas, coupled with an additional performance based incentive for both regular and contractual staff.
- Second ANM needed at Sub-centres
- Baseline assessment of competencies of all SNs, ANMs, Lab Technicians to be done and corrective action taken thereon. The same should also be linked to the training plan.
- Comprehensive revamping of training is required to build capacities for assessing functionality of training centre as per protocol, training needs, monitoring training quality along with follow-up for better performance
- Better linkage between programme and training needs to be taken up on priority.
- All HR at delivery points should be saturated with critical trainings like SBA, NSSK, IUD, etc.
- Monitoring and supportive supervision tool disseminated by GOI needs to be implemented and followed-up.
- All Programme Officers and In-charges need immediate orientation on key programme elements and monitoring.
- MOUs for contract services should have clauses to ensure that protocols designed and defined by GoI/State are built-in. Termination clauses of contract should be clearly laid down.
- Performance sheet of doctors and other HR can be redesigned so that the columns related to their performance can be filled for effective monitoring.
- ANM Training centre in Mathura District to be strengthened.
- New PHCs / Additional PHCs which have been constructed / upgraded in the past 2-3 years need to be operationalized fully, in terms of ensuring adequate skilled manpower.
- Public health cadre to be created.

PRI and VHSNC

- Out of 106704 villages, 51914 villages have constituted VHSNCs, however participation and involvement of PRIs in VHSNCs was found to be lacking.
- VHSNC meetings are not being conducted regularly and inadequate utilization of funds was observed in most of the places visited (an exception being Raniganj block in Pratapgarh). There was found to be no involvement of ASHAs in VHSNCs, especially on use of united funds.
- 3750 facilities (148 DH, 466 CHCs, 460 PHCs, 15 other than CHCs and 2661 other health facilities above SC) have been registered with RKS.
- There was no mechanism for community based monitoring, surprisingly even district officials in Pratapgarh were not familiar with the term. Monitoring by the DCM was found to be weak in both the districts, resulting in lack of orientation of PRIs and poor involvement of the community in CBM.

Village Health and Nutrition Days

- VHNDs are being conducted regularly, however major gaps were observed in the package of services provided during VHNDs in Pratapgarh -
 - Services were limited to immunization sessions for children and pregnant women, but ANC was limited to giving TT injections and distribution of IFA tablets.
 - There was no individual or group counselling by health workers on maternal and child health and nutrition issues. In a few cases, women reported consuming wrong dosage of IFA due to lack of information. Moreover, there was no assessment of reasons for delay in first dose and drop-outs.
 - Both ANM and ASHAs had due list prepared on paper by hand but work plan generated through MCTS was not available.
 - In Raipur Baghdra, Kaithola Bazar, list of eligible couples was not available with the ASHA.
 - ANMs were able to take BP but no competencies for Hb and Urine testing were found neither any equipments were available.
 - Only 1 AWW was monitoring growth chart, this was attributed to proactive supportive supervision by the ICDS Supervisor.
- There was field level convergence of ANM, ASHA and AWW in organizing VHND and promoting health awareness at the community level, however, it needs to be strengthened to ensure better monitoring and follow up of malnourished children.
- In Besaihya SC (Pratapgarh), VHND is conducted every 1st Friday of the month covering 6 ASHA areas and 6 AWWs. With such a large geographical coverage, women and children are mobilized from only 1 ASHA area adjoining the SC, while remaining areas are covered during the ANM outreach sessions, but not through structured VHNDs. While this case may seem as an aberration, it dilutes the entire concept of VHNDs.

ASHA Training & Performance

- In the state, 136094 ASHAs have been selected, of which 135130 are trained in 1st Module, 121640 ASHAs are trained upto 5th Module and 1203 ASHAs trained in Round-1 of 6th & 7th Modules. ASHA Sangini's have been recruited and trained in 17 districts of the state.
- In both the districts, ASHA's played a prominent role in motivating pregnant women for utilization of ANC services from government health facilities. Most of the ASHAs were found to be vibrant and active, for promotion of institutional deliveries and immunization, making regular visits to mothers/pregnant women in their villages and counselling them.
- Orientation of ASHAs on outreach activity for Family Planning services was found to be lacking. Awareness on FP schemes was low, especially regarding incentives for birth spacing. Implementation of home delivery of contraceptives scheme is also poor in both the districts.
- Since only a handful number of ASHAs have been trained in Round 1 of 6th & 7th Modules, their role as community level care providers is very limited. Where they have been trained, there was some awareness on the schedule of home visits as per Home Based Newborn Care Guidelines.
- Performance monitoring, mentoring and supportive supervision was lacking.
- Most drugs are not available in ASHA drug kits. Nischay Kits were being purchased by ASHAs themselves to ensure that pregnant women come along with them for delivery. Timeliness and structured mechanism for drug replenishment was also lacking.
- ASHA and ANM meeting registers are not being maintained regularly, with no structured minutes detailed out.

ASHA Incentives & Support Systems

- The state has established a system for recognition and cash reward for best performing ASHAs through annual ASHA Sammelan's.
- ASHA Resource Centre has not been established at the state level.
- ASHA restrooms/*ghar* were not available at any of the health facilities visited. As a stop gap arrangement, they use the restrooms meant for attendants of pregnant women.
- Payments of ASHA incentives is delayed by 2 to 3 months on an average.
- There is no formal mechanism for Grievance Redressal system. Monthly meetings are the only platforms where ASHAs reported their grievances being addressed.

Convergence

- Convergence between peripheral health workers for service delivery, especially for immunization services was good. However, inter-departmental coordination at district and block level needs to be strengthened.

ToR VI Information and Knowledge

- Health Management and Information System
 - The state has adequate number of staff at all levels in place right from the state to block level.

- HMIS data entry being done by block accounts manager at 2 facilities visited (in Mathura) compromising quality of output in terms of both data management and financial management.
- State is currently implementing 100% facility based reporting upto the Subcentre level.
- The data reported however is of poor quality of HMIS despite of adequate staff available hence the data managers have to be oriented and need to take up regular monitoring to ensure quality and completeness.
- There is a graving lack of awareness amongst program managers about standardised and analytical reports readily available on HMIS portal hence data utilization for programme planning and monitoring is not being undertaken at divisional, district and block level.
- MCTS
 - Mismatch in figures reported in MCTS and HMIS at Pratapgarh
 - Similar situation seen at District Combined Hospital, Vrindavan
 - Service delivery not linked with MCTS
 - Analysis of critical indicators not being undertaken at district or block levels. Thus no corrective actions possible.
- SHSRC not constituted at State level
- SIHFW and RHFWTCS needs revitalization, their involvement in dissemination of guidelines, on-job training, preparation of training load and calendars and post traing follow-up along with supportive supervision of trained staff are areas of improvement is quite weak currently. Integrated plan for monitoring, evaluation and learning to be developed for better program outcomes and adherence to protocols.

Areas of concern -

- quality of training provided
- training plans
- criteria for selection of trainees
- adequacy of faculty and clinical staff

RECOMMENDATIONS

- ASHA Resource Centre to be created for effective functioning
- State, district and block data managers must be responsible for reflecting critical indicators and their analysis by 7th of every month to their controlling officers
- Nursing roadmap for all ANMTCs and GNMTCs be developed on priority and if needed help of JHPIEGO can be taken for this
- Nursing school at KGMU and other state nodal nursing centres be involved and given responsibility for monitoring quality of pre-service teaching & training at ANMTC & GNMTCs
- Computerized Supply chain management with simple Excel sheet can be introduced immediately
- Comprehensive revamping of training is required to build capacities for assessing functionality of training centre as per protocol, training needs, monitoring training quality along with follow-up for better performance
- Better linkage between programme and training needs to be taken up on priority
- All Programme Officers and In-charges need immediate orientation on key programme elements and monitoring
- Performance sheet of doctors and other HR can be redesigned so that the columns related to their performance can be filled for effective monitoring
- Monitoring and supportive supervision tool disseminated by GOI needs to be implemented and followed-up
- HR analysis should be done at state and district level
- Rational deployment and gap filling through skilled based trainings and regular recruitment should be initiated on priority
- Deployment of HR from non-functional or less utilized facilities to a functional and high volume facility to be undertaken on priority
- Huge vacancies under state health services and particularly under RNTCP needs to be filled on priority and walk in interviews involving NHSRC or GOI representatives can be organized to fill the existing vacancies
- All supplies to the health facilities must be linked with the demand and utilization of drugs
- Orientation of PRI members and Health functionaries at VHSNC/ SC level

ToR VII Healthcare Financing

Finance & Administration

Vacancies in Finance & Accounts Staff

Vacancies have been noted in the Finance and accounts positions (mainly at District Account Managers at the District level and Senior Manager Finance at the State level). The vacancy position is given under:

S.No.	Position	Sanctioned	In Position	Vacancy	%
1.	Director Finance	1	1	0	0
2.	Senior Manager Finance	2	0	2	100%
2.	State Finance Manager	5	4	1	20%
3.	State Accounts Manager	6	6	0	0
4.	District Accounts Manager	75	63	12	16%
5.	Internal Auditor	6	4	2	33.33%
6.	Computer Operator cum accounts assistant	2	1	1	50%
7.	Block Data cum Accountants Assistant (BDAA)	820	777	43	5.24%

- In Pratapgarh District out of seventeen blocks, BDAA was in positions in 15 blocks. Two positions were vacant for more than two years.
- In Mathura District out of blocks, BDAA was in position in all the blocks.

Irrational Workload

- Contractual accountant at the block level (Block Data cum Accounts Assistant) has also been given responsibility for HMIS and other data entry work except MCTS, in addition to regular accounting activities (even though data entry operators are in place in all the blocks of the District Pratapgarh). This leads to excess work load on BDAA and also affects his routine accounting and supervisory role.
- The salary of MCTS operator and Block Programme Manager was approved at Rs. 10000/- and 20000/- respectively by GoI. However, these positions have been filled through an outsourcing agency. The salaries actually paid to the MCTS operator and Block Programme Manager (approx 5500/- and 14500/- only) are much lower than the amount agreed to be paid to the agency (i.e. Rs. 6700/- and Rs. 17000/-). Therefore there is large variation in the salaries paid by the State and amount approved by GoI which in turn affects the quality of work at the lower levels.

Lack of Training & Orientation

- No systematic orientation/ training is provided to the finance and accounts staff at sub-district level leading to inadequate understanding of financial guidelines and weaker financial management at the block and lower level. In the blocks visited, no training/ orientation was ever provided to the BDA since their appointment.
- It was also noted that the Accounting Handbooks developed by GoI for providing handholding support to the finance staff at the sub-district level were not disseminated to the blocks and the lower levels adequately. (In Mathura District, handbooks were not found in any of the units visited, even the DAM was not aware about those).

Funds Flow

Delays in disbursement of funds/ release of financial guidelines to spend

- Delays have been noted at all levels in disbursement of funds. some of the specific instances given below:
 - E.g. in Pratapgarh District,
 - Funds received at the Kunda CHC of Rs. 4.00 lakhs on 07.01.2013, however these are further transferred to lower units only on 15.03.2013- delay of approx. two months at CHC level
 - Funds were disbursed for orientation of VHSNC leader of Rs. 16.47 lakhs in March, 2013 by State to Pratapgarh District. The guideline was received from the State to District in September, 2013 which was further approved in the DHS meeting in November, 2013. Expenditure not incurred yet.
- Specific Guideline/orders are awaited at District level to initiate expenditure in the beginning of the year, despite of availability of funds from previous year. This has led to delays in even recurring expenditure like contractual salaries, etc. Instances of substantial delays in payment of contractual salaries were noted in both the districts in the current financial year.

Fund releases not necessarily linked to performance / utilization

- Funds are not released performance wise to the facilities. At few facilities, funds were exhausted at the beginning of FY, but no funds released in the current year as noticed in DWH Pratapgarh where the closing balance under RKS was Rs. 685/- as on 31.03.2013 and the same balance is with the hospital on 20.10.2013. Same case was noticed in CHC Kunda where the closing balance under RKS was Rs. 22 on 31.03.2013 and no funds were released to the facility upto October, 2013.

Issues: Banking Arrangements

- E-transfer is implemented upto the Block PHC level. Funds to some of the Sub Centres for untied funds and VHSNC are transferred through cheques.
- At some VHSNCs/SHCs, current bank accounts have been opened instead of savings bank account (example, in current accounts were noted at VHSNC/ SC level with Farah block of Mathura)

- Multiple bank accounts were noted at block level, out of which almost 35% remain non operational at all blocks, such as NIDDCP etc.(Pratapgarh District)
- Some bank accounts at SHCs are not being operated as only contractual ANMs have been posted (for e.g. Adig SHC, Mathura).

CPSMS yet to be implemented

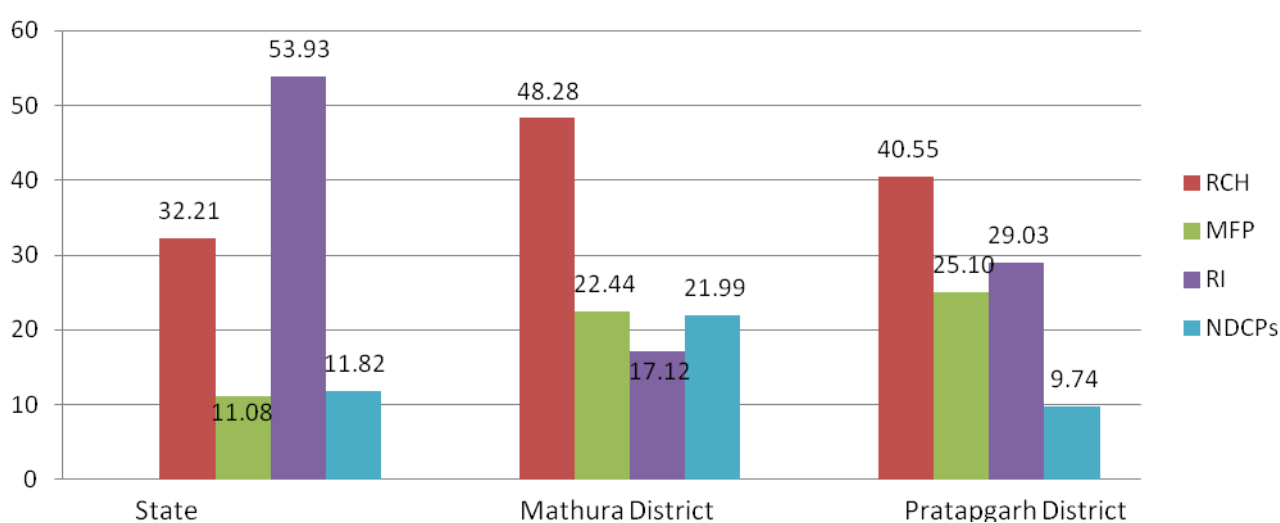
- CPSMS is yet to be operationalized from State to District and below. It was informed that initial trainings have been carried out and registration of accounts is underway.

Fund Utilization

- The utilization trend of both the districts i.e. Mathura and Pratapgarh and the State level for FY 2013-14 upto October is given below:

(Rs. in Lakhs)

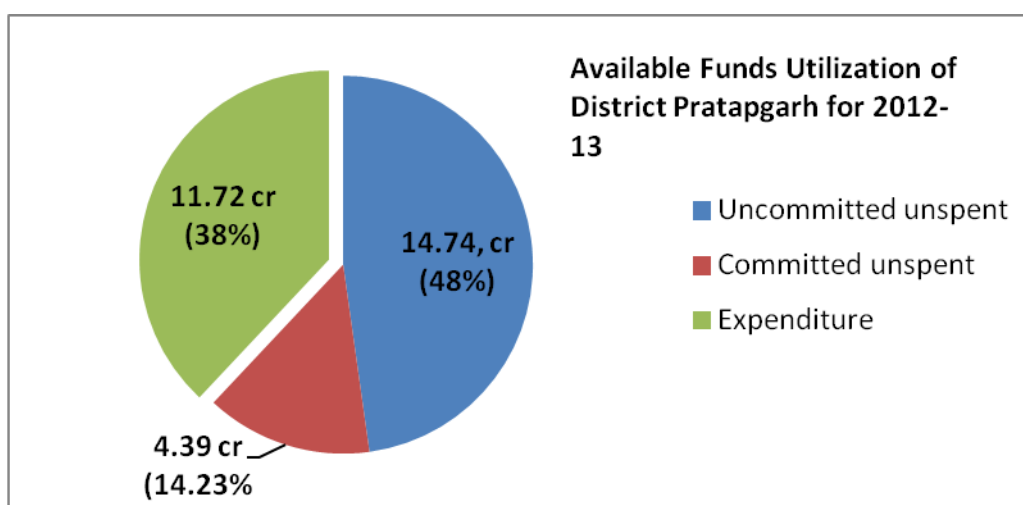
	State			Mathura District			Pratapgarh District		
Prog.	Approved Amount	Exp	% of utilization	Approved Amount	Exp	% of utilization	Approved Amount	Exp	% of utilization
RCH	120655	38858	32	1030	497	48	1754	711	41
MFP	190155	21075	11	307	69	22	617	155	25
RI	16404	2209	13	170	29	17	244	71	29
PPI	13385	5417	40		81	0		94	0
NDCPs	15121	1787	12	143	31	22	174	17	10
	355721	69345	19	1650	708	43	2789	1048	38



District Level (utilization against funds received)	FY 2012-13	FY 2013-14 (till Oct 2013)
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Pratapgarh	38%	37%
Mathura	55%	41%

- Overall utilization at the state level is quite low i.e. 19.5 %. The primary reason is extremely low utilization under Mission Flexi-pool. Key areas of low utilization are Untied funds (2%), RSK funds (3.44%), JSSK-MH (5%), FP (2.43%), training (1.14%), Hospital Strengthening (0.33%) etc.
- As per the District wise expenditure report was provided by State for 2013-14 upto October, 2013, the overall utilization of Mathura and Pratapgarh district against the available funds was 41.92% and 36.69% respectively. However, the utilization is extremely low under Mission Flexi-pool (22.97%) and RI (24.30%) in Mathura District and under Mission Flexipool (17.32%) in Pratapgarh District.
- In case of Pratapgarh District, the total approved fund available in 2012-13 was Rs. 30.85 crore. Out of which Rs. 14.74 crore was the uncommitted unspent balance and Rs. 4.39 was the committed unspent balance which shows that the district was not able to utilize almost 62% of the funds approved for DHAP 2012-13.



Huge unspent balances under Civil Works

- In Mathura District, material balances under civil construction were noted for upgradation of District Hospitals as under:
 - Rs. 2.48 Cr - Released to PACFED (in past years), not admitted by PACFED in their Expenditure statements
 - Rs. 2.16 Cr - Released to PACFED (Last year) – progress of work very slow
 - The Renovation work of ANMTC for Rs. 10 Lac is yet to commence even though the funds were released last year.

- The Strengthening of SHCs Rs. 3.48 Crores (49 SHCs X Rs. 6.9 Lac) was received in 2008-09 and are still lying in DHS account. Expenditure is still pending, awaiting necessary decisions.
- In Pratapgarh District, there is a committed unspent balance of Rs. 40.00 Lakhs under Training institutions (Rs. 10.00 lakhs) and Construction of AYUSH Wing (Rs. 30.00 Lakhs) as on 01.04.2013. Letter was issued by CMO to the various civil works agencies for the estimated cost such as UPPCL, PACCFED, PWD, RES and UP Jal Nigam only in July, 2013. But the reply was received only from PACCFED and no other agency till date. Therefore, the work was not yet started and the amount is still lying in the bank account of District Health Society.

Rogi KalyanSamitis

Lack of adequate details in RKS meeting registers

- RKS meeting registers are generally maintained, however, only administrative discussions are noted, no financial estimates/ approvals etc. are noted in most of the facilities visited in both the districts.

Lack of control over user charges collected in cash

- RKS user charges collected at facilities are not deposited on a daily basis, substantial cash balance is generally kept with the registration counter clerk. In most of the units, visited, cash is deposited on a monthly basis. For instance, at District Combined Hospital, Mathura cash amount of approx. Rs.85,000/- was available with the registration counter clerk .
- There is also huge variation in the monthly RKS user charges deposited in the bank from Rs. 1000/- to 20000/- approx. at CHC Raniganj which indicates improper management of cash.

RKS Audit requirements not complied with

- The audit of Rogi Kalyan Samiti was not conducted regularly and had been last completed upto 2010-11. No audit was done for the last two years.

Untied/ VHSNC funds.

Low utilization/ huge balances lying at the units

- The Overall utilization of untied funds at VHSNC / SC funds was very low and is only 2% of the approved budget.
- Huge fund balances were noted at SC/VHSNC level in the district noted (as on 31st Mar '13)

	SC (AMG & Untied Funds)	VHSNC
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Mathura	Rs. 68.77 Lakhs	Rs. 137 Lakhs
Pratapgarh	Rs. 30.37 Lakhs	Rs. 39.74 Lakhs

- Expenditure is not incurred at any level till guidelines are received from state with every transfer of funds even after the approval of DHAP. Therefore, the utilization is negligible during the first three months of financial year at all facilities even though funds are lying with them.
- In some cases, it was also informed that there is lack of cooperation from the GP Sarpanch, which adds to delays in incurring expenditure as he is the signing authority.

Lack of Orientation of PRI members/ Health functionaries

- Lack of adequate understanding was observed amongst PRI and health functionaries regarding where to use funds. E.g. in a few facilities, cleaning / sweeper expenses were being paid out of ANM's own pocket or through beneficiary instead of drawing them out of untied funds available. An orientation for the PRI members was planned in 2012-13 for which Rs. 9.27 crore was approved. However, no expenditure was incurred in both the districts visited.
- Rs.150 /- given to ASHA for attending VHSNC meeting – consumes large part of untied funds despite GoI circular to use ASHA incentive funds

Releases booked as expenditure at block level

- As noted in some of the facilities visited, Untied funds released by blocks to SHCs and VHSNCs are treated as expenditure without actual expenditure being incurred, and further funds are released to the same units. (e.g. Raniganj and Farah blocks).

JSY Disbursements

Delays in JSY Payments

- Delays have been noted in JSY payments at most of the facilities visited
 - 15-20 days at Block level
 - 20-30 days below block level
- Distribution of cheques below BPHC is an issue which was leading to substantial delays. Sub Centres were having high case load of deliveries all over UP. The ANM at SC or the beneficiary herself is supposed to collect the JSY cheques from the BPHC which delays the payment.

Lack of control over payments

- Bearer cheques were issued for JSY disbursements and not the account payee
- Few instances were noted where receiver's signatures were not there in the JSY register (DCH Mathura)

Old JSY cheques

- Old JSY cheques were noticed as pending for presenting in bank account. Validity of some of the cheques were expired also.

Other issues

- No estimation of outstanding liabilities of JSY payment was done at any level. Since the funds were released activity wise, improper estimation may lead to shortfall of funds in a particular activity.

Different practices were followed at various districts. In some district such as Mathura, Rs. 20-30/- paid by beneficiaries for photo proof. **Accountability**

Substantial delays noted in both Statutory Audit as well as Concurrent Statutory Audit

- There is substantial delay in completion of statutory audit for FY 2012-13. The due date for submission was 31st July, 2013, however, the audit is still underway and is expected to be completed by January 2013, which means delay of approx six months. It is also to be noted that statutory audit report for the previous year 2011-12 was also delayed by one year and received in June, 2013.

Concurrent Audit

- There are also substantial delays in appointment of concurrent auditors at the District level. Current year appointment has been done in the month of November, 2013 only, while it was supposed to be done by March, 2013. The District had already submitted their documents for approval of the State Health Society in the month of June, 2013. But the approval from the State level was received only in the month of November, 2013.
- It is to be noted that state has started Internal Audit which has covered 36 districts already and next 16 districts are proposed in the next round of audit. The team comprises of Internal Auditors and State Finance Managers etc.,

Internal Control Mechanism/ Monitoring

- Overall environment of financial monitoring/ supervision was found very weak.
 - As discussed in the blocks visited, no field visits are not undertaken by block level accountants to the periphery units.
 - Huge Cash withdrawals were noted at SC / VHSNC level (e.g. Rs. 50,000/- withdrawn in Ranhera SC in one go)
 - Cheques issued in the name of ANM husband out of SC bank accounts (Ranhera SC)
 - Most payments at SC / VHSNCs incurred are in Cash.
 - FP incentives to ASHAs are paid in Cash. (Lohwan SC).

- There are wide differences in the physical and financial reporting done in the FMR submitted by the State for October, 2013 under the following heads

Activity	Physical achievement	Financial Achievement
JSSK Diagnostics under MH	62%	5%
Free Referral Transport	55%	11%
Facility Based New Born Care	96%	7%
Accreditation of private providers for sterilization	104%	32%
Life Saving Anesthesia skills Training	100%	16%

Financial Management

Inadequate Accounting/ Bookkeeping

- Manual Accounts are maintained at block level. Although Tally has been installed, it is not being used below district level in most cases.
- No standard upkeep of books of accounts, bills and cash registers was noted. Several weaknesses were noted in the financial and accounting records
 - Instances of inadequate accounting:
 - Filing of vouchers/supporting was not proper, serial numbers not mentioned.
 - Records in Ranhera BPHC, Mathura before 2012-13 was not available.
 - At Mandhata and few other facilities in Pratapgarh, none of the account related registers were provided for perusal of CRM team
 - Pass Books not regularly updated at SHCs (Besaihya SHC, Pratapgarh)
 - Main cash book not maintained at block level (Internal Audit findings).
 - Two Cash books are being maintained of RKS in DCH, Mathura however single bank account is being operated for the same.
 - A difference of about Rs.37000/- at PHC Mandhata, Pratapgarh in the Cash Book v/s Bank Account Statement carried forward from previous years without any reconciliation.
 - Variation found in opening balances of RCH Flexipool (Rs. 120,544/- and Mission Flexi pool account (Rs. 3,575/-) maintained at District, Mathura.
 - Bank Reconciliation Statement is not prepared at any facility below the District level at Pratapgarh District from April, 2013 and cash book was not updated on a daily basis. Therefore, there is no record or statement which can justify the exact financial position of any facility.
 - The District Pratapgarh has hired 22 vehicles for the mobility support for RBSK, School Health programme and for Monitoring work. Tender was invited and 20 quotations were received out of which 3 could not qualify. The parties submitted with the tender a deposit amount of Rs. 15000/- . The list was finalized on 01.10.2013. Ten DD totaling Rs. 150000/- was still lying

with the DHS and not been deposited in bank account and the rest twelve parties had submitted their FDRs with DHS.

Interest Earned is not utilized

- The State/District/Blocks are not utilizing the interest earned under different programmes. The bank interest earned at different programmes at different facilities remain in their bank accounts and is carried forward to the next year as the unspent balance. The GoI guidelines state that the funds received as interest earned can be utilized in the same year under the approved activities.
- For instance, the interest earned at the State level upto October, 2013 is Rs. 6.96 crore and the total interest earned under different pools of DHS, Pratapgarh in 2013-14 is given below:

Programme	Interest Earned (Rs. in Lakhs)
RCH Flexipool	3.57
Mission Flexipool	24.57
RI	0.68
PPI	0.09

Other Issues:

Lack of coordination

Lack of coordination and communication gap was noticed between the facilities entering into agreements /policy formulation and the actual implementing units. (Eg. A letter was issued by the District Health Society, Pratapgarh for execution of minor civil works at the CHCs, PHCs and Sub Centres to be carried out by M/s Hari Constructions under the supervision of Assistant Engineer. An agreement for the same has been entered between the firm and DHS for carrying out the work at the .01 % rate less than standard PWD rates. A deposit of security for Rs. 100000/- was done by M/s Hari Constructions in FDR/NSC with a condition of 'further requity @10% over of above will be deducted from the work schedule and for completion of contract in accordance with terms and contract' at the district. Later on an amount of Rs. 3.00 lakhs were received at CHC Raniganj on 18.02.2013 for AMG/Untied of CHC and APHCs under it. The estimate for the work was submitted by Hari Construction to the CHC as asked. The work was completed and the payment made by the CHC in March. 2013 without any involvement of district official. As informed and discussed with the concerned district officials, the copy of the agreement was not circulated to the CHCs/PHCs which are the implementing units and therefore the above additional condition of 10% requity could not be complied with. Moreover, the work was completed without the involvement of AE as stated and no compilation of any data was available at the district showing the actual cost of work executed by M/s Hari Construction in the whole district and at what rates. And the same case is with M/s Singh agency which had been awarded contract for electric works.

Recommendations

Enhance Capacity of Finance and Accounts Staff

- Vacancies in FM staff at the State, District and Block level need to be filled-up.
- Work-load at the level of block accountant should be re-assessed and data entry work (other than accounts related) should be excluded from his responsibilities. The designation should also be revised from BDAA (Block Data cum Accounts Assistant) to BAM (Block Accounts Manager).
- Systematic and regular orientation of FM staff, particularly at sub-district level, should be conducted. Detailed training calendar should be prepared and sessions should be planned. e-training modules shared by GoI should be used for this purpose.
- The State should ensure adequate dissemination of Accounting Handbooks till implementation level.

Improve monitoring mechanisms

- Monitoring at all levels should be enhanced with emphasis on the following points in order to bring in financial discipline at all levels:
 - Regular field visits from supervisory units (District and block level)
 - Periodical physical verification of Stores and Cash
 - Avoid cash withdrawals and expenditures
 - Ensure monthly BRS at all levels
 - Regular updation of Books of accounts
 - No Current accounts to be allowed

Expedite implementation of CPSMS

- State should take necessary steps to expedite implementation of CPSMS at state and below level.

Allow recurring expenditure out of previous year unspent funds

- State should allow districts and below to incur recurring expenditure (such as, contractual salaries, etc.) out of the unspent balances available from the previous financial year without specific requirement of guidelines/ orders.
- The expenditure against the committed balances should be incurred within the period of 6 months in the next financial year.

Effective utilization of Untied funds

- Orientation of PRI members and Health functionaries at VHSNC/ SC level should be conducted to improve the pace of utilization of untied funds.
- Utilization of untied funds at the sub-district level should be monitored closely by District authorities.
- Unit-wise reconciliation should be carried out within each district in respect of the untied funds released till date, actual expenditure incurred and balances pending in the bank accounts

of the implementing agencies.

- State and District authorities should further ensure that expenditure under untied funds should be booked based on actual expenditure only and not on the basis of funds released.

Closer monitoring of funds released under civil construction

- Unspent balances lying under Civil works should be followed up rigourously by district as well as state authorities.
- Progress of construction works allotted to agencies should be monitored closely and any bottlenecks should be addressed at appropriate levels efficiently.

Ensure compliance with audit requirements

- State authorities should ensure timely appointment of Statutory and Concurrent Auditor and submission of audit reports as per the timelines prescribed by GoI.
- RKS audits should be conducted on an annual basis as per requirement of Societies Registration Act.

Streamline JSY payments at delivery points below block level

- The JSY payments need to be streamlined for delivery points below Block level. Option to disburse cheques on a weekly basis through the official authorized from the block level should be explored.

Improve RKS record-keeping and controls over user charges

- RKS user charges must be timely deposited into bank account (maximum on a weekly basis).
- Emphasize recording of financial proceedings/ estimates in the RKS minutes registers.

Address issues relating to current / multiple bank accounts (wherever applicable)

- Existing current accounts should be closed and replaced with saving bank accounts on an urgent basis.
- Non-operational bank accounts should be identified at the block level on a periodical basis and action should be taken to close the same.

Need to improve inventory management

- Improve inventory management procedures at the facility level including updation of store records, maintenance of store building, adequate stacking of the drugs and consumables.
- Necessary trainings should be departed for this purpose to the store keepers

ToR VIII Medicine and Technology

- Drugs, Equipments and Diagnostics
- Procurement:
 - The medicines were not available at the Pratapgarh District in most of the facilities. As discussed with the concerned officials at the DHS, it has come to notice that the procurement rate contract was finalized at the office of DG (FW) at the State level. The list for the medicines and the rates are circulated to all the Districts. The Districts directly place the order to the agencies for the supply of medicines. However, no monitoring is done at the DG (FW) regarding the supply orders placed by the different districts to the supplier agencies and the actual supply made by them. In most of the cases no supply was given by these agencies and also no intimation was given to the DHS by these agencies regarding the non supply or delay in supply of the medicines. The Pratapgarh District has a huge committed unspent balance under different activities for the supply of drugs and which has not been supplied by the agencies and remains unspent upto October, 2013. These are:

Activity	Committed unspent Balance (Rs. in Lakhs)	Unspent Amount upto October, 2013
JSSK - Budget for drugs and consumables for normal deliveries @ Rs. 350.00 per ND & for C/S @ Rs. 1600.00 per C/S	21.01	21.01 (additional funds given in 2013-14)
Procurement- Iron Tablet and Foliv Acid	10.95	10.95
Post MTP- Drugs for all MTPs including traditional MTPs	1.12	1.12
Rh-Anti D Sera	2.00	2.00
Drugs and Supplies for CH	15.60	15.60
Procurement of IFA & Deworming Tablets for School Health Programme	0.89	0.89
First Aid Box for School Health Programme	28.35	28.35

- In Mathura, there were discrepancies noted in stocks on a test basis (Sohne BPHC, Farha BHPC) and records were also not updated in Sohne BPHC.
- There are no regular system of Physical verification of stocks, Inj. Gentamycin, ORS and Zn available at few SHCs in both districts Instances of shortage of IFA (Mathura) and nnavailability of Inj. MgSO₄ and Oxytocin in Pratapgarh was observed during the field visit. PTKs was issued with Short expiry of in one Block (Sohne Block), Mathura.

- In Mathura, lack of proper stacking /arrangements of drugs in the stores There was also inadequate storing facilities and dampness noted in Store at FRU-Farah block -short receiving of Suferexime.
- EDL was well displayed in most of the facilities visited, however the stock was limited due to the shortage of supply from the identified manufacturer.
- Storage & Supply Chain Management & Quality Assurance
 - Supply chain management system and QA systems for drugs and supplies not in place.
 - A systematic computerized system for drug inventory management and checking stock positions, stock out, usage etc was not in place.
 - No provision of prescription audits in place. Rational use of drugs observed except few instances of augmenting labor by use of oxytocin, Methergin is being used as drug of choice for AMTSL. Supplies like IV fluid and IV Iron Sucrose being pushed at SHC though ANMs are not authorized to use it
 - Annual drug requirement for facilities not being calculated and indenting not done based on expenditure.
 - The districts officials also reported that since there was mostly only one supplier identified by the state hence the supply of medicines is usually inadequate and not as per the indent that they have submitted hence there was shortage as all the district order simultaneously. Thus, rate contracts done for only one company generates pressure and lack of timely of supplies in Pratapgarh

Annexure-I

7 th Common Review Mission -Teams	
Pratapgarh	Mathura
GoI Representatives	
<ol style="list-style-type: none"> 1. Dr Himanshu Bhushan, DC (I/c MH) 2. Sh. Padam Khanna (NHSRC) 3. Dr. Rajeev Vishnoi, RNTCP Consultant 4. Ms Chaitali Mukherjee, PHFI 5. Dr Praveen Bhalla, BMGF 6. Dr Arpana Kullu, NRHM Consultant 7. Ms Isha Rastogi, FMG 	<ol style="list-style-type: none"> 1. Dr A.K. Puri, ADG, Leprosy 2. Dr Biswajit Das, Dir (Evaluation) 3. Dr G.P. Garg, Sr. Chief Chemist –Ayush 4. Ms Anagha Khot, USAID 5. Mr.Gurminder Singh Talwar, TMSA 6. Dr Nimisha, FP Consultant 7. Sh. Vindhesh Kr. Singh, Cons, Finance, SCML, Communicable Disease
State Representatives	
<ol style="list-style-type: none"> 1. Dr Uttam Kumar, AD(DGFW) 2. Dr.Farzana, Assistant Prof, SIHFW 3. Dr.R.C Chaddha, Consultant (NP, SPMU) 4. Dr.Sulbha Swaroop, Consultant, M&E, SPMU 5. Dr.Sandeep, Consultant UPSACS 6. Mr.Arvind Pandey, Div Prog Manager, Basti 	<ol style="list-style-type: none"> 1. Dr.A.P.Chaturvedi, JD(DG FW) 2. Dr.Vikas Singhal, DGM(MH, SPMU) 3. Dr.Bhartendu, Consultant (NPMU) 4. Mr.Devesh Tripathi, Div Prog Manager (Aligarh) 5. Dr.Rashmi Shukla, WHO 6. Dr.S.K.Pandey, RO SIHFW 7. Dr.Ashok Shukla, Asst.Dir, UPSACS

Annexure-II

List of Facilities Visited

Health Facility	Pratapgarh	Mathura	Total
District Hospital	District Hospital-Male & Female	District Combined Hospital, Mathura District Male Hospital, Mathura District Womens' Hospital	2
Community Health Centre	Kunda, Raniganj (Block CHC)	Faraah, Goverdhan	4
Primary Health Centre	Babaganj, Mandhata (Block PHC)	Chatta, Sonai	4
Sub Health Centre	Besaihya, Baraipur, Jariyari	Ranhera, Lohaana, Ol, Ading	7
Urban Health Post	Ajitnagar	Sukhdeo Nagar	2
Village Health and Nutrition Day	Baraipur, Raipur Bhagdra, Kaithola Bazar	Bahai	6
ANMTC		ANMTC Mathura	1
Focused Group Discussion	ANM Meeting, ASHA Training, Home Visits, interaction with women – Post Natal Ward		